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Towards the Implementation of the Long-Term Care Insurance Law in Israel

Introduction by the Director-General of the National Insurance Institute of Israel • The Long-Term Care Insurance Law: Background, Principles and Deployment for Implementation • Vision and Reality • Issues in the Planning of a Long-Term Care Insurance Law for the Aged and the Social Security System in Israel • The Graying Sabra: A Demographic View of the Elderly Population • Approaches to the Long-Term Care Insurance Law and their Cost Implications • The Long-Term Care Insurance Law • Response of Formal Support Systems to the Social Changes and Patterns of Caring for the Elderly • Developing Services in the Framework of the Long-Term Care Law • Evaluating the Needs for Long-Term Care Services and their Cost • The Quality of Institutional Care for the Elderly in Israel: Study and Application • The Organization of Long-Term Services in Israel: An Evaluation • Appendix: Israel's Long-Term Care Insurance Law translated into English.

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This issue of Social Security which is devoted entirely to the Long-Term Care Insurance Law, opens with an introduction by the Director-General of the National Insurance Institute of Israel, Mr. Mordechai Zipori, which has been written especially for this issue. The background of the Law and the deployment for its implementation are discussed in an article by Shlomo Cohen who regards fruitful and sincere cooperation among all state and public bodies operating in the field as the main element in the success or failure of the Law's implementation. This cooperation depends first and foremost on a defined and agreed division of roles among all the factors participating in the Law's implementation.

Professor K.Y. Mann, who headed the committee appointed to suggest principles for the formulation of a long-term care insurance law for the aged, presents in his article the professional controversy and different approaches of the Committee's members and indicates the differences between the principles formulated by the Committee and those which were finally approved in the Law which actually constitutes a compromise between the various approaches. The article of Brenda Morginstin and Nira Shamai deals with the issues which were discussed in the course of the Committee's deliberations and they raise some penetrating questions regarding the implementation of the Law.

The demographic aspect of the Law's target population is discussed in an article by Yaakov Kop who regards aging in Israel as a process and not a phenomenon; he refers to the rapidness with which this process is taking place (particularly as reflected in the proportion of old people aged 75 and over) compared with the age of the State and its consequences for the organization of the system of services.

The financial implications of the new Law's implementation in view of the various approaches which influenced its formulation are discussed by Jack Habib and Haim Factor. The legal aspect of the Law is analysed by Dr. Dan Schnitt, who also refers to the fact that the Law is the result of compromise and therefore contains quite a few defects which are liable to frustrate the lawmaker's intention. He too fears a "budgetary flight" since the Law does not contain any provision to prevent it and some of those whom the Law is intended to assist will have to bear the consequences.

An article by Brenda Morginstin deals with the question of how the formal support systems will respond to the patterns of caring for the elderly compared with the situation in other countries. Here too the great importance of the family is stressed in connection with care for the aged and it is recommended that the formal services encourage care in the community framework and assist it. Dr. Uri Laor discusses the development of the services required for caring for the aged as a result of the Law's implementation, in terms of manpower. He states that there is no doubt that a minor revolution can be expected in everything that concerns the organizational and professional system in order to implement the Law to the letter.

Jack Habib, Haim Factor and Shmuel Be'er discuss the needs of handicapped old people for various services, at present and in future. The quality of institutional care for the elderly is discussed in the article of Rachel Fleishman and her colleagues, whilst Jenny Brodsky and her colleagues deal with the organizational procedures of the management of care for the elderly in the light of the whole system's functioning. The appendix contains the text of the Law.

The Editor

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INTRODUCTION BY THE DIRECTOR-GENERAL OF THE NATIONAL INSURANCE INSTITUTE OF ISRAEL

Mordechai Zipori

"Do not escort me on my last
journey — visit me in my
old home as in former times. Do not
eulogize me after my death —
care for me as long as I live"

Y. Avizuk

Following the final approval of the Long-Term Care Insurance Law and the commencement of its implementation, the National Insurance Institute has the honor of devoting a special issue of "Social Security" to the subject of long-term care. The journal contains a series of articles which cover selected issues in the field of long-term care of the elderly in general and the Long-Term Care Insurance Law in particular, starting with a survey of the various stages of the law's preparation, through a presentation of its main features and a legal analysis of its various aspects, a description of the preparation of the National Insurance Institute towards its implementation in its various stages, a theoretical and ideological analysis of possible alternative models for a long-term care system and concluding with a brief summary of selected research studies on the subject of long-term care carried out in recent years during and following the work of the Public Committee for the Introduction of a Long-Term Care System in Israel, headed by Professor K.Y. Mann. All the articles were written by experts in the field of long-term care of the aged and researchers in the field of gerontology who were involved in one way or another in formulating recommendations for the various stages of the legislation or implementation of a long-term care system in Israel.

As is known, the preparation of the Long-Term Care Insurance Law lasted for six consecutive years, and was accompanied by serious debates on its nature and form in view of the various contradictory professional approaches of the community bodies involved. Each of these approaches is legitimate in itself and has a firm ideological and pragmatic basis. The law that was finally passed is a compromise combining what is common to and agreed upon by all factors, with a partial concession on the part of each Ministry with regard to important elements in its own basic concepts.

The law is essentially a community law and this was not disputed. Benefits to those entitled will be given in the form of services only to old people living in the community, at home and in their natural environment; they will not be granted to anyone living in a nursing home. This basic decision is founded on the approach that a person should not be cut off from his surroundings towards the end of his life if he does not wish to be, and that he should be able to spend a full life in his own home with the assistance of community services. This approach is further strengthened due to budgetary considerations, since the maintenance cost of a person at home who receives supplementary community services, in addition to those supplied to him by his family, is generally lower than that in a nursing home. As a result, community services are faced with the great challenge of developing community long-term services so as to expand their supply and make it possible to maintain people within the community, thus observing the spirit of the law concerning the provision of benefits in the form of personal care services and help in household management.

The experience accumulated during the first year of the law's operation indicates a doubling of the direct services given to the elderly population as a result of the massive allocation of resources from the law's funds. Hence, even if at this time there is still a serious shortage of care manpower to meet expected needs with the full operation of the law in April 1988, a potential manpower reserve exists which has not yet been fully utilized. At present, great efforts are being made to develop and expand long-term care manpower in the framework of existing budgets for services development.

In contrast to other National Insurance schemes, the Long-Term Care Insurance Law will be implemented as the joint responsibility of all State authorities dealing with Israel's long-term care system, especially the Ministry of Labor and Social Affairs, the Ministry of Health and the National Insurance Institute. However, the overall responsibility towards the elderly claimant of rights falls on the National Insurance Institute, which is charged with legal responsibility of the Law's operation. Only real full and fruitful cooperation among all these factors is likely to ensure the proper implementation of the letter and the spirit of the law. The joint work of the inter-Ministerial team established to consolidate rules and procedures for operating the law during its first year, instills hope that these expectations will be realized and that it will be possible to ensure the proper and efficient operation of the law. It is particularly important to ensure that the well-being of the needy elderly person will be the central consideration in every decision, so that he will receive the services in a dignified manner, according to his wishes and preferences, and in particular, that his rights will be fully materialized within the shortest possible time without grinding him between the wheels of an unnecessary bureaucracy.

The National Insurance Institute regards the smooth operation of the law as one of its central aims in the next few years and is giving it high priority in the allocation of all the resources necessary in the professional and administrative fields, in the belief that the efficient operation of the law constitutes an acid test for the attitude of society towards its older members, who until now have been pushed aside in the national scale of priorities. In order to ensure the maximum smoothness of the law's operation, an experimental implementation started early in May 1987 in four selected localities. The purpose was to study on the spot, in the most authentic conditions possible, all the processes, tools and systems to be operated in the law's framework. The experiment will be accompanied by an ongoing research to be carried out by the Institute's Bureau of Research and Planning headed by Yossi Tamir. The tools and various other means will be adjusted and improved insofar as is necessary, according to the experience accumulated in the course of the experiment.

On this occasion, I regard it as my pleasant duty to thank the Minister of Labor and Social Affairs, Moshe Katzav, for his great personal contribution in encouraging, supporting, directing and compromising between opposing positions; without this contribution, it is doubtful whether the legislative process could have been brought to completion.

Thanks are due to all the authors of the articles for their contribution to the development of the long-term care system, and for the efforts invested in the preparation of the papers which made this publication possible.

Thanks are also due to the employees of the Institute who accompanied the preparation of the law in all its stages and who are concerned with it in the implementation stage, especially to Mr. Shlomo Cohen and Mrs. Brenda Morgenstin of the Bureau of Research and Planning, Advocate Shmuel Britzman, the legal advisor, Advocate Simcha Kapitcovsky of the Benefits Department and Mrs. Bracha Ben-Zvi, Director of the Long-Term Care Insurance Branch, who is responsible for the law's implementation.

Special thanks are due to Mrs. Nira Shamai, former Director of the Bureau of Research and Planning, who was among the initiators of the Long-Term Care Insurance Law, and the moving spirit in the Public Committee on Long-Term Care, headed by Professor K.Y. Mann, and, last but not least, to Dr. Arye Nizan, who coordinated and edited the publication and due to whose devotion and perseverence the work has been completed.

Thanks are extended to all the other people in and outside the Institute whose names are not listed here due to lack of space, for their part in and contributions to the preparation of the Law and its current implementation. The full and successful operation of the law will be their reward.

THE LONG-TERM CARE INSURANCE LAW: BACKGROUND, PRINCIPLES AND ORGANIZATION TOWARD IMPLEMENTATION

by Shlomo Cohen*

1. General

In April 1980, the Knesset (Israel's Parliament) passed a framework law for the introduction of long-term care insurance in Israel in the form of a special chapter in the National Insurance Law. The framework law defined in general terms the intention of the legislators regarding the insured population; it also determined the rate of current insurance contributions to be collected from the insuree's income (0.2% of insured income) which was intended to create a reserve for the implementation of the law. As in other insurance branches established within the framework of National Insurance, the framework law provided for the determination of the detailed rules and tests connected with the introduction of a long-term care system in Israel at a later date in the law itself. The Minister of Labor and Social Affairs at the time, Dr. Yisrael Katz, appointed a public committee headed by Dr. K.Y. Mann and composed of representatives of the public and experts in the field of long-term care of the aged to recommend to him a detailed program for a system of rights and duties toward the introduction of a long-term care insurance law in Israel. The Committee deliberated for over two years and in the course of its work had to cope with various professional approaches as well as with a serious lack of basic data on what existed and what was to be expected in the sphere of care of the aged in Israel. A considerable number of research studies which were carried out by the National Insurance Institute and the Brookdale Institute accompanied the Committee's discussions and constituted the empirical and scientific basis for the formulation of its recommendations. The Committee's recommendations were submitted to the Minister in May 1983 together with a report of a small number of the Committee's members (mainly to government representatives) who did not agree with the majority's recommendations on a number of central points.

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* The Bureau of Research and Planning, the National Insurance Institute, Israel

During the time that has passed since the recommendations were submitted, the government Ministries, with the active intervention of the Knesset's Labor and Social Affairs Committee, headed by M.K. Ora Namir, made great efforts to reach a final version of the law, acceptable to all concerned. The consistent and energetic actions of the Minister of Labor and Social Affairs, Moshe Katzav, towards the completion of the legislation, while bridging the gap between the various positions, were finally crowned with success and in April 1986, the new law was enacted by the Israeli Parliament.

In general it may be said that the law which was finally approved remained faithful in its general principles to the basic approaches and concepts recommended by most of the members of the Public Committee but it definitely contained significant changes regarding the scope of the population eligible for benefits, the form in which the benefits would be granted, etc. which were not entirely consistent with the accepted patterns of the national insurance system. This was largely due to the state of Israel's economy and the wish to reach a general understanding and consensus among the various government and public bodies which are at present entrusted with running Israel's long-term care system. In this sense it may be said that the law constitutes a compromise between various ideological approaches and concepts and the practical possibilities of Israel's economy to operate such a system by force of a State law.

A main element in the law's implementation is the connection between and the necessary integration of all the State factors operating in the sphere of long-term care of Israel's aged, particularly the Ministry of Health and the Ministry of Labor and Social Affairs, which will be joined later by the National Insurance Institute as the State body responsible for co-executing the Long-Term Care Insurance Law. The Sick Fund, too, which at present operates within a semi-voluntary framework in the long-term care sphere, will play an important role in implementing the law. In fact, it appears that its proper implementation will not be possible without a joint effort and fruitful and efficient cooperation among all the bodies mentioned which must regard the well-being of the elderly as the main goal and strive towards materializing their rights in the shortest, most efficient and most dignified way.

The law is to be implemented in two stages:

Stage A — started as soon as the law was approved in April 1986 and intends to provide solutions to the problems of those old people suffering from severe functional handicaps and in need of community or institutional services, as well as to develop and extend the infrastructure of long-term care services both in the community and in institutions.

Stage B — which constitutes the main part of the law, i.e, the granting of a personal right to long-term care benefits, will be fully operated as from April 1988. During the two-year period between the approval of the law and

the introduction of personal benefits, the National Institute and the other State factors must complete all the professional, legal and administrative preparations necessary for ensuring the smooth and precise operation of the system.

Following is a short survey of the law's main principles with emphasis on the administrative and organizational aspects involved and the patterns of the system's organization towards the law's implementation.

2. *The Main Points of the Long-Term Care Insurance Law*

The main principles of the Long-Term Care Insurance Law were dictated to a large extent by the forecasts regarding future developments in the number of old people and their composition and out of consideration for the situation of Israel's present services systems for old people and their ability to bear the additional burden expected as a result of the entry of thousands of new entitled persons under the law. The aged population of Israel, aged 65 and over, constitutes at present approximately 9% of the total population, compared with only 4% when the State was established, a fact which testifies that the population is aging at a rapid rate. Today there are about 380,000 elderly people in Israel and according to all forecasts for the next ten years, there will be no significant increase in their relative weight in the total population. On the other hand, dramatic changes are expected in their internal composition which are of considerable importance for the development of long-term care needs.

The proportion of the oldest section of the aged population (75 years and over) will grow at a more rapid rate. Whereas in 1980 this section constituted some 28% of the total aged population (108,000 persons), in 1990 it is expected to constitute 40% of it, i.e., approximately 160,000 persons. This tremendous absolute growth of a population that constitutes the main potential consumer of long-term care service, strongly underlines the necessity of finding speedy and appropriate solutions to the problem of the long-term care of Israel's aged.

The Long-Term Care Insurance Law does not operate in a vacuum, nor does it commence at square one in theory or practice. The Ministry of Labour and Social Affairs, the Ministry of Health and the General Sick Fund have done much up to now to provide service solutions for the personal care of old people and assistance in their household management within severe budgetary limitations with devotion and perseverance worthy of credit. however, budgetary restraints created a situation in which most of the needy population found itself outside the cycle of assistance; the few that managed to benefit from the government aid system did so very meagerly and to an extent that was far from satisfying basic needs. The number of aged handicapped in

their daily functioning and living within the community is estimated to be approximately 30,000 at present. Approximately 5,500 of them (in 1985) are in the formal State and public (including the Sick Fund) aid system, i.e., less than 20% of all potential entitled persons benefit from any assistance whatsoever, and the data at our disposal indicate that the number of assistance hours given to them amounts to only about six per week on the average, which is much less than what is required. The annual expenditure on personal care by all public factors did not exceed $5,500,000 in 1985. For purposes of comparison, the Long-Term Care Insurance Law, when it comes into full effect, will grant personal benefits (in cash and kind) to the sum of $20-25,000,000 per annum. In contrast to the scanty allocations to community long-term care, the situation in the sphere of institutional long-term care is better. In 1985 about 5,500 nursing-care and mentally infirm old people were in public and private nursing homes, and the annual public expenditure on their maintenance was estimated at approximately $40,000,000. Even if these resources did not meet the needs in the institutional sphere, it is clear that de-facto preference was given to the expensive institutional care, while community services were relatively neglected, even though this trend was not the result of an intentional policy.

It is against the background of these basic facts, which represent the summary of a rich store of data accumulated in the course of the Mann Committee's work, that the main principles of Long-Term Care Insurance, as adopted in the law, should be examined as follows:

A. *An insurance law in which all the insuree's rights and obligations are anchored.* This is actually the uniqueness of the new long-term care system as compared with the present system which is defined in budgetary terms in the Budget Law. The law will grant personal entitlement to anyone fulfilling the conditions determined in it and there will be no possibility of denying a person his rights due to a lack of finance. This budgetary framework is defined according to the rules of eligibility determined in the law but once these rules have been determined, every insuree will be entitled to receive all the benefits provided for by the law even if the expenditures exceed the estimated and planned cost. Any change in the conditions of elgibility requires and amendment of the law or the regulations enacted under it. The *scope of insurees* under the Long-Term Care Insurance Law is very wide and includes housewives who do not work outside their households and new immigrants who came to the country after reaching the age of 65. It may thus be said that in fact every resident is insured for long-term care. Eligibility for benefits under the law will apply in the first stage to insured women aged 60 and over and to insured men aged 65 and over.

B. *Benefits to the functionally handicapped*, are intended to help an entitled person who has become dependent on the help of others to carry out

basic daily activities, to improve his personal functioning and to manage his household. In other words, a person's entitlement to a benefit is conditional on the severe impairment of his ability to carry out such basic functions as: washing, dressing, eating, controlling excratory organs, etc. The basic test to determine a person's entitlement is a personal-objective test of his ability to carry out these functions independently. The law determines two levels of benefit according to the severity of the entitled person's functional limitation:

1. A benefit equal to a full disability pension (NIS 319 in April 1987) to a person dependent to a large extent on the help of others in carrying out *most* daily activities or in need of supervision.

2. A benefit equal to 150% of the full disability pension (NIS 479 in April 1987) to a person completely dependent on the help of others to carry out all daily activities or in need of continuous supervision.

The long-term care benefit paid under this law is intended to *participate* in covering the expenses of the entitled person on purchasing long-term care services and it does not claim to cover the total expenditure.

C. *A community — not an institutional law*. The law is based on a clear community approach. Entitlement to a benefit is granted only to an insuree who lives in the community and not to one who lives in a nursing home. For this purpose, a person who decides to live in an open institutional framework such as an old-age home and is not maintained at the public's expense, is considered as living in the community and therefore entitled to a benefit. The community characteristic of the law was generally agreed upon in the course of the preparatory discussions in all frameworks, both in the Public Committee on the Long-Term Care Insurance Law and in the Knesset's Labor and Social Welfare Committee as well as in all other public forums. This approach was based on the principle concept that a person is entitled to spend his last years within his natural environment and should not be cut off from his family and social surroundings towards the end of his days and certainly not be compelled to enter a nursing home.

From the budgetary viewpoint too, preference was given to the community approach, since the cost of maintaining a person in the community and in his own environment is generally less than that in a nursing home due to the readiness of the family to bear part of the burden as is proved by all the research studies carried out on this subject. However, it should be borne in mind that even if the basic approach is a community one, there is no question as to the important role of institutions in the future too as a vital link in the continuum of services for the aged, when sometimes the one and only solution for an elderly person is an institutional arrangement.

D. *A Law of Services*. In contrast to other national insurance branches, Long-Term Care Insurance is based on a law dealing with services and not with financial benefits. A person entitled to a benefit will receive *services* to

assist him to carry out day-to-day activities or provide supervision or household management. The services may be given in the person's home or within the community framework, in accordance with the professional decision of the State bodies dealing with long-term care. A financial benefit will be paid only in cases in which the person lives with a relative who takes care of him or in cases where there are no services available or they cannot be provided at the times fixed by the law. The form in which the benefit would be granted was a controversial issue in the Mann committee, and most of the members were of the opinion that the entitled person and his family should be left with the choice regarding the form of its receipt whenever the old person received efficient and devoted care from a relative (according to the professional assessment of the service employees) and that he should not be forced to receive treatment from external bodies. This approach, as stated, was not adopted by the law and the one accepted was to offer the old people services in all cases. The real test of the law's final nature and form will be in its implementation, a fact that presents the community's treatment factors with a great challenge. If the public-community services, i.e., the Ministry of Labor and Social Affairs, the Ministry of Health and the Sick Funds, will be wise enough to develop an extensive, efficient and flexible system of services to meet the treatment needs of the entitled population, then the original legislative intent will be fulfilled and the law will bear a service-treatment character. However, if the community is unable to meet the demand for services, then the financial alternative will be at the disposal of the entitled and the law will be characterized by the payment of cash benefits. This alone will tell what image the law should acquire.

It should be stressed again that the two-dimensional nature of the law — benefits in cash and in kind which interweave and complement each other — demands a full and joint effort on the part of all community services together with acceptance of joint responsibility for implementing the law in accordance with the spirit and intention of the lawmaker.

E. *Income Test.* Entitlement to a long-term care benefit is conditional on an income test. This is inconsistent with the principles of a contributory-insurance law and constitutes a deviation from the national insurance system of entitlement. The view of the National Insurance Institute, like that of most of the members of the Mann Committee, was that an income test should not be introduced into the Long-Term Care Insurance Law. However, the economic difficulties of the country and the desire to complete the legislation at a time of considerable cuts in welfare services finally compelled acceptance of the income test. The level of income and the rules of the test were not incorporated into the law itself but will be fixed in regulations. However, in all the discussions that preceeded the law's approval it was clear that the test would be generous so that only a small minority of insurees would not be

entitled to benefits. In this context it should be noted that in cases in which the insuree is entitled to a financial benefit, the latter's granting will depend on the *income of the relative living with him and caring for him* — a precedent without parallel in National Insurance laws, that makes an insuree's right conditional on someone else'e income. Even if the number of persons affected by this provision is small and insignificant, the damage caused to National Insurance ideology and principles is great and completely superfluous.

F. *Financing the System.* The benefits paid under the law will be financed from the current collection of insurance contributions and from the fund accumulated for the branch since contributions began to be paid in April 1980. Current collection, at a rate of 0.2% of income, liable to insurance contributions, amounted to approximately NIS 33 million in 1986 and the accumulated reserve of the branch amounted to NIS 270 million at the end of the 1986 financial year. Expenditures within the law's framework on payment of personal benefits and other objectives laid down in the law will grow gradually from approximately NIS 23 million in 1986 to an annual average of approximately NIS 55 million (at 1986 prices) when the law is fully implemented, assuming full materialization of rights. Hence it may be assumed that the resources accumulated to date plus future expected current collection will suffice to finance all expenditures for at least the next seven to eight years and there will be no need to raise insurance contribution rates during this period above the rate of 0.2% collected at present. In this context, it should be noted that during the legislative stages of the law, it was strongly feared that when the law would come into effect, sums presently earmarked for long-term care within State and other public bodies' budgets would be reduced. All State and other public bodies faithfully promised that no such negative development would occur and that they would continue, in the future too, to preserve the real value of their budgets so that the Long-Term Care Insurance Law's budgets would constitute a net addition for the expansion of long-term care services. This undertaking was not explicitly and unequivocally expressed in the law and only the future will tell whether this declaration of intent will in fact be realized.

3. *Stages of the Law's Implementation*

The law is to be implemented in two stages, the first immediately after its passing in April 1986 and the second in April 1988. *In the first stage*, the system of personal benefits is not operated; it is, however, possible to transfer money to aims defined by the law to the following amounts and under the following conditions:

A. *To expand the scope of services for personal care and domestic help:*

A sum of NIS 3 million (at March 1986 prices) was allocated in the first two years (1986 and 1987) for each of the two Ministries — Health and Labor and Social Affairs. These sums were intended to help in cases of severe functional disability among the population treated by these Ministries, in accordance with their accepted rules and conditions of assistance. The allocations to these Ministries will be ceased in April 1988 when the law's system of personal entitlement goes into operation.

B. *To increase the number of persons treated in long-term care institutions*: The law allocates each year to each of the two Ministries — Health and Labor and Social Affairs — resources equivalent to 15% of the total annual collection in the long-term care branch. In 1986 the allocation to each Ministry for this purpose amounted to approximately NIS 5 million. This allocation was meant to alleviate the existing hospitalization plight considering that over 1,000 elderly nursing patients are waiting to enter a home and no solution exists due to lack of budgets. This is the case with infirm old people who also need to be hospitalized in an institution.

C. *To develop community and institutional services* was another aim for participation by allocations under the Long-Term Care Insurance Law as soon as it was passed. As stated, the law gives preference to the granting of services to persons entitled to benefits, and supreme importance is to be attached to the accelerated development of community services for personal care and domestic help in the course of the first two years following the law's approval, prior to the operation of the personal benefits system. The budget devoted to this aim during the first three years is 20% of the total annual collection of the Long-Term Care branch, and in the following years it will be reduced to 10% of annual collection. In 1986 the allocation for this purpose amounted to NIS 6.6 million. Recommendations for development plans and orders of priority for developing community and institutional services are submitted by a statutory national committee on long-term care affairs whose composition is determined by law. The *second stage*, the introduction of personal benefits, which is the very heart of the law, will come into effect in April 1988.

4. Stages of Preparation and Organization for the Implementation of the Law

As already stated, the law came into effect gradually, immediately after its approval in April 1986. The numerous amendments introduced into the draft law during the legislative process and the uncertainty regarding its final form until the end of the legislative process prevented the National Insurance Institute from preparing itself in good time for its operation, and it became necessary to mobilize considerable resources in order to keep up with the

dates fixed in the law for the various stages. As regards the main stage the introduction of personal benefits, two years were apparently given for getting organized, but it is already clear that due to the great complexity of the law and the need to cope with varied and complicated problems, most of which are new and of a kind which have so far not been experienced or examined empirically in Israel, a tremendous effort will be needed on the part of all the units of the National Insurance Institute and other State bodies participating in the law's implementation in order to keep to the timetable determined in the law. The National Insurance Institute is giving first priority to this matter and the experience accumulated up to now in the work done jointly with the Ministry of Labor and Social Affairs, the Ministry of Health and the Sick Funds leaves room for hope that this mission will succeed.

Following are details of the main activities carried out till now and the ones expected to be carried out in the future in order to ensure the attainment of this important target.

A. *Establishment of a Long-Term Care Insurance Branch.* At this stage an infrastructure of manpower was established for the Long-Term Care Insurance branch which included a small and proficient team with previous experience in dealing with similar problems at the Institute. The team's task is to prepare all the professional and administrative arrangements for the full operation of the law in April 1988 and coordinate all joint activities required with other units in the Institute and with other bodies concerned outside the Institute. The preparation required actually encompasses all the spheres, starting from the formulation of the operative provisions of the law's various articles, drafting of regulations as the law requires, construction of the administrative mechanism for examining and materializing entitlement on all levels and at all stages, preparation of a training system for the various functions participating in the law's implementation, development of computer programs, preparation of the set of forms to be used at all stages of the process, crystallization of the system of payments of the various types of benefits and the like. With regard to all these functions, general responsibility is placed on the branch but it is shared by many operative units within the National Insurance Institute as well as government Ministries and other public bodies involved in the law's implementation. All coordination, concentration and creation of the necessary contacts and connections are done by the branch according to a detailed work program drawn up by the National Insurance Institute.

B. *Establishment of an inter-Ministerial team for coordination and crystallization of the system.* A team was set up consisting of senior and authorized representatives of the Ministry of Labor and Social Affairs, the Ministry of Health and the National Insurance Institute to consolidate viewpoints regarding all the professional sections of the law and ways of their implemen-

tation, agree on concepts and design processes, procedures and ways of operation. During discussions of specific issues, representatives of other public bodies such as the Sick Fund and the Local Government Center also participate in the team's meetings. The team generally agrees on proposals after they receive the blessing of the various Ministries' directorates as well. In cases of disagreement, the issue is submitted for decision to a joint forum of the highest echelons of the various Ministries.

C. *Guidance committee of the National Insurance Institute.* The branch's work is accompanied regularly by a guidance committee set up at the National Insurance Institute, headed by the Director-General and consisting of representatives of all the functions in the Institute whose involvement is vital to the proper operation of the law — mechanization, branch offices, research, treasurer, organization and methods, as well as medicine, advice to the aged, etc. This committee has an overall view of the activity being undertaken, solves problems and questions in dispute and subject to decision, and directs all activity in accordance with the desired orders of priority and the work program. The decisions of this committee generally express the final position of the Institute.

D. *Establishment of the National Committee for Development.* As mentioned above, the law states that recommendations regarding the financing of development plans by the development budgets of the Long-Term Care Insurance Law shall be submitted by a national committee whose composition is determined by the law. This committee, which consists of senior representatives of the government Ministries, Sick Funds, experts in the field of long-term care for the aged and representatives of other public bodies dealing with long-term care; convened for the first time in December 1986 and set for itself guidelines and criteria for approval of development projects. Preference was given to development plans aimed at increasing manpower for the home-care of the aged such as home-care personnel, domestic helpers, treatment centers for the aged, etc. since the principal aim of the law is the provision of services for the aged. If the supply of services is not increased rapidly until the full implementation of personal entitlement, it is to be feared that entitlement will be materialized in the form of cash benefits, in contrast to the legislative intent. As regards the development of institutional long-term care services, the committee decided to fit into the framework of the multi-annual national plan for the development of nursing beds and to avoid a parallel development of an institutional system which is liable to distort the overall needs in this area. Up to now, the committee has discussed and approved a plan for a considerable increase in the number of home-caregivers employed by the Matav organization. It has also approved an allocation for the gradual development of nursing beds based on a plan submitted by the Eshel Association which is part of the national plan in this sphere.

E. *Establishment of a Long-Term Care Committee of the National Insurance Institute's Council.* As is the practice in all national insurance branches, a branch committee of the Council was set up for the Long-Term Care Insurance Law. Its task is to advise the Minister of Labor and Social Affairs on matters of legislation, regulations, agreements, experimental prospects and other tasks arising from the National Insurance Law. The Committee has already convened a number of times and has generally given its blessing to the initial organizational and preparatory activities undertaken.

F. *Formulation of rules and procedures for allocations to government Ministries under the law.* As stated, the allocations for expanding community and institutional services are for immediate execution. The law states that these sums are subject to reporting on the use of moneys allocated. The National Insurance Institute together with the Ministry of Labor and Social Affairs and the Ministry of Health have formulated rules and procedures for reporting on the expansion of activities in the various spheres and the financing of this expansion with the intentiona that the money allocated under the law should finance a real increase in the scope of the services and should not replace existing State budgets. The basic principle underlying the reporting system is that money is transferred only to finance additional care units to those supplied in 1985, the base year for comparison purposes. Thus, for example, money was allocated for expanding personal care services in 1986 but only for the incremental hours of direct treatment supplied by the Ministry of Labor and Social Affairs and the Ministry of Health, above those supplied in 1985. This was also the case with expansion of hospitalization services in nursing homes where the unit of measurement is the "hospitalization day" and money was allocated only for financing the actual increase in the number of hospitalization days.

The data regarding implementation for December 1986 indicate a considerable expansion in the scope of the community and institutional services supplied to the aged both in terms of the number of elderly who benefitted from long-term care services and in terms of the average number of care-hours supplied per old person. This phenomenon perhaps leaves room for hope that despite the existing lack of long-term care manpower, the care capacity of the existing manpower has not been fully exploited and the direction of resources to this objective, if accompanied by the proper management and organization of the community bodies, can definitely produce tangible results in the field.

The data on the expansion of services for help in household management, for which the Ministry of Labor and Social Affairs is responsible, reveal that in April-December 1986 the number of help hours increased from an average monthly level of 43,000 in 1985 to an average monthly level of 79,000 in 1986 — an increase of about 85% which was reflected both in a

widening of the circle of people entitled to help by some 13% as well as an increase in the average number of monthly hours per person by approximately 65%. A similar development was found in the sphere of personal care in the community too. The total number of hours of personal treatment given by the Ministry of Labor and Social Affairs rose from a monthly average of 12,700 in 1985 to 20,500 in April-December, an increase of approximately 60% which also stemmed from a 20% rise in the number of new persons treated and an increase in the number of care hours supplied per person.

The data concerning the part of the Ministry of Health also point to a steep rise in the amount of personal care services. The number of care hours financed by the Ministry is estimated to have increased from an average 32,000 per month in 1985 to 80,000 per month in April-December 1986, an increase of 150%. In fact, all the resources allocated under the law for the expansion of long-term care services in the community are expected to be fully utilized by the Ministries, a fact that reflects the efforts made by the community services to find solutions for the growing needs of the long-term care population living within the community. As regards allocations to long-term care hospitalization, the number of hospitalization days financed by the Ministry of Health increased from a monthly average of approximately 95,500 in 1985 to approximately 103,500 in April-December 1986, an increase of about 8.3%. During this period, institutional solutions were found for some additional 300 old people with the aid of the law's allocations, a fact that helped to shorten the list of those waiting for an institutional arrangement, whose number today is approximately 1,000. The picture is different with regard to the meeting of the institutional needs of the infirm aged for whom the Ministry of Labor and Social Affairs is responsible. Until now, no use has been made of the money earmarked for this purpose due to absence of agreement on the updating of the tariff per hospitalization day in private institutions which, due to the low level of the tariff, are not willing to absorb old people directed to them by the Ministry. It seems to us that this problem must be solved immediately since it is intolerable that funds earmarked for such an important purpose should remain unexploited for any length of time.

5. *Processes of Entitlement Determination and Materialization*

The overall responsibility for operating the law lies on the National Insurance Institute, but the special nature of the law and the mutual relationships between benefits in cash and in kind in fact dictate the joint responsibility of all the State bodies while defining the division of functions among them. On the other hand, the involvement of numerous bodies in the process is liable to lead to unnecessary clumsiness, prolongation of the processing of claims and unnecessary delay. Great importance is thus to be attached to

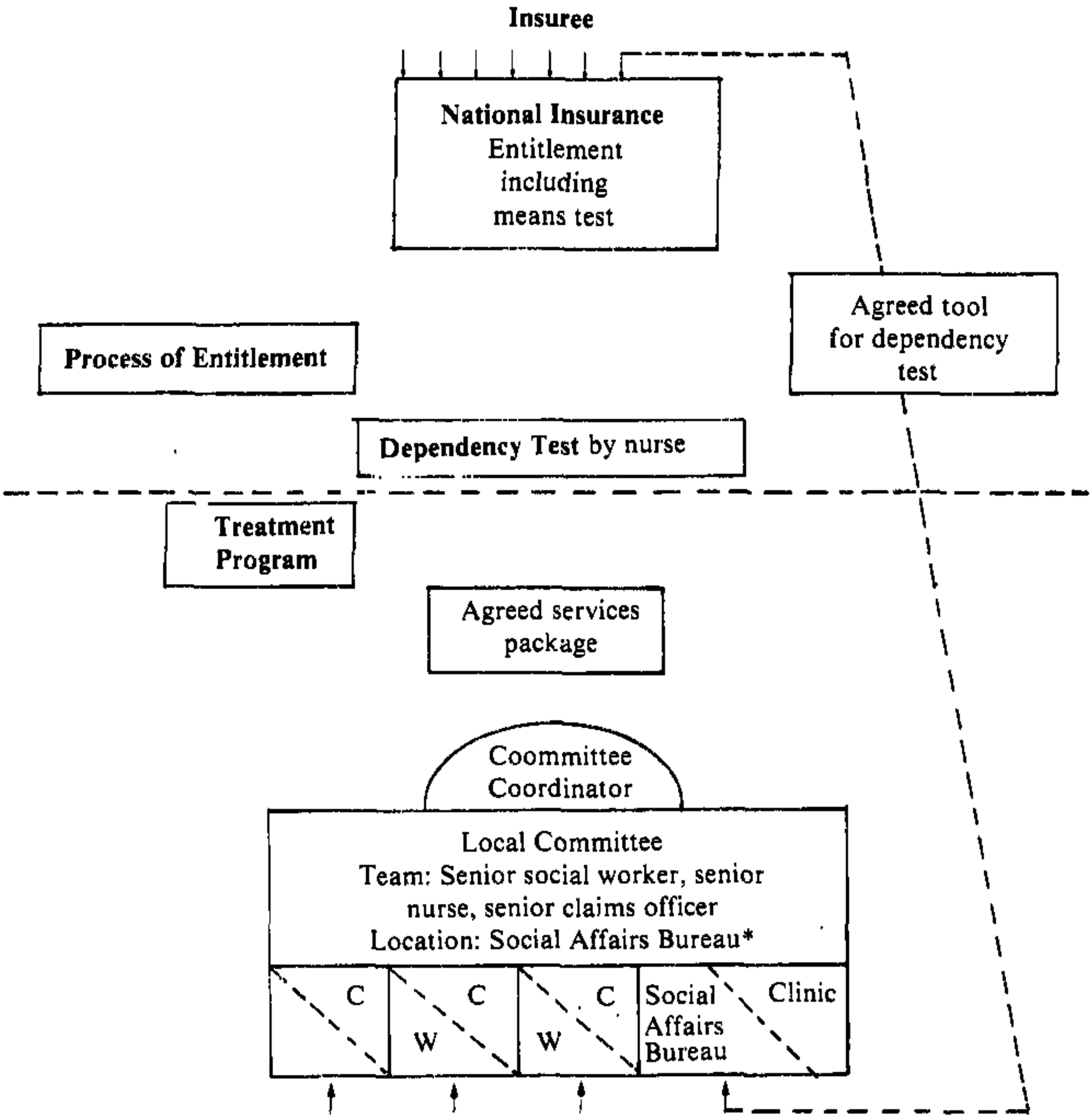
determining a uniform and well-defined process which will not be subject to different interpretations and local changes. At the background of all this is the estimate of approximately 30,000 old people with some functional disability who are potential claimants to a benefit. The system must prepare itself to examine the entire population even if the rules of entitlement in the law enable the granting of benefit to only a third of it, i.e., approximately 10,000 people.

I believe that the administrative system to be set up must relate to the following issues:

a. The determination of uniform criteria for dealing with claims and the limitation of discretion to the necessary minimum, in order to ensure full equality before the law to every resident regardless of his domicile.
b. Completion of the process of entitlement examination and materialization in the shortest possible time. This definitely presents a problem in view of the complexity of the law and the processing stages determined by it.
c. The finding of rapid solutions for the population in distress and the examination of the possibility of granting "intensive care" to particularly severe cases with the necessary caution in order not to disrupt the regular processes.
d. An overall view of the long-term care and other needs of the aged together with an effort to maintain a maximum degree of coordination and integration among all the community bodies dealing with the matter. Reduction of the present fragmentation and prevention of duplicity are one of the important aims of the organizational system in materializing entitlement in accordance with the law.
e. A defined and agreed division of functions among the various bodies partners to the operation of the law and the creation of skills and expertise for each function. It appears to me that this issue is the key to the success of the law's operation. The organizational system for implementing the law is at the center of the discussions of the inter-Ministerial professional committee consisting of senior representatives of the operative government Ministries and public bodies in the long-term care sphere. These discussions have been going on for many months with the intention of reaching agreement on a formula which would be acceptable to the directorates of the various organizations and would constitute the central link in the law's implementation.
f. Easy access to the various systems in order to materialize entitlement. The geographical proximity of the old person's residence to the various stations of the process is of great importance due to the low level of mobility of this population.

It appears that the proposals that have been consolidated with the agreement of all the Ministries, whose principles are concisely described

Long-Term Care Insurance Law — Process of Dealing with Claims (Schematic Description)



* In small localities with few entitled people, the team will be located in the National Insurance branch office. The diagram was prepared by the Long-Term Care Branch, the National Insurance Institute.

below, are capable of offering a suitable solution to the problems presented above.

1. *Non-dependency test*. Agreement was reached regarding the nature of the test which will be carried out at the old person's home by a registered nurse and will focus on the old person's ability to carry out the daily activities defined in the law (washing, eating, dressing, mobility, control of excretory organs, etc.) and the need for supervision. The results will be summarized and translated into a level of entitlement to benefits. In general, the test to be used is the ADL test which is accepted in Israel and abroad and is used with success in the special services system in the framework of the Disability Insurance Law. Emphasis will be placed on the role of the nurse in the examination of the functional capacity of the old person, i.e., on an objective professional examination of his personal capability of carrying out daily activities with the specific means and arrangements to which he resorts or the assistance that he receives from his relatives and others in order to improve his condition. The introduction of an objective examination based on a uniform and defined method will ensure an equal attitude and uniform criteria for every claimant regardless of his specific place of residence.

2. *Long-term-care service*. The Long-Term Care Insurance Law is not meant to cover all the needs of the elderly population but focuses on one part only, which is most important in itself, and which is defined in the law. Long-term-care services, as defined by the law, are services intended to extend assistance in carrying out daily activities or supervision or household management. The law does not go into details of the services included in this definition in order to leave a certain amount of room for maneuvering according to the needs and the professional decisions of the community organizations. Nevertheless, this matter cannot be left open to the exclusive discretion of the professionals in each locality or region. The inter-Ministerial team therefore formulated a definition of the "services package," the framework of which gives a certain freedom of action to local factors to decide on the types of long-term services most suitable for the old person in question, considering the latter's wishes, the services already being supplied to him, the family's preferences, etc.

Obviously, all these services must be strongly linked to the functional situation of the old person in question and are meant to help in the direct care of the latter as decreed by his condition. The agreed "services package," including personal care, help in household management, supervision, transportation to wherever the long-term care services are given (excluding transportation for purposes of medical services), laundry and diapers for old people who have no control over their excretory organs. There is a certain degree of flexibility within the package's framework, according to the specific condition of the old person and his family but in principle it is clear that most

of the services must be given in the form of personal care hours, domestic help and supervision according to the spirit of the law. The determination of the services package in such a way is consistent with the basic principle of a uniform system of rights, equal for everybody, with local discretion reduced to a necessary minimum.

3. *The processing of claims for benefits.* According to the law, the process of materializing entitlement to benefits consists of two stages.

Stage A — Determination of entitlement to the benefit;

Stage B — Materialization of benefits — preparation of a treatment plan.

The distinction between these stages also stresses the need for a division of functions among the various bodies participating in the claims processing, as formulated and agreed by the inter-Ministerial team and as illustrated in the diagram attached herewith.

Stage A is the exclusive responsibility of the National Insurance Institute. Any claim submitted at a branch office of the Institute will be examined for fulfillment of the preliminary conditions fixed in the law (insurance, income test, qualifying period, etc.). The functional capacity of the applicant will be tested and if his degree fo dependency on others reaches the necessary level, the Institute will confirm his actual entitlement to benefits and its level (high or low). The dependency test, according to the agreed instrument, will be carried out by a nurse, but the Institute does not intend to establish a new staff of nurses for this purpose. It will use the existing services of the Ministry of Health which will be responsible for making the functional tests by means of public health nurses who already exist or will be trained especially for this purpose under the Ministry's guidance and vocational training. Obviously, the Ministry may also, at its professional discretion, use professional manpower outside its own organization. In this connection it is worth noting that in the course of their long discussions, the inter-Ministerial committee voiced the opinion that from a professional point of view, it is preferrable to separate the dependency test function from the direct treatment function. In other words, it is not desirable for the nurse who gives the functional test to be the family nurse who knows the old person and treats him regularly.

Stage B is the stage of entitlement materialization, preparation of the treatment plan and arrangement of the services supply. The law states that a professional local committee consisting of representatives of the health and welfare services and the National Insurance Institute in the locality will determine the specific treatment plan of each elderly person and see that it is executed. The committee's task is also to determine that there are no long-term care services in the locality and thus the person entitled has a right to receive a monetary benefit from the Institute under the circumstances defined in the law. The coordinator of the local committee shall be the social worker of the local welfare bureau who is also responsible for the committee's func-

tioning and passing on its decisions to the National Insurance Institute. The proposed system offers immediate solutions to cases of exceptional hardship (the arrows at the bottom of the diagram), according to which in special circumstances and according to the rules to be made, the local bodies — the welfare bureau of the clinic — are permitted to commence treatment on the spot of elderly people needing urgent help before completion of the entitlement examination process. On its completion, the benefit will be paid retroactively from the time that entitlement began if the person in question is entitled to a benefit; if not — the community body will bear the cost from its own long-term care budgets. It seems that the proposed administrative plan will define the sphere of responsibility of the various bodies and thus prevent unnecessary friction.

4. *Dispersion of the local committees.* The target population is characterized by its high level of disability and limited capacity of mobility; it is therefore most important to avoid moving the claimant far and frequently. In other words, easy access to the bodies dealing with the claims is essential in the case of this population group. The inter-Ministerial committee's members were aware of this question even though it is problematic and complicated due to the fact that there is no uniformity in the dispersion of the various Ministries' service units. The Sick Fund's services are spread out over 1,200 clinics throughout the country and there are over 200 social service bureaux whereas the National Insurance Institute extends full services in seventeen branch offices and partial services in a similar number of sub-branches. Any attempt to spread local committees over a wide area will involve considerable administrative expenditure which will bite off large portions of budgets earmarked first and foremost for supplying direct long-term care services. The compromise reached was that there will be only 33 local committees in the complete classic model — including a committee coordinator from the social services bureau — which would hold their meetings at the bureau in 21 settlements, thereby covering approximately 80% of the elderly population. In the remaining settlements where about 20% of the elderly population live, the committee's set-up would be slightly different. The treatment plan will be prepared in each settlement by the local social workers in the medical and welfare fields and because of the small number of cases expected in these localities, the committee will meet formally at the National Insurance Institute branch office nearest the settlement.

6. Experimental Operation of the Long-Term Care Insurance Law in Selected Settlements

The complexity of the law, the multiplicity of bodies operating within its framework, the new professional and administrative aspects contained in it,

which have not been tried or tested in the past, all led the National Insurance Institute to the conclusion that the countrywide operation of the proposed system in April 1988, without preliminary examination and experimentation in the field, would be liable to cause blunders and confusion when implementing the law which could not be easily corrected.

It was therefore agreed by all parties to carry out an experimental operation of the proposed system's components in four localities: Rehovot, the Be'er Tuvia Regional Council, Yehud — a development town — and Kfar Kassein. The experiment is to be carried out, as far as is possible, under authentic conditions, including the introduction of personal benefits in cash or in kind, and the research team of the Institute's Bureau of Research and Planning will accompany it in all its stages. The research is to refer to the proposed system's administrative and professional aspects such as: duration of the claim processing in each of its stages, the form of the local committee's operation in both the proposed models, the contribution of each of the professional functions to the process, examination of the "services package" and the possibility of supplying care services, the patterns of assistance preferred by old people and their families, the degree of satisfaction with the services supplied, the amount of those entitled to benefits in various cross-sections of demographic and economic variables, etc. The experiment is to be dynamic so that all the processes can be amended and improved in the course of its execution, after the professional steering committee accompanying the experiment has examined their significance and decided on the necessary adjustements. In parallel to the experiment, the Institute's preparation is to be completed, in the light of the findings reviewed from the experiment, in the sphere of the manpower required for the countrywide operation of the law, the required logistics, the preparation of the computerization, the formulation of a training program for manpower at the various levels, preparation of the Institute's local branch offices and the social services bureaux for the "smooth" reception of the law, etc. The experiment began in May 1987.

7. *Summary*

The Long-Term Care Insurance Law presents Israeli society with the important challenge of solving one of its severest problems which will become more and more serious in the future as a result of the aging of the population and its demographic developments. The successful operation of the law will depend on the fruitful and reliable cooperation of all State and public bodies operating in the field and the mobilization of the human, administrative and professional resources required. The joint work of the various bodies during the past year leaves room for hope regarding the chances of success of the system's operation. Nevertheless, it is clear that the law is only the beginning

of the comprehensive State treatment of elderly people in the community and refers to one link only in the total complex of needs of the aged. One should, therefore, avoid fostering illusions that it will alleviate all the hardships and difficulties of the elderly, which is a population group that deserves the fair, sympathetic and warm attitude of society and its authorities. It is a small opening which, hopefully, expresses a positive change in the State's attitude toward its treatment of elderly people in the future.

THE LONG-TERM CARE INSURANCE LAW — VISION AND REALITY

by Professor Kalman Ya'akov Mann*

1. Introduction

The steep rise that occurred in the number of old people in Israel, who today constitute approximately 10% of the total population, and the social, economic and medical problems that afflicted them, caused the Minister of Labor and Social Affairs at the time, Dr. Yisrael Katz, to advise the Knesset (Israel's parliament) to set up a committee to formulate guiding principles for a long-term care insurance law for the aged in Israel.

It was hoped that this law would lighten the organic, emotional and social burden borne by Israel's elderly population. In addition, the Minister of Labor and Social Affairs agreed to transfer, as of April 1, 1980, 0.2% of workers' incomes to a special fund which would form a basis for the operation of the Long-Term Care Insurance Law upon its implementation.

The Knesset approved these proposals and in August 1980 passed the framework of the Long-Term Care Insurance Law as a special chapter in the National Insurance Law (The National Insurance Law Amendment No. 42) 1980. At the same time, the Minister of Labor and Social Affairs appointed a committee of 23 members — some of whom were experts in the field of geriatrics and other employees of State and public institutions operating in this field. The Committee, which was assisted by research projects and surveys carried out on its behalf by the National Insurance Institute and the Brookdale Institute of Gerontology, submitted its recommendations to the Minister of Labor and Social Affairs in May 1983, i.e., about three years after its appointment.

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* Chairman, the Committee to Propose Principles for a Long-Term Care Insurance Law; formerly Director-General of the Hadassah Medical Organization; Chairman of the Department for the Organization and Administration of Health Care of the Hebrew University-Hadassah Medical School
The author thanks all members of the Committee and the National Insurance Institute for the many hours that they devoted to the discussions and the preparation of the Committee's report as well as to the preparation of the law which was passed by the Knesset on April 7, 1986.

On receiving the Committee's report, the various government Ministries — Labor and Social Affairs, Health, Treasury and the National Insurance Institute — began to discuss its recommendations. However, only towards the end of 1985 was a draft Long-Term Care Insurance Law formulated. The law, which received the support of the government, was based on a number of principles which diverged from those determined by the Committee. The bill was submitted to the Knesset in January 1986 and the law was finally passed on April 7, 1986.

There is no doubt that the Long-Term Care Insurance Law is one of the main pillars of social security in welfare states in general, and in the State of Israel in particular. It is therefore interesting to analyze the evolution of the present law through its various developmental stages. Obviously, the Committee's discussions and recommendations were guided mainly by professional principles, whereas the government's discussions and final recommendations were formulated against the serious economic background prevailing in Israel. The suggested analysis of the present Long-Term Care Insurance Law should be a most instructive exercise for students and experts in the field of social security. Accordingly, we shall study the professional principles that guided the Committee in its recommendations and compare them with the final product submitted by the government to the Knesset early in 1986.

2. The Principles Which Guided the Committee in Its Discussions and Recommendations

The Committee proposed the Long-Term Care Insurance Law be based on the following principles:

a. The duties and the rights of the elderly to receive financial benefits or services in kind should be determined by law and not be subject to the discretion of officials operating according to the guidelines of one or other government Ministry.

b. The financial sources for providing services in cash or in kind to the aged should be drawn from the population's insurance contributions as a percentage of its income which could provide the suggested services.

c. Services in kind and financial benefits should be granted only to those old people who are in need of long-term care and the help of others as a result of an impairment in their functional capacity due to organic, psychological or social reasons.

d. The services and benefits to be granted to old people within the framework of the Long-Term Care Insurance Law should be given *in addition* to the services already provided to them at present by the various government Ministries, local authorities and sick funds and not as a substitute for existing budgets and services.

e. The services and benefits should be granted to the aged in order to enable them to continue functioning *at home* and within their *family* framework which is the most convenient one from a financial and psychological point of view.

Only in the last stage of one's life, when one is no longer able to function within the family, should this assistance be extended to include entry to an old-age home or admittance to a hospital which are the most expensive and artificial links of health care.

f. The benefit to be given to the aged or their families should be essentially a financial one in order to encourage the family to bear the burden of caring for their aged with the help of intra-family forces or by services purchased outside the family circle. It is only in cases in which the family cannot supply these services to their aged that the Committee agreed to transfer the financial benefit to one of the authorities supplying them to the local *community*.

g. The Committee recommended that the burden of the insurance for services in kind and financial benefits be divided among the employer, the employee and the government with each contributing initially 0.25% of the monthly income of the insured employee. Furthermore, the Committee proposed that 25% of the money received regularly each year and 50% of the fund accumulated from the transfer of 0.2% of the employers' and employees' incomes since April 1980 be set aside for the development of services and manpower in the community and institutions serving the elderly. The suggested initial current insurance percentages and the percentages to be set aside for the development of services and manpower would be reviewed in the light of the experience gathered in the course of the first three years of the law's operation.

h. The assistance to be provided should include personal help in washing, dressing, eating and the like; as well as in operating the various home systems and developing the physical and human elements in community and institutional services.

i. The assistance to be provided to the elderly or their families should not be conditional on an analysis of the person's or his family's income. The Committee regarded this assistance as stemming directly from the insurance of the person in question and thus an assistance to which he is entitled regardless of his or his relatives' incomes.

j. The Committee proposed that the National Insurance Institute should be the institute which will determine the insuree's entitlement to benefits in kind or in cash. The National Insurance Institute should also be the body that would transfer the money to the insuree, his family or the supplier of the service.

k. In order to make it easier for the old person and his family, it was

proposed to establish in each region a committee consisting of representatives of the various authorities operating in the region, while the National Insurance Institute would determine the entitlement of the "client" to the services provided either by the old person and his family or by one or more of the authorities operating in the region. The regional committee would follow up and determine whether the assistance promised has indeed been provided.

The committee would also collect data on the elderly population in its region and formulate its special needs. These would be reflected in the region's annual budget which would be submitted to the Supreme National Committee for approval. The latter would determine the policy of assistance to the aged throughout the country, the percentages of insurance contributions required to implement this policy, the State allocation to this purpose and the distribution of the grants among the country's various regions.

l. The amount of the financial benefits and the volume of services supplied could be expanded or contracted according to the needs of the insured population and the financial and manpower resources that the State is willing to place in fulfilling these aims. These changes would be anchored in amendments to the Long-Term Care Insurance Law.

3. *The Principles Which Guided the Final Crystallization of the Long-Term Care Insurance Law*

We shall now study the principles which guided the various government Ministries in the formulation of the Long-Term Care Insurance Law; which was submitted to the Knesset in January 1986 and passed on April 7. 1986.

a. The duties and rights of the aged should be determined by law. This principle was accepted by the government.

b. The principle that the financial sources for implementing the law should come from insurance of the population for long-term care in old-age was also accepted.

c. The government also agreed that services in kind and cash benefits should be given only to those old people who need the help of others in their daily functioning.

d. The government and the Knesset accepted the principle that long-term care insurance funds be added to the government budgets allocated at present to long-term care, yet the law does not contain firm guarantees that this intention will actually be carried out and that there will be no "flight of budgets" following the introduction of the Long-Term Care Insurance Law. These fears arise from the fact that already within the present framework of the law, large amounts of money are transferred to various government Ministries to finance current maintenance services and current operations which by their nature should be financed from the State budget and not from the

monies received from the Long-Term Care Insurance Law. Expenditure of this kind amounts to approximately $8 million during the first two years to expanding the scope of services for assistance in personal care and household management; another $45 million will be taken in the next ten years to increase the number of patients in nursing homes. In addition, about $20 million will be allocated during the next decade for developing the infrastructure of community and institutional services. This expenditure of $20 million is indeed the only one which is consistent with the recommendations of the Public Committee on the Principles of Long-Term Care Insurance.

e. The government accepted the principle that the assistance granted to old people under the Long-Term Care Insurance Law should enable them to continue to live at home and is intended to help the family to continue to bear the burden of care of their aged.

f. Despite the government's recognition that the home should be the main framework for the care of the aged, it did not consider the cash benefit as a factor capable of helping the old person to stay at home or encouraging *the family to coninue to bear the burden of his care and thereby deter the old* person and his family from exerting pressure on State and public institutions to establish extensive and expensive community and institutional services which would supply the care provided at present by the family. There is no doubt that this approach of the government to give priority to services and not to financial benefits will lead to the establishment of extensive and expensive community and institutional services, as against the cheap and natural frameworks of the home and the family.

g. The government did not accept the Committee's recommendation that the burden of insurance be divided among the employer, the employee and the Treasury. In the meantime, only employees and employers will continue to contribute a total of 0.2% of their income to long-term care of the aged.

This payment will bring in approximately $15 million per annum to the insurance fund, which is a meagre sum considering the needs of a population group constituting 10% of the country's citizens whose requirements are unaccountably greater than those of the general population. This sum represents only 0.07% of the total State budget — a minute amount earmarked for *the welfare of citizens who devoted their best years to the advancement of the* State and have reached the end of their lives without the State recompensing them adequately for their contribution to it.

h. In its draft law, the government recognized the need to grant assistance to the aged in personal care, household management and the development of community and institutional services with respect to both their physical facilities and manpower. In fact, the government in its present law expands the scope of assistance and includes in it the maintenance of the aged

in the community and of additional beds for the aged who need long-term care. The government hopes to achieve this comprehensive aid with the funds that have accumulated since April 1980 as well as the meagre annual sums that it has allocated for this purpose. It is clear that the assistance to be given to the aged in need of others' help will, at this stage, be minimal. Under these circumstances there is no doubt that the needs of the elderly population in the future will constitute a driving force to expand and deepen the aid given within the framework of the Long-Term Care Insurance Law.

i. The Long-Term Care Insurance Law, as passed by the Knesset, makes aid to the aged conditional on an income analysis of their own and their closest relatives. The majority of the Committee's members expressed their deep sorrow that a "means test" would determine the assistance to be given to an old person who had insured himself for it by means of deductions from his income which in most cases would have been made over a considerable number of years.

j. The principle that the National Insurance Institute would be the leading institution in implementing the law was accepted by the government. The experience accumulated in the Institute in dealing with a number of issues connected with social security ensures that long-term care insurance will be operated as it should be.

k. The government generally accepted the Committee's proposals for organizing aid to be given to the aged on the regional and national levels by means of local committees which would deal with old people needing help in the region and by means of a national committee which would determine policy, budgetting and priorities for allocating funds for the development of services to be supplied within the framework of the Long-Term Care Insurance Law.

l. The Long-Term Care Insurance Law, as passed by the Knesset, fixes stages for its implementation. In the first stage, which will extend over the first two years, the main effort will be concentrated on reinforcing and expanding existing services as well as developing and expanding the infrastructure of the services which will facilitate in the future the full implementation of the law. In the second stage, which will commence in April 1988, personal benefits will be granted to those persons who are entitled to it in accordance with the provisions of the law. Nevertheless, the legislators left considerable room for flexibility in order to expand the scope of the services and the number of beneficiaries in accordance with regulations that will be enacted under the Long-Term Care Insurance Law.

4. *Summary*

The Long-Term Care Insurance Law which was passed by the Knesset in April 1986 differs in a number of its principles from those formulated by the Committee.

a. The aid provided under the present law includes aid in matters which up to now were clear items in the annual budgets of the Ministry of Labor and Social Affairs and of the Ministry of Health. As a result, these Ministries are now free from seeking additional financial resources for expanding their activity because they can now use the income from long-term care insurance as a source for covering their deficits.

b. The law stresses the aid to be given in the form of services in kind and minimizes the role of the cash benefits. Thus, it encourages the expansion of public services in the community and weakens the motivation of the aged to stay at home and of the family to continue to care for them.

c. The insurance contributions, which were fixed at 0.2% of the employees' incomes, are minimal and do not include any participation on the part of the government. Consequently, the sum received — $15 million annually — is very small and the aid that it can provide is limited.

d. The law provides for help for the elderly — whether in cash or in kind — only after an "income analysis", despite the insurance framework of the law. it is doubtful whether this income test will contribute very much to reducing the financial burden imposed on the government for expanding the scope of aid or increasing the number of the assisted population.

In spite of these differences of principles which guided the Committee in its recommendations, on the one hand, and the government in formulating the law, on the other hand, the latter's approval by the Knesset was a most important step for the elderly population and a landmark in Israel's social security and strength. There is no doubt that the increasing needs of the elderly population will constitute a driving force for expanding the assistance to be given to it in accordance with the professional principles that served as a guiding light for the Committee's recommendations.

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ISSUES IN PLANNING LONG-TERM CARE INSURANCE IN ISRAEL'S SOCIAL SECURITY SYSTEM

by Brenda Morginstin* and Nira Shamai**

1. Introduction

Long-Term Care Insurance was legislated by the Knesset in 1980 as a framework law, as were the General Disability and Unemployment Insurance Laws ten years earlier. Its aim was to expand Israel's social insurance system by defining basic rights in the area of long-term care. This aim was achieved by providing for the establishment of a fund, or branch, under National Insurance, in which contributions by employers and employees, at rates fixed in the framework law, would begin to be accumulated from the law's inception, although benefits were not yet granted.

The legislation of the framework law should be understood against the background of the development of Israel's income maintenance system during the 1970s. At that time, the primary goal of the system was to guarantee to individuals who dropped out of employment for various social reasons, a minimum standard of living relative to that of the working population, in accordance with legally defined rates and eligibility requirements. Special attention was paid to the question of adjusting over time this minimum subsistence level, or level of guaranteed income, in accordance with changes in the general population's standard of living and rates of inflation. There were three basic principles underlying this legislation: First, as mentioned, guaranteeing a minimum subsistance to those who lost their earning capacity or dropped out of employment for various reasons; secondly, preserving over time their relative share of the "national cake"; thirdly, centralizing income maintenance within a national institution — National Insurance — in order to ensure uniform entitlements and implementation as defined by law.

Covered under this law were the disabled, mothers in single-parent fami-

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lies and former welfare recipients who are unable, for various reasons, to assure themselves a minimum subsistence within the labour market..

Parallel to the gradual implementation of this policy, another issue arose which required the formulation of appropriate measures: the issue of adequately meeting important needs other than those met by guaranteed minimum incomes. This referred particularly to needs of the ill, the disabled and the aged who are dependent on the help of others in their daily functioning needs in the areas of health, medical and para-medical services and social supports. Most pressing were very basic personal requirements associated with performing activities of daily living, such as assistance with mobility, washing, eating, dressing and personal attendance, as well as household maintenance. While some personal care and home help services were covered by public or State bodies, such as the Sick Funds, the Ministry of Health, the Ministry of Labor and Social Affairs, municipal social services bureaux and various voluntary organizations, they were inadequate in terms of availability and coverage, uniformity in criteria for provision and quality.

The creation of attendance allowances provided under Disability Insurance was one step towards providing a universal benefit for personal care in the second half of the 1970s. The attendance allowance is provided to disabled persons, who, in addition to having lost their earning capacity (for which they are entitled to a disability pension), are also limited in their daily functioning and require the help of others in personal care and household maintenance. Eligibility for an attendance allowance is determined on the basis of an assessment of activities of daily living, and is provided to the eligible person living at home.

The attendance allowance, as well as a similar benefit for disabled children who are dependent on others, constituted a turning point in the development of Israel's social security system: in addition to an income guarantee, there was an attempt to cope, by means of universal social legislation, with the non-income needs of population groups for whom existing State agencies had not found appropriate solutions.

The legislation in the area of disability raised with greater intensity the need for similar legislation for other population groups, especially the elderly who are not eligible for an attendance allowance if they apply after retirement age. Problems of shortage and quality of existing services, together with the growing need for such services, constituted the basis for discussions in the National Insurance Council for extensive legislation for the dependent elderly.

Thus, in response to concern with the growing burden of long-term care and the inadequacy of existing programs to meet needs, in November 1980 the Knesset enacted a framework law which created a Long-Term Care Insurance Branch under National Insurance. As with several previous laws, this

law defined a specific framework within which the National Insurance Institute was authorized to collect contributions to a long-term care fund that would be used to provide benefits and services which would be defined by legislation and implemented at a later date. In the interim, a Public Commission was appointed by the Minister of Labor and Social Affairs, with the specific function of formulating guidelines concerning the operational goals, scope and content of Long-Term Care Insurance.

The Public Commission had two basic functions:

(a) to define the specific content of Long-Term Care Insurance in terms of eligibility criteria and benefits in order to meet needs which are currently being inadequately covered, as well as to expand and improve the quality of services through service development;

(b) to provide a comprehensive framework for the law's implementation, which would define channels for coordination and cooperation between statutory benefits and selective services provided within other frameworks. Coordination of this nature was considered essential in order to ensure over-all efficiency and effectiveness of resource allocation and service provision to the functionally dependent individual and his family.

Specifically, the Commission was requested to define principles and guidelines in the following areas:

(a) target population and eligibility criteria in terms of the most critical long-term care needs of various population groups;

(b) the kinds of benefits and services that would be provided within the framwork of the law, as well as suggestions for determining conditions for providing benefits in cash and in kind;

(c) sources for financing benefits and services;

(d) stages of implementation according to order of priorities based on systematic data regarding critical needs and existing services;

(e) an organizational infrastructure for implementing the law which would link provisions of Long-Term Care Insurance with existing services;

(f) supervision and control mechanisms for monitoring quality, availability and effectiveness of service provision and care of the chronically ill;

(g) estimating the cost of providing benefits and services during the first years of operation.

The Commission's work encountered many difficulties and lasted over two years. There were differences among members regarding basic principles: a universal approach which advocated personal entitlement to benefits under law according to clear-cut eligibility criteria versus a restricted budgetary approach, which would provide benefits on a selective basis. According to the latter, services would be provided only to those who do not receive adequate informal care from family members, whereas an individual whose family provides adequate care and services, thus bearing the heavy burden of care,

would not be entitled to assistance. In addition to the basic differences regarding the law's goals and means of allocating resources, there were also organizational interests in relation to means of implementation and division of responsibility among the various government Ministries and public bodies.

The Commission's work culminated in differences of opinion: the majority of its members, who represented professions and several institutions, and included geriatricians, experts in gerontology and social work and academicians, supported the broad approach of ensuring personal entitlement under the law, with its budgetary implications. This approach was also supported by the representatives of the National Insurance Institute. The minority, which consisted of representatives of the Ministry of Finance, the Ministry of Health and the Ministry of Labor and Social Affairs, supported providing benefits on a more selective basis in a closed budget. The Commission's report was submitted in May 1983 to the Minister of Labor and Social Affairs.

Following the report's submission, the National Insurance Institute prepared to translate it into a detailed law according to the majority's recommendations. However, basic differences between the government Ministries concerned and the National Insurance Institute were difficult to reconcile. The law that was finally approved in the Knesset (Israel's parliament) in April 1986 was thus one of compromises.

Another article which appears in this journal[1] discusses in detail the differences between the principles which were accepted by the majority of the Commission's members and the law that was finally passed in the Knesset. We shall therefore not discuss these differences but will concentrate on the issues that were discussed in the course of the Mann Commission's work. These issues were raised in discussions prior to legislation, are currently being considered during plans for implementation and will continue to be focal points of future evaluation research on the impact of the Long-Term Care Insurance Law.

2. *Long-Term Care Insurance (LTCI)*

A comparison of social insurance programs in various countries indicates that, in addition to general disability pensions provided for income maintenance, in 1981 95 countries provided some form of special attendance allowance to seriously disabled individuals, whether under general disability, work injury, or veteran programs (Callahan and Wallach, 1981; Grana, 1983). In Israel, the special attendance allowance for personal care and home help provided under General Disability Insurance covers eligible disabled

1 "Vison and Reality in the Long-Term Care Insurance Law" by Professor Kalman J. Mann.

individuals below retirement age only, whereas no statutory arrangements exist for persons who have become disabled in old age.[2] Similarly to other Western countries which have experienced an increase in the proportion of elderly, this group today comprises the largest population in Israel in need of long-term care services. Whereas in 1955 the over 65 group comprised 4.7% of the general population, this proportion reached 7.2% in 1970, and 9.7% in 1980. In absolute terms, the number of people aged 65 and over increased 70%, from 186,000 in 1970 to 318,000 in 1980. According to forecasts (Kop, 1980), this number will reach 415,000 by 1995.

Moreover, changes in the size and composition of the aged population projected over the next decade are expected to create an increasing need for long-term care (Kop and Factor, 1980; 1982). Of special significance is the rapid growth of the over 75 age group. Survey data have shown that the proportion of elderly requiring assistance with personal care and household maintenance activities increases with age, as does the level of care required (Morginstin, 1984; Zilberstein, 1982). Thus the over 75 age group comprises the principal population at risk requiring long-term care services provided in the home and in institutions. According to forecasts, this group will grow from 30.8% of the total aged population in 1980 to 38.7% in 1995. In absolute numbers, the size of this group will increase from 98,000 to 161,000.

As mentioned, the primary aim of the bill submitted to the Israeli Parliament was to formally define the State's statutory obligation to provide long-term care benefits and services to the seriously disabled chronically ill, especially the elderly, on the basis of personal entitlement and clearly defined eligibility criteria. It is important to emphasize that LTCI was legislated as part of social insurance law, and is therefore an additional stage in the development of Israel's social and security system. The law will enable provision of specifically defined benefits, as a statutory right, to eligible individuals characterized by determined levels of functional disability in addition to discretionary selective services currently being provided via the Health and Social Affairs Ministries, but which are unable to respond adequately to expected increase in need.

The immediate implication of creating an LTCI Branch in Israel's social security system is the infusion of a new source of funds which, however, are in themselves insufficient to cover total needs on the community and institutional levels. Thus a guiding principle accepted by all members of the Commission during the early stages of its deliberations was that the intent of legislation was not to finance existing formal services, but to complement the present system of service provision in terms of scope and quality, as well as to

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2 Only individuals who were granted an attendance allowance prior to retirement age (60 for women, 65 for men) are entitled to continue receiving the benefit after they reach retirement age.

enhance the family's role as primary caregiver. LTCI should therefore be viewed at the first stage of implementation as an additional element in the broader spectrum of long-term care — institutional and non-institutional. The long-range goal was viewed as a second stage of development, which would involve a restructuring of resources from all sources into a single, comprehensive coordinated system of long-term care which would provide continuous care and support to the elderly and his family and would efficiently link the various care frameworks both in the community and institutions.

3. *Factors to be Considered in Planning a LTC Program*

Israel's experience in planning LTCI is especially useful to examining the factors which ought to be taken into consideration in policy and planning. The literature on long-term care generally tends to focus on need defined in terms of demographic and epidemiological characteristics of a target population, or the estimated need for specific services. Experience in Israel has shown that, although useful for a small community, a broader approach must be adopted when planning a national program of long-term care; one based on a comprehensive model of needs which identifies a multiplicity of interrelated and sometimes conflicting factors. The resulting program was in fact a compromise among the various exigencies of the model in terms of content, scope, order of priorities and stages of implementation.

Following is an outline of the theoretical framework which formed the basis of planning for long-term care in Israel. Three dimensions are included: program needs, desired program impacts and system characteristics or constraints. Several factors are included under each dimension, such as a particularistic definition of individual needs, local and national circumstances, as well as inherent constraints within the system, patterns of formal and informal service supply and delivery, funding practices, budgets, division of responsibility, and conflicting interests — all of which in themselves constitute needs generated by a given situation. Finally, the concept of needs takes into consideration short and long-term goals, or expected impacts of the program to be developed.

The model of needs is not exhaustive and clearly its content could be modified or expanded in greater detail. Several points, however are immediately apparent:

(a) Identification of target population needs alone, while these can be easily extrapolated from survey data, is insufficient for program planning.
(b) Many program needs, desired impacts and system constraints, while they cannot be easily quantified and measured, are no less important to program planning than measurable population needs.

(c) There are *conflicting* needs in the model, especially in the area of short and long-term goals. These factors should be taken into consideration in policy and program planning, especially in determining priorities and defining stages of implementation, the objective being to design an *optimal* program which might meet some needs at the expense of others at certain stages of program implementation. Israel's experience shows that making policy decisions which will affect program design must be especially sensitive to these various elements.

From the start, it became clear that the type of individual needs designated as targets by the program will inevitably affect decisions regarding the kinds of benefits to be included, eligibility criteria, and the cost of LTCI. The Commission decided to carefully define individual needs for long-term care only in terms of the level of personal care and household assistance required by an individual due to functional disability in activities of daily living: mobility, dressing, washing, eating, use of toilet and personal attendance, resulting in dependence on others.

In line with the specific definition, the Commission proposed that benefits to be covered by LTCI include those services which derive directly from functional disability: personal care and home care. It is important to point out that the definition of needs is exclusive; excluded are needs for primary health and home health services, which are viewed as being within the realm of medical and para-medical services, as well as the entire range of supportive social services which may in fact be required by dependent individuals but which remain the responsibility of the Ministry of Health, the Sick Funds, and the Ministry of Labor and Social Affairs.

According to the above definition for identification and measurement of individual needs, elderly who might be receiving care from families would still be assessed for need according to functionability. It is important again to point out that measuring individual needs in this way is based on the principle of personal entitlement and therefore does not exclude from eligibility individuals who are receiveing adequate care from informal sources, thus recognizing the implied cost of this informal care. Most selective programs generally tend to disfavor providing benefits to disabled persons who receive adequate care from family members either by focussing home care services primarily on aged living lone (Parker, 1980), or by favoring funding practices which reimburse costs of institutionalization (Morginstein and Werner, 1982). This short-sighted approach to defining needs has the immediate effect of reducing the size of the eligible population and might perhaps, in the short term, meet national goals of cost containment. The Commission, however, was concerned with the question of whether this kind of program would encourage the continued provision of informal care provided by the family

Some Factors to be Considered in Policy and Program Planning for Long-Term Care Dimensions

Program Needs

Individual Needs

a. The chronically ill, dependent individual: measures of dependency in population in terms of functional ability (ADL).
b. The family: measures of need defined in terms of resources (financial, other) needed to provide necessary care by means of acquiring services or by direct provision of care.

2. *Local, Community Needs*

a. Decentralization in service provision.
b. Development of an adequate and diversified system of balanced, continuous care by providing long-term services directly to individuals living at home, providing congregate services in the community and providing institutional care for those chronically ill unable to remain in their homes.
c. Developing mechanism for coordinating need assessment and service provision among informal and formal care providers.

Desired Program Impacts

1. *Immediate, Short-Term Effects*
   a. Meeting acute, inadequately covered needs for long-term community and institutional services;
   b. Providing funds to families to enable continued provision of adequate care at home or in institutions.
   c. Expanding availability of diversified formal services and trained manpower.
   d. Meeting current demand for nursing home beds.
   e. Meeting immediate need for improved quality of institutional and non-institutional care.

2. *Long-Term Effects*

a. Encouraging continued provision of informal care as well as development of the voluntary sector.
b. Creating an incentive to enable the chronically ill individual to remain in his home and community as long as feasible by strengthening the family and providing more alternatives for care in the community.

Existing System Characteristics[1]

1. *Characteristics of Long-Term Care*

a. Care of chronically ill, dependent individuals is being provided primarily by the family while only low proportion of aged (1-2%) are receiving organized services from the public sector partially covering need.
b. 1.4% of aged 65+ are in nursing home beds, which are being funded almost entirely by government funds.
c. Lack of sufficient community services.
d. Division of responsibility for services provision and resulting conflicting interests among various public and governmental organizations:
   - Ministry of Health
   - Ministry of Labor and Social Affairs
   - Sick Funds
   - Municipal governments
   - Voluntary organizations
   - Private sector
   - Families
e. Existing fiscal policy and funding practices for long-term care, which are based on government allocations from

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1 Included are only minor points, as examples.

Program Needs

3. *National Needs*

a. Centralization of statutorily defined rights to benefits and services, as well as central regulations and procedures to implement these rights; monitoring efficiency of provision according to law.
b. Assuring personal and regional equity in resource allocation for long-term care.
c. Encouraging the continued provision of informal care so as to prevent unnecessary *replacement* of informal systems by costly organized services.
d. Efficient utilization of resources and manpower for long-term care; reducing fragmentation and duplication of service provision by various public and government organizations.
e. Controlled allocation of development funds.
f. Cost containment.

Desired Program Impacts

c. Improving quality of institutional and non-institutional care.
d. Meeting long-term projections for nursing home bed needs.

3. *Prevention*

Preventing imbalance between institutional and non-institutional funding resulting from budgetary incentives.

4. *Future System Goals*

Reallocation of all existing funding sources, including LTCI funds, in order to develop a comprehensive, efficient system of long-term care, in the community and in institutions, according to changing needs of the aged population.

Existing System Characteristics[1]

general taxation (excluding sick funds and voluntary organizations).
f. Current provision of long-term care services according to selective criteria and budget constraints, resulting in regional differences, lack of uniform eligibility criteria and inadequate coverage.

2. *Policy for Development of Related Services which may Affect Long-Term Care System*

Services which are not in themselves defined as long-term care for the chronically ill, functionally disabled, but which may affect the need for and use of long-term care services, including: residential homes, sheltered housing, acute hospital care for the aged (such as admission and release procedures), preventive health care, development of geriatric units and day hospitalization, etc.

today. Research has shown that in Israel the family is the primary provider of care and is in fact the most important resource in long-term care (Morginstin, 1984; Zilberstein, 1983; Shuval, 1982). Would a program designed to meet the needs only of those who have little access to family care achieve the long-term effects outlined above, i.e., encouraging continued provision of informal care, enabling the individual to remain in his home and community? On the contrary, the opinion of professionals in the Commission was that this narrow approach might, in the long run, constitute a disincentive to continued family responsibility. Moreover serious problems of equity were pointed out: limiting benefits only to persons who do not receive adequate family care would have meant "punishing" families who are currently meeting heavy responsibilities.

For these reasons, the Commission proposed that eligibility to benefits under LTCI be based primarily on the principle of personal entitlement according to the degree of functional disability, irrespective of whether the family is providing care. The existence of family might affect only the level of eligibility or the kind of benefit required. For example, persons living alone might be eligible for a higher benefit which would reflect the higher cost of services they must obtain. None or inadequate family care might affect the kinds of services required but not the benefit level.

A second issue considered by the Commission centered on the kinds of benefit to be included: cash or kind. Given the fact that the principle service provider is the family, the Commission proposed that a basic cash benefit, in addition to in-kind services, be an effective instrument in assisting the eligible individual and his family by covering part of the costs incurred in providing or obtaining services. At the same time, services would be developed in order to increase availability. The Commission's approach recognized the right of the disabled and their families to utilize a cash benefit, when provided, *according to personal preferences and requirements*. In those cases when professional assessment indicates that the family is unable to provide an accepted, adequate level of care, the benefit would be provided as a service in-kind via existing agencies, thus limiting extensive professional involvement and case management to complex cases. This approach was quite different from long-term care programs in other countries, both the U.S.A. and in Europe, in which entitlement is defined in terms of *services*, both institutional and non-institutional, and which has led to spiralling costs due to increased demand for expensive services, inevitably financed by the government.

In other words, one important proposal made by the Commission was to include a cash benefit in LTCI provisions. Those receiving adequate care from family would be eligible for a benefit which would, in fact, be a form of partial compensation for services being provided, generally at a significant cost to the family. It was believed for example, that by providing a cash

benefit which would cover part of the cost of service provision, it would be possible to meet family needs, as well as encourage family responsibility. This type of program would enable the individual and his family to acquire services in the community, according to its own preferences, thus facilitating the link between formal and informal support sectors. The social policy guideline underlying the Commission's work, which was also supported by research findings regarding the role of the family in Israel in caring for the disabled, was that implementation of LTCI ought to assist the family, wherever possible, to continue carrying out its important functions by providing cash benefits *or* services in kind, according to the specific situation.

Arguments against a cash benefit in Israel has been that this type of program is costly and will not sufficiently meet needs for service development, It was argued that those who are currently being adequately cared for by the family, at none or little public cost, will become eligible for publicly funded benefits. The concern was that if large numbers of older people apply, the ultimate cost of an insurance-based program might be unpredictable and possibly unsupportable.

On the other hand, proponents of a cash benefit, as *part* of a comprehensive program of cash and in-kind benefits, made a case for strengthening the family's role by enabling it to make decisions regarding the utilization of public resources according to personal preferences (Sager, 1983). Moreover, cash benefits meeting only part of the cost of service provision, were viewed by some as less costly in the long run than the evolvement of expensive service structures. Indeed, it was believed that defining social responses to meet needs only in terms of expensive public services would lead to increased demand, spiralling costs of services, and perhaps fewer resources ending up in the hands of the eligible person. To provide in-kind services only would require designing a costly and complicated administrative framework for case management, service provision, payments, reporting and monitoring. Conversely, a program which would provide in-kind benefits only to complex cases would have limited this administrative framework to hard-core cases requiring professional intervention and monitoring.

The compromise decision which enabled the law to be passed in 1986 was in essence a shift in focus from a program which would emphasize cash benefits to a program in which the basic benefit would be an in-kind service, a cash benefit being provided *only* when there are no available services in the community and if the eligible person is being cared for by a relative living together with him. By providing in-kind or cash benefits to the eligible person living at home, and at the same time expanding the network and variety of community services, it is hoped that LTCI will enable the disabled person to remain in his home and community as long as feasible. However, it should be emphasized that the role of the benefits is not to replace family functions and

responsibilities. The family will continue to have primary responsibility for the care and welfare of the individual. Therefore, the benefit, whether in cash or in kind, is aimed at covering only *part* of the needs and basic costs incurred in caring for the functionally disabled elderly, in order to alleviate the burden of care as well as to constitute an incentive for the family and a recognition and appreciation of its caregiving role.

A basic decision was therefore made by the Commission to meet the needs of individuals and families, while simultaneously encouraging service development:

(a) *The Law's Response to Individual and Family Needs*. Benefits will be provided in cash or in kind to eligible individuals and their families, on the basis of *personal entitlement*, in order to enable them to provide necessary long-term care services. The assumption was that provision of benefits under law would increase available resources, constitute an important form of assistance to families who are caring for their dependent elderly, and will have an effect on service development by increasing demand for in-kind services. In this way personal benefits will in themselves provide an impetus for formal service development on the local level, thus encouraging the differential development of patterns of informal care and formal services according to local and individual needs and preferences.

(b) *The Law and Service Development*. Resources would be made available under law specifically for development of long-term care services and manpower, including services provided to the individual at home, services provided in an organized manner in the community, and services provided in institutional settings. The explicit goal was to increase the range and availability of services, as well as to improve the quality of services in the community and in institutions. These provisions under LTCI would, it was hoped, enable Israel to meet several of the goals outlined above: assuming personal and regional equity in response allocation, encouraging the continuation of family care, and developing services.

4. *Non-Institutional and Institutional LTC*

Another issue in long-term care arose from the need to develop a broadly diversified system of services to meet a continuum of changing needs. On the one hand, the long-term objective was to assist the family and develop services so as to enable the disabled individual to remain at home in the community as long as feasible and to confine the use of nursing home beds to the most seriously disabled. On the other hand, an acute and most visible need in Israel was, and continues to be, the current demand for nursing home beds. The issue behind these two seemingly conflicting goals was important first in terms of the basic conception underlying the program, but for the Commis-

sion became became a practical question of priorities in allocation of limited funds in a model where cost containment was in itself a basic issue.

The Commission proposed that during the first stage of implementation, LTCI would give priority to the primary system of care, by supporting the family and developing community services. Personal benefits will not be provided toward covering the cost of nursing care, but only to aged living at home.[3] Admission to nursing homes would continue to be provided on a selective basis by the Ministry of Health. At the same time, however, development funds would be allocated toward meeting immediate acute needs for additional beds and for raising the quality of care in the institutions. This approach was adopted in the law passed in 1986, which also provided some funds for increasing the number of institutional beds.

4. Coordinating Long-Term Care — The Administrative Framework

Many countries report a lack of coordination in long-term care, whether at the stage of referral and need assessment, performing gate-keeping functions, professional decision-making regarding care plans and case management, or with procedures for service provision, reporting and monitoring. Although some countries have regulations for coordinated planning or allocation of funds on the central level, there seem to be few statutory provisions which set forth regulations for use of resources and administering case management functions at the local, implementation level.

Most experiments at coordinating the administration of long-term care constitute attempts to provide a continuum of adequate care at home and in institutions in a most cost-effective program. Issues most often addressed relate to the following functions:

- short and long term social planning, goals and program strategy;
- efficiency in allocation of resources according to regional and population needs;
- overall need identification on the basis of data-gathering;
- defining and implementing criteria of eligibility for benefits on the basis of individual need assessment according to uniform regulations;
- determining the types of services required by the eligible elderly and his family according to professional assessment;
- case management, including coordinated service provision, monitoring effectiveness, etc;

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3 In other words, excluded from eligibility are elderly living in a nursing home or in a nursing ward. On the other hand, in principle those living in a residential institution (for the independent or frail elderly) may be eligible if they meet conditions of functional disability.

— effective utilization of manpower;
— reporting of implementation, monitoring of efficiency;

At the root of these functions is the basic and controversial issue of centralization versus decentralization of long-term care. This issue was seen by the Commission to have implications for program design and administration, and relates to the importance of decentralization in terms of service provision versus the necessity for centrally defined and implemented eligibility criteria, need assessment procedures, monitoring, etc.

In general, there seem to be two main trends in the reassessment of long-term care administration currently being undertaken by various countries. On the one hand, there is a trend for increased decentralization at the level of service provision, primarily due to growing recognition that population needs as well as needs for services development are best understood and dealt with at the local professional level. On the other hand, however, the importance of centrally defined criteria and procedures for determining eligibility and monitoring has been emphasized, in order to ensure regional equity as well as personal equity in service provision and to enable efficient reporting and monitoring of the program. In addition to determining eligibility criteria, there is a need for centrally defined guidelines for resource allocation which will ensure that development funds under LTCI be utilized for their designated purposes at the operational level program implementation, thereby complying with national goals and orders of priority for service development.

In Israel the issue of allocating central and local functions has generated much debate centering on the aforementioned issues. The main question was how to reconcile these various and equally important goals in order to assure equity and uniform implementation of LTCI based on the principle of personal entitlement, while at the same time leaving the responsibility of professional decision making to the local level. During the Commissions's work, while there was general consensus that planning and resource allocation for development is a central function of the National Insurance Institute, which would ensure that funds be utilized for their designated purposes, there was much disagreement regarding who would have responsibility for determining the level of eligibility and the form of benefit provision.

It was apparent that planning an appropriate administrative framework should take into consideration two inherent constraints which are central to the Israeli system and which ought to be reconciled if the desired outcome is a unified, coordinated system of long-term care:

(a) LTCI is a social security program defined by law. As such, eligibility to benefits is statutory. These benefits are not in the nature of reimburse-

ments for services as is the case in several other countries, but constitute transfers to eligible individuals, in kind or cash.

(b) In addition to a universal program of insurance benefits, a system of selective services, based on a closed budget funding through general revenues, *will continue to exist* under the responsibilities of the Ministries of Social Affairs and of Health. These services include personal attendance and home help, above the level covered by LTCI, as well as other related services often required by the dependent elderly living at home (health and medical care, various supportive social services, day-care centers, equipment, housing improvements, etc), as well as placement in and funding of institutions.

The main question for policy and planning an administrative framework was how these various elements, which include cash benefits and in-kind services, could be incoporated into a unified comprehensive system.

The Commission proposed that central functions, including determining eligibility for benefits, *level* and *form* of provision of benefits (cash or kind) would be carried out objectively by branches of the National Insurance Institute, according to centrally defined guidelines and tools, while provision of in-kind services, monitoring and reporting would be the responsibility of municipal agencies of the Ministery of Social Affairs (local welfare bureaux). The Commission recommended setting up local interdisciplinary committees, under the aegis of local welfare bureaux, which would handle cases requiring in-kind services, performing the entire range of case management functions required, from assessment to monitoring and updating.

The concept of local communities became a focal point of the law pased in 1986. The functions of the committee remained basically the same, except for one important difference: the committees would have responsibility for *all* eligible individuals. While the National Insurance Institute remains solely responsible for determining eligibility based on degree of functional disability, the local committee determines the form of benefit provision (cash or kind) as well as the detailed care plan.[4] The creation of local committees is a challenge to professionals in the community and will have to be flexibile enough to permit for differences among the various communities according to local characteristics, needs and resources.

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4 The expanded functions of the local committee, adopted by LTCI in 1986, means that each and every case must go through the local committee which can decide on a cash benefit only if there are no available services. Research is required to examine whether the operation of the committees and the resulting administrative procedure for implementing LTCI, are efficient in terms of resource allocation, and whether they are effective in meeting needs of the eligible and family, in creating an incentive for continued family care, and whether the family's basic right to utilize the benefits according to personal preference are respected.

The main functions of the committees will be as follows:

(a) Determining a comprehensive care plan for individuals, after the National Insurance Institute has determined level of eligibility for a benefit, on the basis of degree of functional disability.
(b) Determining *which* services will be covered by the benefit and which will be funded by other agencies. The National Insurance Institute will transfer the cash benefit directly to the stipulated service provider.
(c) Responsibility for service provision and case monitoring, as well as for need reassessment.
(d) Determining the need for a nursing home when this becomes necessary and making the appropriate recommendations to the Ministry of Health.
(e) Ensuring the individual's continued rights to benefits *other* than those provided under Long-Term Care Insurance.
(f) Gathering data, proposals and requests for aid for local service development projects to be submitted to a Central Development Fund.

The Commission for Long-Term Care also proposed the establishment of a central body comprised of representatives of government Ministries and public organizations, which was included in the law. This central committee will be responsible for:

(a) Setting down priorities and guidelines for allocating funds from the Central Development Fund for service development made available by LTCI.
(b) Approving proposals for projects submitted.

6. Summary

The benefits and services to be provided under LTCI are an important part of the continued development of Israel's social security system which is based on principles of personal entitlement, uniformly defined and implemented under law.

The law legislated in 1986, although consistent with many of the concepts and proopsals made by the Mann Commission, differs in several basic points, especially with regard to its approach to the family. According to the Commission, the family should have been guaranteed a larger measure of independence in determining the kind of benefit and its use, according to its personal preference. The eligible individual and his family were to have been the principle "agent" for resource allocations and service supply, thus reducing to a minimum the need for complicated, extensive and time-consuming administrative mechanisms for implementation, wich might become cumbersome and frustrating for the individual and his family. The ideas was to provide resources in such a manner as to enable the family to cope with the

burden of care within a varied, flexible system of cash benefits and services. Professional intervention would be reserved for complex cases requiring management and monitoring.

Moreover, the Commission was especially emphatic in its warnings against replacing the existing budgets for services by LTCI funds, stressing that the aim was to add social insurance resources to those that already exist, not to replace budgets from general taxation, and not to replace current responsibility of government Ministries and public bodies. Funds made available under LTCI would be utilized for providing basic personal benefits and to expand availability and accessibility of existing services, to train manpower and, in general, raise the quality of service.

Furthermore, since benefits provided under LTCI will cover only part of the cost of service provision, it is important that existing services in kind continue to be provided and developed as a complement to the basic benefits which will be defined under law. It will therefore be important to co-ordinate between elibility for long-term care benefits under law, and eligibility criteria for existing selective measures.

In fact, to a great extent, the success of LTCI in meeting social goals and needs depends on the measure of coordination and cooperation between the various organizations. Beyond the immediate desired impact of alleviating a recognized social condition by providing benefits to the eligible elderly and their families, the ultimate question is whether these benefits will constitute a separate systems or become an integral part of an improved, expanded, more efficient and effective program.

Future evaluation of the law's effectiveness in achieving its goals will be realted to the following issues:

(a) What will be the cost of this program? Will cost for LTCI be contained in spite of the fact that eligibility is defined by law?
(b) As a result of LTCI, will other government and public organizations relinquish responsibility for service development and provision, reduce budgets, or reduce the level of services currently being provided?
(c) Will the system of long-term care and the overall availability of services expand as a result of the law's implication? What will happen to those elderly who will not be eligible under LTCI but who nevertheless require services? Will services other than those now covered by LTCI continue to be dfeveloped (i.e., health, medical and social services)?
(d) What effect will the new law have on the existing procedures for need assessment and decision making, as well as on existing criteria for determining eligibility for selective services in the community or for institutional care?
(e) Whether, and what kind of, coordination will develop between provisions

of LTCI and other frameworks. Will there be duplication of functions such as that of need assessment currently being performed by various bodies?

(f) Will there be sufficient in-kind services to meet needs? Will government and public agencies in fact develop in-kind services to those individuals who will be determined eligible for benefits in-kind rather than in cash? What will be the impact on the private sector?

(g) Will LTCI have an impact on the pattern and extent of informal care? Will there be a substitution effect between informal and formal responsibility?

(h) Finally, and most important, will LTCI raise the well-being and welfare of the chronically ill individual and enhance the family's ability to provide care. Research will be required to examine the manner in which benefits are being utilised and their contribution to the well-being of the elderly and the family caregivers.

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THE GRAYING SABRA
A DEMOGRAPHIC VIEW OF THE ELDERLY POPULATION

by Yaakov Kop*

1. Introduction

Israel is a country that has experienced aging as a process, not as a phenomenon. That is, the "transition period" — the period that elapsed between the time that Israel was "young" in its age composition, and the time that it became a country with an appreciable percentage of seniors — was rather short. Moreover, the change in age composition was swift and impressive. In the fact of this process, the social service matrix has to gear up appropriately. This article examines the nature of the process and its significance with respect to the organization of services.

The first section deals with the dynamics of population aging, and analyzes its origins, the growth trend of the elderly population of Israel and its composition by age and sex. The proportion of elderly in the population is then presented according to the dependency ratio measure, with emphasis on Israel's special situation relative to the developed countries of the world. Demographic characteristics other than age — e.g., incidence of widowhood, composition of whole households, and level of education among the elderly — round out the overall picture as a preface to a discussion of demand for various social services.

The second part of the study deals with distinct patterns of recourse to various services. The health and employment services, and the degree to which the elderly benefit from income maintenance payments, are given special attention.

The last section of the study focuses on a view toward the future, with reference to the demographic forecasts and the information they provide with respect to the projected characteristics of this population and its changing needs. Special attention is devoted to the importance of re-examining the determination of needs.

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2. *The Dynamics of Population Aging*

A. Trends in Age Composition. Israel's population grew at varying rates during the first four decades of its existence. The rapid increase in the first decades, or to be more precise , in the early years of that decade, expressed itself from the transition from a small Jewish settlement of about half a million people when the State was established, to a country with a population of two million people at the end of the first decade. The development in the basic dimensions of the Jewish settlement was the immediate result of the mass immigration. Other continuous developments were reflected at later stages, particularly in the third and fourth decades. One of these developments — which is the subject of this article — was the rapid aging of the population which transformed Israeli society from one with the characteristics of a developing country with elderly people constituting less than 5% of its population, to one with the characteristics of a Western nation with elderly people constituting approximately 10% and even more of its population.

The fluctuations in immigration to Israel were generally short-term and just as the mass immigration in the first three years typified the main part of the first decade, fleeting waves of immigration characterized the following decades. A general view of four decades of Jewish population growth in Israel reveals a slowdown in its growth, from 165% in the first decade (1948-1958) to 35% in the second decade, 29% in the third decade and 16% in the fourth decade (1978-1988). The concentration of the increase in short periods within each of the past decades meant development in the form of upheavals which led to cyclical fluctuations in births with immediate and resonant influences (resonant influences meant that a boom of births in a given year led to a renewed boom twenty years later when the boom generation reached the age of reproduction and so on).

The changes in the number of aged in Israel and in their relative proportion in the population are a result of the aforementioned fluctuations in the size of the population and their timing. Thus, it is possible to discern a tenfold growth in the number of aged and yet notice that the growth occurred in cyclical movements and in timing which did not correspond to that of other population groups. The accelerated growth of the youth age groups took place in the 1950's whereas that of the aged occurred mainly in the second and third decades. In the present decade, growth is concentrated mainly in the oldest age group of the elderly population and this phenomenon is expected to continue in the next decade as well (See Table 1).

The new chapter in the aging of the population is thus characterized by a slowdown in the increase in the total number of aged, while the oldest among them (aged 75 and over) continue to increase rapidly; this means that the proportion of the aged in the population will remain rather stable until the

Table 1. The Development of the Elderly Jewish Population by Five Year Groups

Age	1960	1970	1980	1990	2000
			Years		
		(a) absolute numbers, thousands			
65+	95.9	186.7	318.0	386.8	428.1
		(b) index: 1960 = 100			
65+	100	195	332	403	446
65-69	100	204	315	338	332
70-74	100	191	328	310	362
75+	100	185	358	590	690

Source: Independent calculations based on the Statistical Abstract of the Central Bureau of Statistics for the relevant years and "Projection of Population in Israel up to 2000", Special Series no. 666 of the Central Bureau of Statistics. Jerusalem, 1981.

end of the century, but the proportion of the oldest among them will grow considerably. Even the latter group is aging rapidly; those aged 85 and over, for example, constituted a marginal group of some 4,000 in 1960; in the course of two decades it jumpted to 15,000 (almost four times as many) and in the present decade its rate of growth is dramatic compared with all other age groups so that at the end of the present decade Israel will have 30,000 people aged 85 and over (see Table 2).

This process contains a change in the numerical balance between the two sexes among the aged. Until the second half of the 1970s, there was an almost complete equilibrium between the two sexes; in the 1972 census, there were 102 women for every 100 men. Since then the ratio has undergone a basic

Table 2. The Aged as a Percentage of the Population by Age

Age	1960	1970	1980	1990	2000
			Years		
		(a) As a percentage of the general population			
65+	5.0	7.2	9.7	10.1	10.4
75+	1.5	2.0	3.1	4.3	4.7
		As a percentage of the elderly population			
65-69	39.8	41.8	37.8	33.4	29.7
70-74	30.9	30.3	30.6	23.7	25.0
75+	29.3	27.9	31.6	42.9	45.3

Source: See sources to Table 1.

Table 3. Ratio of Women to Men
(men = 100)

Age	Years 1960	1970	1980	1990	2000
65+	109	102	112	126	138
65-74	106	98	111	119	124
75+	118	113	116	137	157
80+		124	146	176	

Source: See sources to Table 1.

change and according to the latest data (1985), there are 115 women for every 100 men. This process will continue to become stronger and the ratio towards the end of the century will be 138/100 (Table 3).

B. Dependency Ratio — An International Comparison. Economic-demographic literature uses the "dependency ratio" index to express the numerical relationship between the economically active age groups and the young and old age groups which are economically dependent on the active age groups. As with every definition of this kind, different criteria are determined arbitrarily to identify the dependent groups. One of the usual indices is the overall dependency ratio of youth (0-14) and aged (65+) to adults (15-64). This ratio is sometime split into two components: youth dependency ratio and aged dependency ratio.

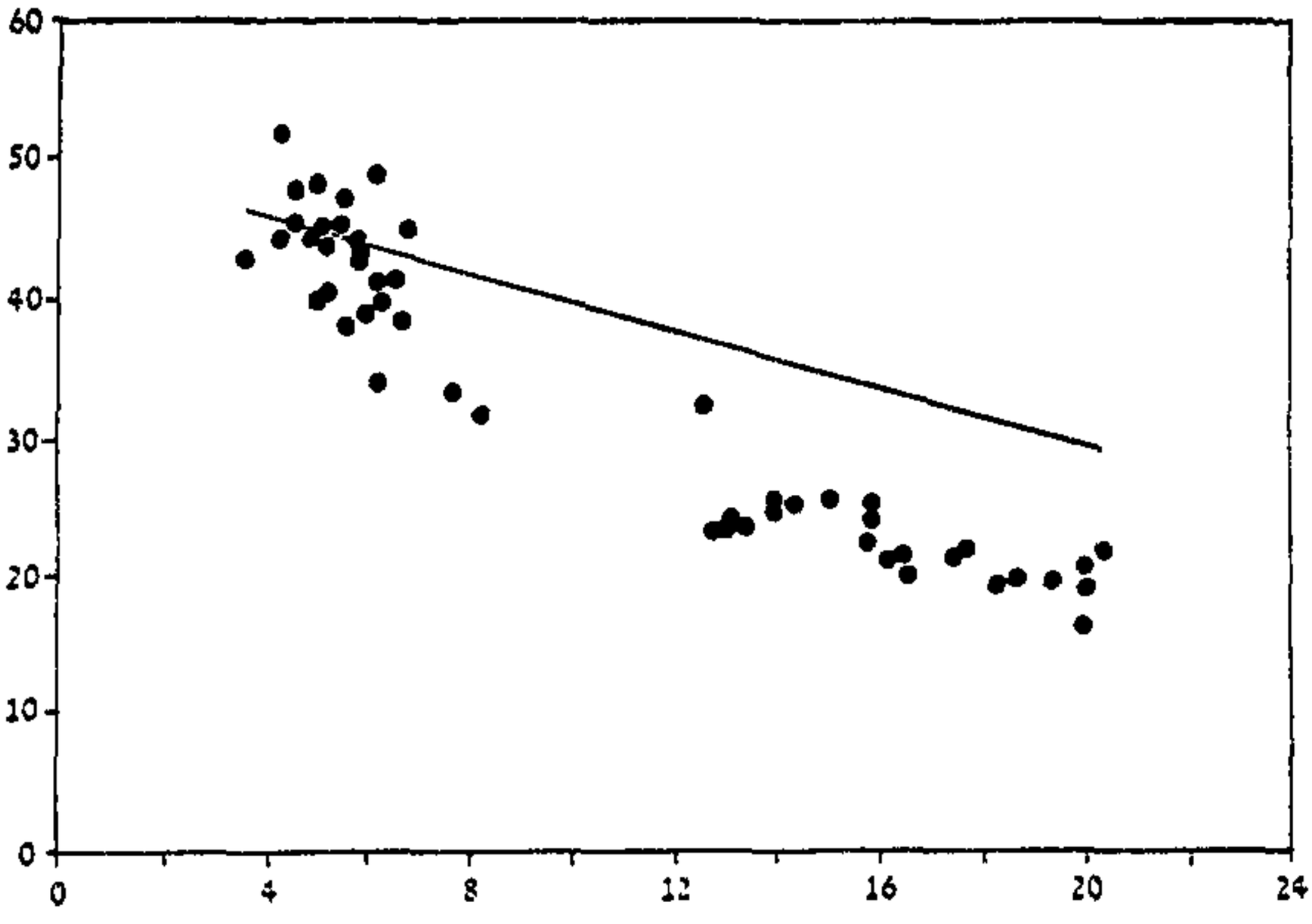
We have already mentioned that developed countries are characterized demographically by their high rate of aged in contrast to developing countries, with their low rate. The other side of the coin is to be found at the other end of the age scale: developing countries have many young people, whilst developed countries have few. It can thus be stated that there is a negative correlation between the percentage of youth and the percentage of aged in any country. If the degree of negative correlation between the two groups of the age pyramid would offset completely, we would find a constant dependency ratio in every society since such an offsetting correlation means: the higher the percentage of aged, the lower the percentage of youth. In reality, the situation is different and there is a considerable gap between the extent to which the percentage of youth decreases and the extent to which the percentage of aged increases.

In order to examine this connection more clearly we have collected data on about 50 countries which contain 82% of the world's population and we have plotted them along axes according to the appropriate rate of youth and

aged in each of them.[1] Each point of Diagram 1 represents a country, and its location indicates the percentage of aged on the horizontal axis and the percentage of youth of the vertical axis. The diagram obviously indicates, first and foremost, the negative correlation between these two percentages. This is the reason that the spread of the points constitutes a curve descending from left to right, i.e., the percentage of aged rises as the percentage of youth falls.

Another feature revealed by the diagram is that the spread is not in a straight line but in a curve with a varying steepness. This signifies that in certain spheres there is a sharp rise in the elderly population whilst in other spheres the relative increase is much more moderate. At the bottom end of the curve one can even discern countries in which the percentage of aged continues to rise, whilst the percentage of youth does not fall but remains

Diagram 1. Dependency Ratio in 53 Countries



1 The data were taken from Encyclopedia Britannica, Inc., *Britannica World Data 1985*, "Comparative National Statistics", pp. 826-831. For most countries, the data are for 1983 or 1984. Due to the limitations on the detailing of the data, we have presented the 60+ age group as representing the aged, which gives an upward bias to the aged dependency ratio.

constant. In these countries, the increase in the percentage of aged is mainly on account of a decrease in the percentage of breadwinners.

A third feature revealed by the diagram is the concentration of the points in two main clusters, i.e., there is a rather dichotomous division between countries in which a high percentage of youth goes together with a lower percentage of aged and countries with the opposite combination.

The convexity of the "implied" curve (i.e., an imaginary curve passing through all the points on the diagram) which expresses the variability of the ratio of aged to youth in the population cancels the possibility of a constant dependency ratio. In order to examine further the varying nature of the dependency ratio, we added a hypothetical straight line to the diagram which represents a dependency ratio of 1 (i.e., the number of youth and aged together exactly equals the number of intermediate ages).

The distance of each point from the straight line indicates the extent to which the dependency ratio is less than 1. The diagram shows that the cluster of developed countries is farther from the straight line, a fact that expresses a lower dependency ratio for these countries. This information can also reveal the source of the dependency ratio, i.e., to what extent it can be attributed to each of the ratio's components (youth dependency and age dependency). This separation of the two components makes it possible to give appropriate weight to the social consequences of the change in the population's age composition. This will be dealt with in Section B, which discusses the elderly population's recourse to services.

In the system which shows the structure of the dependency ratio in various countries of the world, Israel is one of the few countries which is located anywhere between the curve and the straight line. This signifies greater proximity to a dependency ratio of 1, in contrast to all the other countries around it. This proximity is the outcome of the fact that the percentage of aged in Israel resembles that usually to be found in many developed countries (including the United States and Canada), but its percentage of youth is higher than in these countries.

This result reflects to a large extent the fact that Israel's population consists of two societies — Jewish and Arab — with different age structures: the former with a high percentage of aged and the latter with a high percentage of youth.

C. Demographic Characteristics Other Than Age. Recourse of a population group to services is not a function of age structure alone, but of other features too, including demographic ones. One of the principle characteristics which is connected statistically and causally to recourse to services is the elderly person's family situation. Researches have shown that widows and widowers tend more than their married counterparts to live in old-age homes and be

cared for by various health and welfare services.[2] It is therefore important to see whether the family situation is a static or dynamic variable in the aging process.

The incidence of widowhood among women is considerably higher than among men. There are two reasons for this: one is the difference in life expectancy between the two sexes (women live longer than men, on the average) and the other is the difference in the age of marriage between the two sexes. An analysis of the contribution of each of the two factors to the difference in the rate of widowhood shows that the second factor is the dominant one.[3] The fact that elderly men are married to women younger than themselves increases the possibility of a woman to become a widow earlier; therefore a family situation of "widowhood" is more frequent among women than among men. Nevertheless, a change seems to have occured in the course of time in this matter; the data show that the median age-differnce between men and their wives is 6.3 years among those aged 65+ compared with 3 years among those aged 30-34.[4] In other words, age differences between the spouses have become smaller during the years and consequently a narrowing of the gap was to be expected between the widowhood rates of men and women. Indeed, a comparison of the family situation of elderly women in three population censuses (1961, 1972 and 1983) indicates a rapid decline in the percentage of widows over a period of twenty years: from 55% two decades ago (1961 census) to 43% in the 65-74 age group. The decrease in the proportion of widows was not offset by a parallel rise in the proportion of widowers, so that the average rate of widowhood among the elderly population in this age group also dropped considerably, from 32.5% in 1961 to 30% in 1972 and to 27% in 1983 (see Table 4).

The trend towards a narrowing of the gap between the ages of spouses is a prolonged one, which has not yet reached its fullest expression among the aged. Therefore, a continued decline may be expected in the age gap of elderly couples and, correspondingly, it may be stated that the decline in the proportion of widows is not only a phenomenon which is not passing, but it is rather a process that has not yet reached its peak.

The "family situation" characteristic is accompanied by a "household composition" characteristic. The traditional society was characterized by a

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2 See, for example: Yaakov Kop & Haim Factor, "Changing Characteristics of the Israeli Population and the Utilization of Health Care Services,"*Israel Journal of Medical Science*, vol. 21, no. 3 (March 1985), pp. 205-211.

3 See: Yaakov Kop, "On the Different Rates of Widowhood among Men and Women," The Brookdale Institute of Gerontology and Adult Human Development, Discussion Papers 71-81, Jerusalem 1981 (Hebrew).

4 Source of the data: The Central Bureau of Statistics, "Characteristics of Couples in Israel, Average for 1980-1982," *The Monthly Bulletin of Statistics*, Supplement, vol. XXXVI, 1, January 1985 (Hebrew).

Table 4. Widowhood Rates Among the Elderly by Age and Sex
(The rates are within the relevant population groups)

	Census Years		
	1961	1972	1983
	65-74 years		
Total Jews	32.4	29.9	27.5
thereof:			
men	10.3	10.6	9.4
women	55.4	49.5	43.3
	75+		
Total Jews	56.4	55.5	49.2
thereof:			
men	29.2	29.3	24.6
women	79.4	78.7	71.1

Source: Central Bureau of Statistics, Census of Population and Housing Publications for 1961, 1972 and 1983.

multi-generation compositon, i.e., in many cases a grandfather or grandmother (or both) lived together with their children and grandchildren. The frequency of this phenomenon, however, decreased in the course of time[5] and in this matter too one can discern marked differences among the censuses of the beginning of the second, third and fourth decades: the percentage of non-married aged living alone in their households rose from 11% at the beginning of the 1960's to 19% at the beginning of the 1970's (1972 census) and 25% in the early 1980's (1983 census). Among aged couples too one can discern an upward trend in the percentage of those living on their own, without other relatives. Data from the three censuses indicate an increase from 32% to 46% in 1972 and stabilization at this level until the 1983 census.

There is no doubt that the family constitutes a non-formal alternative system of support to the public services, but the family support is not conditional on a joint residence and may be provided by children even if they live separately from their parents.[6] Therefore, the data on the decline in the frequency of multi-generational residence should not be regarded as necessarily indicating a potential rise in the need for public services. It may be sup-

5 See: Hanna Weil & Ayala Biber, "Reasons for Applications to Independent Old People's Homes", the Brookdale Institute for Gerontology and Adult Human Development, Discussion Papers 24/78, Jerusalem, 1978 (Hebrew).

6 See: Y. Shuval, R. Fleischmann & A. Shmueli, *Non-formal Support of the Aged: Non-Formal Networks in a Jerusalem Quarter*, The Brookdale Institute for Gerontology and Adult Human Development, Jerusalem, 1982 (Hebrew).

posed also that the increasing frequency of residence without other relatives stems partly from a greater capacity (or readiness) to function independently. However, one should not ignore the fact that one of the factors in it is a socio-cultural one.

Another most important demographic characteristic is the level of education. This variable also influences actual recourse to services and it certainly determines the nature of the services required and the way in which they are provided. The basket of services required for an educated population differs in its composition — as far as culture, employment and other matters are concerned — from that required by a less educated population. The way of activating old people is also influenced by this population's level of education and so on.

In the 1961 census, the population of elderly men consisted of three equally-sized groups: one third had little or no education (0-4 years), another third had elementary education (5-8 years) and the rest had partial or complete secondary education or higher education. The younger ages were generally more educated and when they aged, the elderly population's level of education rose, a fact that already became apparent in the 1972 census. The force of the change was revealed in the last census's data: the proportion of those without education dropped from a third to a fifth, whereas the proportion of the more educated rose to almost half of the elderly population (see Table 5).

Similar and even more rapid changes were found among elderly women, despite the fact that their absolute average educational level remained lower than that of men of the same age. The proportion of women with little

Table 5. Elderly Jews, by Education Level (years of learning)
(percentages)

Years of Learning	1961	1972	1983
Men	100	100	100
0-4	32	28	20
5-8	33	35	34
9-12	23	26	30
13+	12	11	17
Women	100	100	100
0-4	53	41	28
5-8	29	30	32
9-12	15	23	30
13+	4	6	10

Source: See sources to Table 4.

education fell from a half to a quarter and the proportion of the more educated ones more than doubled itself (from 18% in 1961 to 40% in 1983).

The difference in the degree of improvement between men and women led to a narrowing of the gap between the sexes and today it exists at the two extreme levels only: 28% of women have little education, compared with 20% of men, and 10% of women have post-secondary education (13+ years) compared with 17% of men.

Another expression of the cultural dimension is the literacy variable (knowing how to read and write) and this too indicates a rapid improvement that took place during the two previous decades. According to forecasts, the trend will continue in the future and in the 1990's there will hardly be any elderly man who cannot read or write; among women there will be a small minority compared with 40% at the beginning of the 1960's.

A demographic factor of special significance in the Israeli economy is seniority in the country. In the past, Israel was a young country and even today it is still regarded as belonging to the youngest of the developed countries. It is exceptional insofar as most of its elderly people were born abroad and came to the country at a quite advanced age. This fact reduced the degree of the elderly person's social integration as compared with other countries and in the past it prevented them from accumulating adequate pension rights prior to their retirement. However, in the course of time, the number of veterans whose socio-economic status was more established, grew considerably among the aged.

We have indicated a number of demographic variables which exercise an influence on the demand for various services. The nature of the connection between the variables that have been discussed and the demand for public involvement will be more extensively discussed in the next section, where we shall also study the implications of changes in the level of education for participation in the labor force.

3. *Reliance on Public Services and Involvement in Economic Activity*

The degree of benefit from various services is not — nor is it meant to be — distributed equally among the aged. In order to study the different patterns of utilization of services among various population groups, we shall examine the subject with reference to health services, income maintenance benefits and employment characteristics.[7]

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7 See: S. Bergman & Bar-Zuri, *The Attitudes and Opinions of the Aged towards the Welfare Services System*, The Economic and Social Research Institude of the General Federation of Labour's Executive Committee, Tel Aviv, 1976 (Hebrew).

A. Health Services. The most important factor influencing recourse to health services is age. In this respect, old people aged 75 and older differ from the elderly of lower ages. This is reflected in at least three spheres: hospitalization, doctors' visits and residence in long-term institutions — old age homes and others.

Previous research studies[8] showed the differences among various age groups with regard to the degree of hospitalization of their members. It was found that the share of the aged in the total number of hospitalization days was considerably greater than their share in the population, and it has even grown relatively. The immediate impact of this characteristic can be studied from a combination of the findings on the "differential hospitalization index" with the findings presented in the previous section on trends in aging. We saw that in the two previous decades, the elderly population grew considerably and in the present decade it has undergone a process of internal aging with the rise in the weight of those aged 75 and over. It is possible to weigh the population data by means of an index based on hospitalization intensity by age[9] and thus measure the consequences of aging directly. In Table 6 the combined impact was calculated and it teaches us that whilst the share of the aged has ceased growing in the general population, it is expected to continue to grow in total hospitalization. The datum on the total population, weighted by the hospitalization index, indicates an increase of 20% in the present decade, but the elderly population, weighted by the same index, will increase by a factor of 1.5, i.e., 30 percent.

Ambulatory services and doctors' visits are provided to the aged more than to the other parts of the population even though the difference is smaller than that discerned in hospitalization services. Therefore we may expect, in this respect too, an increased recourse to health services.

Another measure of the connection between age and reliance on public services is residence in long-term care institutions. In the 1972 census it was found that the rate of institutionalization by age — which is measured by the ratio of those living in institutions at different ages to the general population group of those ages — increases in a geometrical progression with age. A similar finding was repeated in the 1983 census, as well as in a special census of institutions.[10]

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8 See, in particular, the article of Yaakov Kop and Haim Factor mentioned in Note 2 above.

9 For every age group, the ratio of its weight in hospitalization to its weight in the population was calculated. For details, see: *Changing Social Policy — Israel 1985-85*, The Center for Social Policy Studies in Israel, Jerusalem 1986, p. 32 (Hebrew).

10 Shimon Bergman, Haim Factor & Iris Kaplan, "Census of Long-Term Care Institutions in Israel, 1983: Scope of Population, Functional Level and Finance," The Brookdale Institute of Gerontology and Adult Human Development, Special Series 26/86, Jerusalem 1986 (Hebrew); and the Central Bureau of Statistics, "The Aged in Israel," 1983 Census of Population and Housing Publications, No. 11, Jerusalem 1981, pp. 234-238 (Hebrew).

Table 6. The Aged as a Percentage of the Population and as a Percentage of the Hospitalization Index
(weighted population, by age)
(percentages)

Year	The Aged as a Percentage of the Population		Weighted Population	
	65-74	75+	65-74	75+
1970	4.8	1.9	14.4	7.7
1975	5.5	2.4	16.5	10.0
1980	5.9	2.8	19.6	15.6
1985	5.2	3.4	17.3	19.1
1990	5.1	3.8	16.8	21.0

Source: See sources to Table 1 and also: "Changing Social Policy — Israel 1985-86" (ed. Yaakov Kop), The Center for Social Policy Studies in Israel, Jerusalem 1986 (Hebrew), pp. 27-39.

The age variable is not the only demographic factor affecting the extent of institutionalization. A very important variable in this connection is that of "family situation". Old widowers and widows tend to be in institutions more than the married elderly. The explanation is that being at home as a couple constitutes a mutual support unit which in many cases disposes of the need to enter an old-age home. The development that occurred during the past decades in this variable, i.e., the decline in the frequency of widowhood, offsets to a certain extent the increasing aging of the population and acts to reduce the pressure on long-term care institutions (see Table 7).

B. Income Support. The aged are the largest population to enjoy income support benefits which are paid to them as old-age and survivors' pensions by the National Insurance Institute. These pensions are paid to every woman reaching the age of 65 and every man reaching the age of 70. Men and women of a younger age are also entitled to a pension if they have no adequate income (the law contains an exact formula on the subject). A widow is entitled to a survivor's pension if her spouse dies, even if she has not reached the age of 65. Insurees who have accumulated seniority in national insurance are entitled to a pension increment whose sum depends on the amount of their seniority.

All the demographic factors mentioned in the previous section have a direct influence on the total sum of the old-age and survivors' pensions and

Table 7. Old People Living in Institutions and Their Rate in the Relevant Age Groups (1983)

Age Group	Total	Jews		
		Total	Men	Women
Total	3.1	3.2	2.2	4.0
55-59	0.8	0.7	0.8	0.7
60-64	1.0	0.9	0.8	0.7
65-69	1.6	1.5	1.1	1.9
70-74	3.0	3.0	1.9	4.0
75-79	6.0	6.1	3.8	8.4
80-84	12.5	13.3	8.3	17.3
85+	19.5	21.2	15.4	26.0
Total	3.1	3.2	2.2	4.0
65+	5.0	5.1	3.3	6.7
75+	9.9	10.4	6.6	13.8
85+	19.5	21.2	15.4	26.0

Source: The Central Bureau of Statistics, "The Aged in Israel" 1983 Census of Population and Housing Publications No. 11, Jerusalem, 1986 (Hebrew).

on the pension as a source of economic welfare for elderly families. An increase in the number of elderly persons is accompanied almost automatically by an increase in the number of pension payments. A rise in the relative weight of old people aged 75 and over within the total elderly population increases the compulsory element in the pension (in the younger stratum of the elderly population, receipt of a pension is conditional, as mentioned, on an income test). Longer seniority in the country also tends to increase the overall monetary value of the old-age pensions. On the other hand, the drop in the rate of widowhood operates, as stated, in the opposite direction because, among other things, the individual's pension is higher than half the pension of a couple. A further influence in this direction is exercised by the accumulation of seniority in the country, since it allows a person to establish himself economically and thus defer the retirement and receipt of the pension.

C. Employment. The economic activity of the aged and its contribution to their welfare has many aspects. One of them is the personal material one — its being a source of income for the elderly family. Another aspect is the material one from the economy's viewpoint. The increase in the number of aged who continue to work after the accepted retirement age increases the economy's labor force.[11] However, it appears that among all these aspects,

11 On deferement of the retirement age from the economy's point of view, see also: A. Helman & M. Sonis, "Aging of the Population, Employment of the Aged and Retirement Policy," *Social Security* no. 17 (March 1979), pp. 119-129 (Hebrew).

the wider social aspect stands out in every discusson of the issue.[12] Participation in the labor force — if it is not compelled due to economic and other similar pressures — prevents deterioration of morale and gives the aged the possibility not to change their way of life at some arbitrary point of time.[13] Gradual retirement in accordance with one's functional capacity and personal needs prevents the sudden isolation and seclusion in one's home, phenomena which have been found to make life difficult for the individual and his environment. Characterization of the elderly population according to the extent of its economic activity is, accordingly, a demographic factor of far-reaching social consequences.

Participation of the aged in the labour force has been continually on the decline during the three past decades. In the mid-1960s, 40% of all elderly men participated in the labour force. In the mid-1970s, the rate fell to 30% and continued to do so in the present decade till it reached 25% in 1983.[14] Does this reflect a change in the willingness of the elderly to work? Can this be regarded as a reflection of a deterioration of conditions in the labour market? Such questions call for a deeper examinaton of the dynamic character of participation in the labour force.

Another dynamic factor is the internal age compositon of the elderly population. A single figure on the rate of employment of the aged cannot give a true picture of the situation, and one must take into account the separate rates of the various age sub-groups.

Data on annual participation[15] in the labour force based on the 1983 census show that the average participation of all elderly men (aged 65 and over) was 33.5% at the time. This general rate was an average of 43.5% — the rate of the younger stratum (aged 65-74), and 18% — the rate of the older stratum. It is also possible to calculate the particpation rates divided into additional sub-groups and then we shall see that in the lower group (65-69 years), the rate is 50% and in the highest age group (85 and older) — 8.4% only. The specific rate for each intermediate group range between these two rates. This graduation of participation rates according to age, when it is related to changes in the internal age composition of the elderly population,

12 Yaakov Kop, "Involvement of the Aged in Working Life and Voluntary Activity — Scope and Trends," *Gerontology* (Autumn-Winter, 1983-1984), pp. 3-9 (Hebrew).

13 On the importance of work for old people from a viewpoint of their morale, see also: I. Rosow, "Status and Role Change Through the Life Span," in R.H. Binstock & E. Shanas (eds.), *Handbook of Aging and the Social Sciences*, New York, Van Nostrand Reinhold, 1976, pp. 457-482.

14 The data refer to rates of participation in the labour force in the weeks of the survey as presented in the publications of the manpower surveys. Participation of elderly women was and remains marginal and the data on it do not change the general picture. Their rate of participation has not exceeded 6%.

15 The figure on annual participation quoted here is higher than the previous one on participation in the labour force in the week of the manpower survey, discussed in the previous paragraph.

helps us to understand the decline in the average employment rate of all the aged.

Another factor which distinguishes among the sub-groups of the elderly population is education.[16] Data from 1983 manpower surveys show considerable differences among employment rates of elderly people with different levels of education and indicate quite a high correlaton between educational level and participaton in the labour force. Those with little education have an employment rate of 10%; the rate increases to 25% among those with primary and partial secondary education (up to ten years), and climbs steeply to 37% among those with full secondary, post-secondary and higher education. This finding is not exceptional, and similar employment patterns can be found in previous manpower surveys. The motives behind the varying participation rates lie partly in the nature of the employment of the various educational groups. It may be supposed that people with academic occupations, such as doctors, lawyers and other literal professions aspire more than others to continue working after the usual retirement age. Moreover, the working conditions in such occupations are less restrictive than those of manual labour. To all this may be added "employment status," i.e., whether the elderly person is an employee or self-employed. Self-employed persons are naturally free to decide whether to continue working after retirement age, whereas wage-earners are subject to rather strict institutional restrictions. Here too there is a certain correlation among education, occupation and employment status.

In the final analysis one might have expected an upward trend in employment with the rise in the educational level, but the employment status composition (employee vs. employed) may have changed for the worse in the elderly population group.

4. A Look at the Future

A. Demographic Forecast. Demographic developments are generally not easy to predict. Two central elements in population projections in Israel are: (1) forecasts of migration; (2) forecasts of changes in the birth patterns. The first, at least, has an almost speculative nature and the second is not very firmly based. Nevertheless, the most firmly based demographic forecast, especially in the short and medium terms, is that concerning the elderly population. Migratory movements will not change the number of elderly persons expected in the next five to ten years to a large extent and therefore it

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16 See the discussion in M. Sicron, "Employment and Retirement of Older Persons in Israel," in: U.O. Schmelz & G. Nathan (eds.), *Studies in the Population of Israel in Honor of Roberto Bachi*, Jerusalem, 1986.

is possible to estimate with considerable certainty the aforementioned number. However, the *percentage* of elderly persons is affected by errors in estimates of migration and natural reproduction because this rate is based not only on the number of aged, but also on the size of the rest of the population which, as mentioned, is determined to a considerable extent by external and internal migration.

A demographic forecast of the elderly population can be quite reliable not only with regard to its number but also with regard to its characteristics. The educational structure can be estimated with great certainty because some of the aged of the next decade are already aged today and the others consist mainly of today's 55-64 years age group. The educational level of these people is fully known and is not expected to change in the course of the decade. This is also the case, though to a lesser extent, with knowledge of the Hebrew language and illiteracy.

The next variable on the scale of variables according to predictabiity is "family situation". It is possible to employ a series of forecasting methods — simulations of the individual's data, grouped analytical forecasts and the like — and by means of them predict developments with considerable certainty, basing oneself on information concerning age differences between spouses among tomorrow's aged and using the known life tables.

Consideration of the development of the aforementioned variables makes it possible to predict at a lower but reasonable level of exactitude such variables as household composition, participation in the labour force, etc. We shall therefore briefly survey the main developments expected in the elderly population of the next decade.

The absolute increase of the elderly Jewish population will decelerate until the end of the present century. In the next five years, an absolute increase of 45,000 elderly persons is still expected, but in the 1990's the slowdown will be sharper and only 40,000 elderly persons will be added to the population during the entire decade. In the same period the number of non-Jewish aged will also grow and reach 8.1% of the totaly elderly population (in 2000) compared with 6.5% today.[17]

The most outstanding numerical change in the present and next decades is that in the age composition of the elderly population. In the two previous decades, the oldest stratum (75 years and older) constituted approximately 30% of all the aged; at the end of the present decade it will constitute 40% and at the end of the century — 45%. In other words, almost half of the elderly population will be aged 75 and over. A similar trend is to be see in each of the other high age groups (e.g. 85 years and over).

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17 The various forecast data presented below are based on: The Central Bureau of Statistics, "Projection of Population in Israel up to 2000", Special Series Publications, no. 666, Jerusalem, 1981 (Hebrew).

Another development in the quantative data is the deterioration in the numerical ratio of women to men. The proportion of women in the total elderly population will grow to 58% in 2000, up from 53% today, and 50% at the beginning of the second decade (1961). Fortunately, this development will not be accompanied by a parallel incrase in the number of widows because, as explained above, of the changes that occurred in the past in patterns of marriage which brought in their wake a narrowing of the average age gap between husbands and wives. The educational cross-section of Israel's elderly population will bear greater resemblance to that of its adult population and will be more equal than in the past as well as on a higher average level.

In the economic sphere an improvement may be expected due to the increased accumulation of pension rights at work. Most of the aged will have longer seniority in the country than in the past and the extent of reliance on pensions from places of employment will no doubt be greater. Other economic conditions too, which are reflected, for instances, in the ownership of durable consumer goods, improved rapidly in the past and the progress is expected to continue in the next decade.

B. Adjustment of Services to Changing Needs. The aging of the population and the rise in the proportion of the oldest stratum in particular will supposedly increase demand in a wide variety of services, starting from institutional ones and ending with community ones. It would seem that reliance on institutional services such as old-age homes of various types will present society with numerous difficulties and will necessitate greater resources than in the past, whilst meanwhile a considerable deficit has been created in this sphere. However, it should be made clear that the tendency to prefer community services is not to be found among economists alone but also among experts in the various service spheres (doctors, geriatricians, social workers, psychologists, etc.). Here, relative-cost considerations go hand-in-hand with professional treatement considerations. Therefore, the most important direction in services adjustment is the proper stress on the development of the services that will enable support of the aged at home instead of referring them to old-age homes or similar institutions. No doubt, even after such services will have been suitably developed, there will still be many elderly persons whose family situation and functional capacity will not permit treatment in a community framework and it will be necessary to work towards completing an adequate network of long-term care institutions to meet their requirements.

When adjusting services to the changing needs, one should pay attention to the changes taking place in the characteristics of the aged, and the influence on the standard and nature of the service required. The existing services system, adapted to a given socio-cultural standard, is not necessarily identical

to the type that will be required by the future population. This will not require larger budgets but a different allocation of resources, a correct identification of needs and planning the response to them.

This approach is in line with the position that advocates having the elderly themselves be the ones to supply services. One framework that should receive full expression is the voluntary one. The Israeli economy contains unexploited or wasted human resources which are sufficient to meet a large part of the growing needs. Many elderly people who have retired from work and who, in some cases, cannot continue working for fear of jeopardizing their pension rights, are likely to play a vital role helping other aged in need of social intervention. Moreover, the actual employment of such elderly persons (in voluntary and other frameworks) constitutes a sort of preventive treatment for the persons themselves. Active involvement of an elderly person prevents a deterioration of morale and functioning which has been often observed at a time of retirement and in its wake. The bringing together of elderly persons in need of assistance and elderly persons who can extend this assistance provides a useful and important service to both sides alike.

C. New Concepts of Old-Age. Development of the aforementioned approach of mutual help and more involvement of the aged in providing services is bound up with the need for a reexamination of the determination of needs. Institutional, demographic, research and similar reasons necessitate the determination of an arbitrary limit to the definition of "old age", "elderly person," "old person," etc. Some of those using these notions conceive them simply as referring to a given age or to an arbitrary point of time in an elderly person's life.[18] Institutional convenience lies behind the present custom of defining a given age as old age, but all understand that it is a matter of an average and every average has deviations above and below it. What has been said so far is accepted and needs no proof.

A stronger argument concerns the actual determination of the average age employed in inter-periodical and international comparisons of old age. The accepted approach is generally a basically static one and it adopts the relevant range of ages in given limits which are unchangeable. But is reality really like that? Does the rise in life expectancy in recent decades only mean lengthening of the period of old age? In the same way it may be claimed that longer life expectancy really means deferment of old-age and not merely deferment of death. According to this approach the norms which were fixed in the past for age of retirement from work, etc., should be examined anew.

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18 On the definition of old age and the cultural variance that characterizes it, see: J.B. Kessler, "Aging in Different Ways," *Human Behavior* 5(6), (1976), pp. 56-60.

It is feared that the continued adoption of the traditional retirement age constiutes a self-fulfilling prophecy. A person who reaches retirement age adopts behavior patterns which appear to him to fit expectations with regard to retirement.[19] The functional harm involved in doing so is clear.

True, all this is still subject to study and proof but a reasonable supposition for research is the supposition that a rise in life expectancy of X% is linked to a deferment of old age (and the need to retire) by X% or a similar percentage.

The following is not a matter of factual estimation but an intellectual exercise to clarify the implications of confronting the static concept with the dynamic concept. If we assume that old age moved in the past three decades in a similar way, relatively, to life expectancy[20] then we shall see that the real "65 year-olds" are 67.5 years old today. According to those data, the proportion of elderly persons has increased only slightly in the aforementioned period.

All this should serve as an incentive to research as well as reforms in various institutional arrangements. The first and foremost of these should be a transition from forced retirement to voluntary retirement (whilst applying suitable checks); a transition from final one-time retirement to gradual retirement; and a trasition from inequality (in the opposite direction to what should be) between the sexes to full equality between them. Modern society should be able to refresh its thinking and attitudes towards old age and elderly persons.

It is difficult to concentrate all the facts that have been presented above into a single summarizing statement but it is possible to direct the searchlight to one of the main implications of this article:

Israel has aged rapidly; as a result, the image of its society has been transformed within a short period of two decades. As a *process*, however, aging in its major components has already peaked. Although various links in the chain are still evident and will be so in the future, a sharp slowdown is expected by the next century's second decade in the growth of the special needs that aging produces. The object of the major effort must be to close an existing gap between past growth of the elderly population and the development of the services it needs. The target should be pursued with attention to changes in this population's characteristics and demands, with an innovative

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19 On this subject, see: B.L. Neugarten & G.O. Hagestad, "Age and Life-Course," in: R.H. Binstock & E. Shanas (eds.), *Handbook of Aging and the Social Sciences*, New York, Van Nostrand Reinhold Co., 1976.

20 A calculation of the change in the life expectancy of Jewish males since the beginning of the 1960's up to the present shows that it rose by 3.7%. The application of this change on the age of 65 results in the age of 67.5.

perception of society's attitude toward aging. Sagacity in these respects would not only prevent the emergence of a cumbersome and costly service system, but would also help coalesce a society that affords its elderly a continued active role, both among the elderly themselves and relative to the general population.

APPROACHES TO THE LONG-TERM CARE INSURANCE LAW AND THEIR COST IMPLICATIONS

by Dr. Jack Habib* and Haim Factor**

1. Introduction

The Long-term Care Insurance Law[1] is one of the most complex pieces of social legislation ever passed in Israel. It was created in order to meet the needs of the disabled elderly and their families.

On the surface, the objective appears simple — to finance the personal and homemaking services needed by the elderly to function on a day-to-day basis. In reality, the problem is extremely complex.

The difficulties which arose during the planning process are likely to plague the Law's implementation. They arise from the different and, at times, conflicting approaches regarding the provision of services to the elderly, and from the financial implications of these approaches.

The primary contribution of the Law in its current form is:

a. The allocation of additional resources to assist the disabled elderly.
b. The decision to expand forms of assistance which will help the elderly remain in the community.

This article will review the principal approaches which influenced the Law's formulation and their financial implications. We will also examine the compromise, reflected in the Law, which was worked out between the various approaches and those factors which will affect the cost of its implementation.

2. Review of the Principal Approaches

The Law's designers were faced by two primary questions: (1) How to combine the formal assistance provided by the State to the elderly with the

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1 National Insurance Law (Amendment No. 61) 5746-1986, *Book of Laws* 1178, Nisan 16, 5746.

informal assistance provided by the family; (2) Whether to provide the required supplementary assistance through services in-kind or through cash benefits. These two questions are intertwined and will be discussed together.

Proponents of the various approaches agreed that the responsibility for meeting all of the needs of the elderly should not be shouldered by the elderly and their families alone, but that the State should assist. Such assistance has several objectives: To ensure that there is an adequate response to the elderly's needs; to prevent a heavy financial burden from falling on the elderly and to lighten the burden of care imposed on the family; to avoid, to the extent possible, institutionalization of the elderly and to encourage the elderly to remain in the community.

However, there were differences of opinion with respect to the division of responsibility between the State and the individual and the level of public resources required to encourage families to continue supporting the elderly. Another factor which distinguished the various approaches was a difference in social and economic goals related to family assistance. There are those who view this assistance primarily as a means of reducing public expenditure; there are those who see it as a solution to the problem of finding suitable and sufficient manpower to provide care; and there are those who see the provision of assistance by the family as valuable in and of itself because it is often the most preferable arrangement from the viewpoint of the elderly and even the family. An emphasis on the intrinsic value of family support can justify giving incentives to families to provide care. Such incentives, as in all incentive systems, would also reach families who would have provided assistance in any case and so are likely to raise total public costs. However, those who sufficiently value family care may be willing to bear this additional cost.

We will now describe the two principal approaches which vied for approval during the Law's formulation — the "willingness" approach and the "compensation" approach — and present an analysis of the relative cost of each. It should be pointed out that we have coined these terms for the sake of convenience and that they were not used during the public discussion.

A. Willingness principle

According to this principle, the State's role is to supplement the assistance which the family is willing to provide. One of the important roles of the professional working with the elderly and their families is to help them define what they are willing and able to do by themselves. However, there is no intention to impose tasks on the families. According to this approach, a family which is willing and able to assist the elderly, will be given less assist-

ance from the State, but the State promises to increase assistance when the family requires additional help.

B. Compensation principle

According to this approach, the State provides assistance irrespective of the family's willingness to support the elderly and the assistance it actually provides. Obviously, this approach means that financial assistance is given and not service entitlements. Only in this way is it possible to provide equal public assistance to a family which provides assistance and to a family which is interested in formal assistance. This also explains why we chose the name "compensation" approach — the money compensates the family for the assistance it provides. Some proponents of this approach justify it on the basis of fairness — that a family should not be penalized because it provides the assistance, while others justify it as a way of encouraging families to assist the elderly.

Beyond these two approaches, there is another principle at work which significantly affects the nature of the public obligation — the degree of commitment to meet all the elderly person's needs. In the willingness approach: Is the State willing to provide the assistance required to meet all the elderly person's needs when the family is either unable or unwilling to provide care? In the compensation approach: Is the State willing to compensate the family for all the assistance it gives? There are usually constraints in public systems with regard to the amount of assistance. These constraints act as limits on the maximum amount which it is reasonable to spend to enable an elderly person to remain in the community. This is because at a certain point, this cost exceeds the cost of institutionalization. Sometimes these constraints are fixed at a lower level than the cost of institutionalization and reflect the desire to save on public expenditure. However, there are also those who prefer to enable the elderly to remain in the community even if the cost is greater if that is the elderly's preference.

These constraints have a greal deal of significance with respect to the principles described above. They introduce an element of coercion because the family must choose between the provision of assistance to the elderly and the risk that the elderly's needs will not be met.

In order to illustrate the two approaches and estimate the difference in their costs, we will present an example of three families (see Table 1). In all three cases, a similar degree of care is required — some 30 hours of assistance per week. The difference among the three cases lies in the families' willingness to provide assistance: The Levy family is not willing to help at all; the Hazan family is willing to provide some 20 hours of assistance; and the Cohen family is willing to provide all the assistance that is needed.

Table 1. Alternative Approaches to Provision of Formal Support

	Hours needed or provided (per week)		
	Levy	Hazan	Cohen
Needs	30	30	30
Family willingness	0	20	30
Formal Assistance			
Willingness Approach			
Full needs	30	10	0
Partial needs	20	10	0
Compensation Approach			
Full needs	30	30	30
Partial needs	20	20	20

Table 1 presents the amount of public assistance the elderly will receive under the "willingness" approach and the "compensation" approach according to alternative degrees of obligation to meet the needs — complete or partial.

We see that the amount of assistance provided to the elderly is the same under the compensation approach and changes under the willingness approach in accordance with the family's willingness. Table 1 also illustrates the possibility of partial treatment of needs by presenting an option in which a maximum of 20 hours of assistance per week is allowed (labeled partial needs). Due to the limits in the amount of assistance, not all of Mr. Levy's needs will be met unless the family decides to provide the missing assistance after all. In the cases of Mr. Hazan and Mr. Levy, this limitation does not have any effect under the willingness approach, as less than 20 hours is required in any case. However, in the compensation approach, all three families lose. It will not be reflected in unmet needs in the Hazan and Cohen cases, but rather in partial compensation to the families for their assistance.

In order to estimate the cost of the two different approaches, we will assume a distribution of the population of elderly between the types of families as presented in Table 2. In order to simplify the calculations we consider only two types of families (Cohen and Levy). First we must determine the population distribution between the two types of families. (The present distribution of families in Israel reflects a situation in which a majority of the families is closer to the Cohen or Hazan families). The primary question is: How will the families be distributed when the services are much more available? Obviously, some of the families will reduce the amount of assistance that they will provide, but the question is — by how much, and whether they will continue to shoulder the main burden of care?

Table 2. Weekly Cost for Systems Based on the Willingness Approach and the Compensation Approach, with Alternative Hypothetical Populations and Alternative Rates of Compensation for Families[1]

	Alternative Distributions[2]		
	A 80% Cohen 20% Levy	B 16% Cohen 84% Levy	C 0% Cohen 100% Levy
Pattern of Assistance			
Formal	600	2,520	3,000
Informal	2,400	480	0
Costs (in dollars)[3]			
Willingness Approach	3,000	12,600	15,000
Compensation Approach			
100% of the formal cost ($5)	15,000	15,000	15,000
80% of the formal cost ($4)	12,600	14,520	15,000
60% of the formal cost ($3)	10,200	14,040	15,000

1 Assuming that in both approaches all of the needs of the elderly are met, and the number of the elderly in the community is fixed.

2 Assuming that there are 100 families that are divided among the two types of families presented in Table 1: the Cohen family, where the elderly person needs 30 weekly hours of assistance and the family is willing to provide all the assistance; and the Levy family, where the elderly person also needs 30 hours of care, but the family doesn't help at all. See Table 1.

3 Payment for formal hours is $5 an hour, while three alternative levels of payment for informal care are considered.

Those who claim that the compensation method will be cheaper assume that the distribution will be very different under the two approaches, and that the amount of familiy assistance will be less under the willingness system. This claim is questionable from a theoretical viewpoint. The contention is, that because the families will receive payment for every hour of care which they provide, this will encourage them to provide more care. However, on the other hand, the compensation provides the family and the client with an additional income which enables them and encourages them, to purchase more formal services. It is impossible to predict which effect will be stronger.

The difference between the two approaches may also be expressed in requests for institutionalization. One of the major arguments put forth during the public discussion was that payments to families will prevent them from turning to institutionalization. But it is important to emphasize that the provision of services under the willingness principle is also likely to reduce

requests for institutionalization, by meeting the needs of the elderly and alleviating the families' burden. So the question is, what is the difference in effect of the two approaches on requests for institutional placement? To look at this question, we will examine the possible quantitative ramifications, of an effect on institutional care.

A second argument expounded by proponents of the compensation principle refers to the cost of an hour of help. In the willingness principle, this cost is determined according to the market price of formal services. Today, the price is about 4 dollars, but with growing demand it may be assumed that the price will rise to at least five dollars. In the compensation approach it is possible to differentiate between the cost per hour of formal help and the cost per hour of family help, and to set a lower compensation rate for the family.

Table 2 presents the relative cost of the two principles, based on different assumptions regarding the distribution of families, and about the gap between the prices of formal and informal assistance. Three alternative distributions of families are presented. In the first — 80% of the families resemble the Cohen family and 20% resemble the Levy family, i.e., similar to the existing situation. In the second — the percentage of families resembling the Cohens is reduced to 16% and the percentage of families resembling the Levys has risen to 84%. In the third distribution, all the families resemble the Levys, i.e., there is no more family care. Part I of the table presents the division between hours of formal care and hours of informal care based on the three assumptions. The costs are calculated in part II of the table for alternative compensation rates for family assistance. Three alternatives are presented: 100% of the formal rate (i.e., identical), 80% and 60%. We assume, at this stage of the analysis, that there will be no difference in the number of families living in the community, i.e., there is no difference in the effect of either principle on the extent of institutionalization.

The cost calculations presented in the table lead to a number of conclusions. If there is no difference in the rate of compensation for an hour of formal assistance and an hour of family assistance then the compensation principle will always be more expensive. Only if families stop providing care altogether, will the cost of both methods be identical. When the hours of family care are compensated at a lower price, the relative cost of the two methods is unclear. The cost depends on the difference in family assistance under the two principles and on the level of compensation for one hour of family assistance. As seen in Table 2, at an 80% compensation level the difference between the distributions needs to be considerable. So that only if the distribution in the willingness approach is as in Assumption B, and the distribution in the compensation approach is as in Assumption A — will the cost of the two approaches be identical. The more we lower the percentage of compensation, the less the required difference in the distributions, in order

that the cost of the compensation principle be less than the cost of the willingness principle.

We now consider the possible differential effect on institutionalization. In Israel today, 2.2 percent of the elderly are in nursing institutions. They constitute 70-80% of the nursing population living in the community. In other words, were we to completely prevent institutionalization, the number of disabled elderly living in the community would increase by this percentage. A 1983 study on the possibility of preventing institutionalization among elderly on waiting lists for institutional placement in three cities (Habib et al., 1986) found that approximately 50% of the severely impaired elderly could have remained in the community, if the community services were expanded. We assume that a lower rate of institutionalized elderly could live in the community — about 30% at most. Based on this assumption, we arrived at a maximum growth of 25% in the number of the elderly in the community. Preventing institutionalization would raise the cost of community care, but there would be a saving in the cost of institutional care. The overall saving is a function of the difference between the cost of these two forms of care. In the above study (Habib et al., 1986), the average difference in cost was found to be about $125 for the severely disabled, which is about 17% of the public cost of institutional care. Thus, it is possible to save on overall costs if the expansion of community services reduces the occurrence of institutionalization. But for purposes of comparison between the methods, not only the absolute effect on institutionalization is important, but also the differences in the efforts between the two methods. There are two aspects to be considered:

1. Will the reduction in institutionalization be greater in one method than in the other? There is no certainty that the difference will be significant; in any case, there is no evidence to this effect in the literature.
2. Will the difference in the cost of care in the community as opposed to in an institution be different in the two methods?

The relative cost itself is related to the amount of family assistance. In the compensation method, the difference will be smaller, unless the rate of compensation for a family is lower than the payment for formal help, and there is a significant difference between the methods in the amount of family assistance. In the final analysis, the effects on institutionalization could bring about an additional difference in cost between the two methods, but this is not unequivocal, and the difference is not likely to be large.

3. *The New Long-Term Care Insurance Law*

The principle behind the law that was finally passed does not purely reflect either of the concepts, but rather is a compromise between the two. The main features are:

a. The law provides an entitlement within the framework of social insurance. This means that there is no budget constraint, and that the needs of everyone who is found eligible are to be met. If the expenditure exceeds revenues, then the law can be changed in order to achieve a balance — either by paring down eligibility or expanding the rate of contributions. This also means that anyone who considers himself unjustly deprived of benefits may appeal to the labor courts.
b. The law entitles clients first of all to receive services. The service provider may be a public or private agency, or even a neighbor. The payment, however, must be made directly by the National Insurance Institute to the provider. Only if the service is not available is the client entitled to a cash benefit, which may be used for any purpose — the client is not obliged to purchase a service with it. The cash benefit, in these cases, will be pure compensation, since if there are no available services, the money cannot be used for purchasing services in any case. The combination of ensuring services and cash benefits is a unique feature that sets the law apart from other frameworks which guarantee services both in Israel and abroad such as public or private health insurance. However, if there are restrictions on types of providers or on wage rates under the law, the family may be able to mobilize the support in cases when the formal system is unable to do so.
c. The law defines eligibility for assistance in monetary terms, and the sums are linked to the average market wage. Here, too, the law differs from other frameworks which guarantee services where entitlements are usually defined in terms of service units. This means that if the relative wages of home-service providers changes, then the real value of entitlements within the framework of the law will also change. The amount of the benefit is in accordance with two levels of disability: "Disabled in *most* activities of daily living" and "Disabled in *all* activities of daily living". Thus, the range of eligibility is not continuous with the range of needs, as is usually the case in laws which guarantee services, but rather, clients with different levels of need are eligible for the same amount of assistance. The significance of this way of defining entitlements will depend on how the law is actually implemented, as will be explained below.
d. Eligibility is determined on the basis of the need for assistance, due to functional disabilities. However, people with the same functional disabilities may require different amounts of assistance from the formal services depending on their living conditions and family relationships. For exam-

ple, an elderly person who lives with a spouse or children will need less homemaking assistance (about 73% of the severely disabled elderly live with their spouse or child), as many families are interested in providing some of the personal care themselves. It is not to be expected, therefore, that the clients will request all the assistance to which they are entitled, and there is no reason to encourage them to do so. The role of the professionals responsible for creating a care plan for eligible clients will be to assist the clients and their families to find the desired balance between formal and informal assistance.

e. The law does not attempt to meet all the needs of the elderly, even with regard to those services covered by the law. Eligibility is limited to a fixed amount which equals, in terms of purchasing power for personal care services, about 12 weekly hours of care for a partially disabled person. This does not exceed the maximum eligibility level available today in the Ministry of Health and Kupat Holim frameworks. On the other hand, a disabled client could need 30 weekly hours of help. If the family is unwilling to meet some of these needs, the client will be forced either to apply to an institution or remain in the community with some needs unmet, or else the family will have to provide more help than they want to. Another possibility is that the client will receive supplemental services from the frameworks which currently supply these services (Ministry of Social Affairs, Ministry of Health, and Kupat Holim), however, this depends on maintaining the real value of the budgets allocated to these agencies for this purpose.

In summary, it appears that the law is a framework that provides a unique combination of entitlements for services and cash benefits, with a partial commitment to meet the needs of the elderly. Against the background of the overall service system, a three-tier system emerges:

a. The first tier, the Nursing Care Insurance Law, thus provides services on the basis of legal entitlement to anyone whose income is below a given level, with no budget limitations and with the right to appeal to the labor court.
b. The second tier, run by Kupat Holim Klalit, provides services within the framework of overall health insurance. As the system works at present, every elderly client who meets the eligibility criteria will receive assistance, regardless of budgetary considerations. However, financial participation geared to income level is expected. Lately, stricter eligibility criteria and higher participation rates for elderly clients have been imposed.
c. The third tier, run by the Ministry of Labor and Social Affairs, provides services within budgetary limitations. This tier is aimed exclusively at low-income populations.

The relationship between these three tiers is described in Table 3. In the first column, which is divided into three parts, we differentiate among three levels of disability according to the amount of assistance required. According to the preliminary plan, only the two categories found below the double line will be eligible within the Law's framework; that is, anyone needing 12 hours of assistance or more. This population numbers about 8,800 disabled clients. The category above the double line, which includes some 22,700 disabled clients who need less than 12 hours of help, will not be eligible within the law.

Table 3. Extent of Need and Extent of Eligibility for Assistance Within the Framework of the Nursing Law and Within the Existing Frameworks

Extent of Need for personal care	Entitlements for Personal Care and Homemaking
	Not Entitled Under the Nursing Law
1-11 weekly hours	*Kupat Holim*: Personal care up to 5 weekly hours
22,700 elderly[1]	*Ministry of Health*: Personal care up to 5 weekly hours **(income tested)**
	Ministry of Social Affairs: Personal care up to 6 weekly hours **(income tested)**
	Homemaking services — (income tested)
	Entitled Under the Nursing Law
12-22 weekly hours 5,460 elderly[1]	*Nursing Law*: Personal care and homemaking 12 hours weekly
	Kupat Holim: Personal care 5-7 weekly hours (participation based on income)
	Ministry of Health: Personal care 5-7 weekly hours **(income tested)**
	Ministry of Social Affairs: Some are entitled to homemaking **(income testing)**
23 weekly hours or more	*Nursing Law*: Personal care and homemaking 18 hours weekly
3,360 elderly[1]	*Kupat Holim*: Personal care 9-18 weekly hours *(Participation based on income)*
	Ministry of Health: Personal care 9-18 weekly hours **(income tested)**
	Ministry of Social Affairs: Some are entitled to homemaking **(income tested)**

1 Estimates for 1985

We will first focus on the bottom part of the Table. This part makes a further distinction, between those who meet the income test under the law and those who do not. Eligibility within the law is divided into two benefit levels. As mentioned above, translating the value of the benefit into purchasing power of hours of care by a home aide, at the market rates, shows that at the low eligibility level a person is entitled to 12 hours of assistance. Clients included in this category will need, according to their functional status, 12-23 hours. When there is a family that provides part of the care, it is likely that 12 hours will be enough, or that the client will not even need the entire 12 hours; but if the client has no family to provide some of the care, then 12 hours will not be enough, and this client will have to receive help from some other sources, or may apply to an institution. According to current eligibility rates, such clients can receive an additional 5-7 hours of personal care, and may also receive, if they have low incomes, homemaking assistance from the Ministry of Social Affairs.

The group eligible for the higher benefit will be able to purchase about 18 hours. This group includes people who need more than 23 hours of care, and who may even need, in some cases, 30-50 weekly hours. Here, too, everything depends on the extent of help that the family provides: if the family gives no help, then the client will need additional assistance from the existing system, which can provide an additional 9-18 weekly hours of help to this group.

This analysis highlights the importance of guaranteeing current budgetary frameworks which are the basis for enabling clients to remain in the community when they are in need of assistance over and above the level guaranteed by the law. However, the importance of family assistance is also evident, since the existing system does not have sufficient resources to provide supplemental assistance to all the clients who will need it, if their families discontinue providing help. It also shows the importance of an organizational system which combines an overall view of the needs and the means available to the system both within and outside the framework of the law.

A large disabled population will not be eligible under the Nursing law. This includes those who are sufficiently disabled, but do not meet the income test. They can receive partial participation from Kupat Holim. For less disabled clients, all the Ministries and Kupat Holim are involved in providing assistance, as reflected in the top part of Table 3.

The size of the non-eligible population emphasizes the importance of continuing to develop the programs earmarked for the populations which are not covered. This population increases rapidly from year to year, and even today, its needs are very partially met. The rather arbitrary dividing line between those who are eligible and those who are not suggests that there will be pressure on the professionals who perform the functional assessments to

somewhat exaggerate the clients' disabilities so that they will meet the eligibility criteria. This is natural in any system that divides entitlements according to arbitrary criteria. It may enhance the pressure on the law's budgetary framework, and it has negative consequences, both from the viewpoint of the client, who is given a label which does not match his condition and from the viewpoint of the professionals' attitude toward the law. A further danger is that the law will create the illusion among the elderly that their needs can be met, while in fact this is not true for a great many of them. This will put the professional caregivers and existing care frameworks in a difficult position. It emphasizes the importance of coordination between the system that establishes eligibility within the law, and the system that establishes eligibility outside the law, so that clients will not be sent back empty-handed. Of course, the ability to meet their needs are a function of the extent to which a realistic budgetary framework is maintained — one which grows with the growing needs of those populations that are not included in the framework of the law.

4. *The Cost of the Law*

Having described the law's principal features, it is possible to analyze the factors which determine its cost. The actual cost of the law depends on a number of factors:

1. The number of clients who apply and meet the functional and income tests.
2. The extent of demand for services by those who are found to be eligible.

As will become apparent, it is not possible to project with certainty the cost of the law, but it is important to identify the various factors that could affect it.

a. Number of people meeting functional and income tests: This depends on four major factors: The disability tests themselves, the population distribution by disability level, the tendency to seek assistance, and the amount of pressure applied by the clients on the nurses who perform the functional assessments.

The disability tests will have to provide a practical interpretation of the law's general intent that people disabled in most or all of their daily activities are entitled to assistance. Information on the distribution of disability in the population is not fully available. During the preliminary preparations for the law's implementation, a person who is disabled in most activities of daily living was defined as one in need of 12 hours of personal care assistance. On the basis of the B'nei Brak Survey (Brookdale Institute and the National Insurance Institute, 1986) it was estimated that about 31,500 people are dis-

abled in personal care, and of these about 8,800 need at least 12 hours of help. The higher level of eligibility parallels a need for 23 weekly hours, and in this category there are an estimated 3,400 people. It is not possible to estimate in advance how many of those eligible will actually apply. It is also impossible to estimate how different the assessments of the functional condition in the survey will be from that determined during the eligibility process. Of those which meet the functional test, some will be eliminated because they will not pass the income test. The severity of this test has not as yet been determined, so the extent of its effect cannot as yet be assessed. It will probably exclude 10-20% of the elderly.

b. Extent of demand by those eligible for services: The cost of the law will be determined, in the end, by the extent to which those eligible utilize the sums available to them. As mentioned above, this will depend on the willingness of the families to provide some of the help; this is a factor that is impossible to determine in advance. Another factor is the extent to which the services are available, so that the assistance will be provided more in the form of services than as a cash benefit. Here, there are two principles at work that have opposite effects on the cost of the law's implementation. If the services are available, we hypothesize that the natural reluctance to accept formal services will act to reduce demand. If the services are not available, and the clients are able to receive a cash benefit, then we hypothesize there will be more applications, and each application will want to receive the total amount that he is entitled to. However, the maximum sum for the cash benefit is only 80% of the benefit given for purchase of services. Because there are two opposing effects, it is impossible to pre-determine the effect of service availability on the final cost of the law. A further question is, what will happen if the services are partially available, but insufficient to meet all of the client's needs. Will he then be entitled to a partial cash benefit, and of what amount?

The budgetary assessments which accompanied the law were based on the conservative assumption that all those eligible would apply and utilize their entitlements to the full extent. According to this estimate, the law's cost will be $20 million in 1985 cash terms. Those who do not pass the income test as well as those who receive a cash payment amounting to 80% of the benefit should be deducted from this calculation. This should lower the cost by 10-20 percent to 16-18 million dollars annually.

By 1995, the number of disabled in personal care will increase by 46% (from 31,500 in 1985 to 46,100 in 1995). The number of eligible elderly will rise by a similar rate, reaching 13,000. The cost of the law, in 1995, based on the same assumptions will thus be $30 million (in real dollars). When the income tests and the smaller payments to those receiving cash benefits are taken into account, the cost declines to $24-27 million.

The estimated annual revenue from the law in fixed dollars are $15 million over time. Thus, the gap between the current expenditure and the current revenues collected will reach, according to conservative estimates, about $5 million in 1985 terms, and about $15 million by 1995. If the income tests, etc. are taking into account, the gap will fall to $9-12 million by 1995.

The gap between the revenues and the current expenditures will be covered in the first stage by the reserve fund that has been building up on the basis of social security contributions since 1980. This, however, will only suffice to cover the deficit in the first years. It will eventually be necessary either to increase the rate of contribution, to find other funding sources, or to lower benefits.

c. Other factors that were not taken into consideration: There are some additional factors that were not taken into account when estimating the costs, but should be mentioned.

As we noted in the first part of the paper, the law may reduce the population in institutions. In such a case, the direct cost of the law would rise, because a greater number of disabled elderly would be living in the community. We estimate that this effect could increase the number of eligible clients by a maximum of approximately 25%. The impact on costs could differ slightly, depending on the level of disability among those whose institutionalization is prevented. However, beyond the direct effect of the law, it should be noted that the projections regarding the development of the cost of the law are based on certain assumptions regarding the availability of beds, and accordingly the number of elderly in the community. Specifically, they are based on the assumption that the number of elderly in institutions will reach 12,400 in 1995, which entails an expansion of more than 50% in institutional solutions. But in fact it is doubtful whether the resources for developing these solutions will be found, and more importantly, there is no assurance that the budget for the daily finance of this many beds by the Ministries of Health and Social Affairs will be available. If the nursing beds are not financed and expanded, the number of those eligible under the law in 1995 could increase by about 2,300 disabled elderly, or about 18%. Another factor is the possible eligibility of some of the elderly in institutions. The law does not allow anyone in a nursing facility to receive a benefit, but people who meet the disability criteria may receive the benefit if they are residents of institutions for frail or independent elderly. This might lead to attempts to keep or place nursing clients in facilities that are not officially recognized as intended for this population, as a way of receiving assistance under the law. There is no way of making a quantitative estimate of the possible impact of this factor.

4. *Summary*

In this paper we have tried to analyze the different approaches that were proposed in the public debate on the nursing insurance law, and their possible cost implications. As we have seen, it is impossible to determine unequivocally the expected difference in cost, as it depends on how each option is specificed, and on assumptions regarding the response of the elderly and their families to the different options. We have also analyzed the version of the law that was finally passed, and showed it to be a compromise between the various possible approaches.

It is impossible to project the cost of the law that was passed because it depends on the nature of the public's response to the law and on how the law will be implemented. In particular, we emphasized that the calculations of the law's cost were based on the assumption that every disabled person would make full use of his eligibility. This will not necessarily be the case in a system that first and foremost guarantees eligibility for services. In this type of system, the extent of the family's willingness to provide care is a factor that affects whether or not the potential benefits are claimed. At the same time, the law guarantees that when the elderly are interested in using their eligibility to the full extent, assistance will be avaiable to them. We also emphasized that the law provides only a partial solution to the needs of the disabled elderly. If indeed the actual cost is smaller than the projected and planned cost, it will be possible to channel the surplus to enlarging the extent of assistance to those populations that are eligible and those that are not currently eligible.

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THE LONG-TERM CARE INSURANCE LAW — THE LEGAL ASPECT

by Dr. Dan Shnit*

1. Introduction

About two years ago, on April 25, 1986, the Knesset (Israel's parliament) passed the Long-Term Care Insurance Law[1] which constitutes an important contribution to Israel's system of welfare legislation. The law will enable the provision of personal long-term care services to those entitled to them as from April 1, 1988.[2] During the transition period up to the time of the law's full implementation, the National Insurance Institute will allocate resources to the amount fixed by the law, for the development of community services for handicapped people in need of long term care and for the development and improvement of services given in long-term care institutions. At the same time, the Institute will allocate additional funds, to the amount fixed by the law for expenditure on accomodations for the handicapped in long-term care institutions insofar as it is proved that the Ministry of Health and the Ministry of Labor and Social Affairs are increasing the number of people treated by them in these institutions over the number treated before the law came into force.[3]

The version of the law, as it was approved in the course of its rapid and intensive legislative process in the Knesset's Labor and Social Affairs Committee, reflects the compromises and concessions made both in the wake of the conclusions and recommendations of two public committees that dealt with this question[4] and in the wake of the draft law proposed by the government on January 6, 1986.

Before disclosing the law's provisions and subjecting them to a critical

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1 The National Insurance (Amendment No. 61) Law, 1986, *Laws of the State of Israel*, April 25, 1986, p. 154 (hereinafter: The Long-Term Care Insurance Law).

2 Section 7 of the Law.

3 See Sections 127 (97) and 127 (98).

4 (i) Report of the Committee to Propose Principles for a Long-Term Care insurance Law, headed by Professor K.Y. Mann (the "Mann Committee"), Jerusalem, May 1983 (Hebrew); (ii) Report of the "Committee of the Public Council for the Aged", headed by Professor Y. Mancel, which includes recommendations for principles for implementing the Long-Term Care Insurance Law, Jerusalem. October 1985 (Hebrew).

review, we should welcome its appearance, in spite of the criticism and the numerous defects revealed in it. Even its severest critics must admit that the law will be of great benefit to old people suffering from inability to perform daily functions without the help of others. Nobody disputes the fact that the law will grant, for the first time, on the basis of a legal right, long-term aid to old peole who, for reasons of physical or mental impairment, cannot see to their own daily essential needs.

This survey will concentrate on a critical analysis of the present legal arrangement in order to present the reader with its advantages and disadvantages, its good and bad points. Nevertheless, it does not intend to discuss the historical dimension of the legislative stage, nor the contribution of the public committees or other factors involved in crystallizing the recommendations and principles regarding the formulation of the law.

2. *The Situation Prior to the Law's Approval*

In the past, citizens in need of long-term care services had no legal right to receive them from any public organization whatsoever. Until the law comes into force services are being provided on the basis of wide discretion granted to various bodies. Three organizations are at present involved in granting long-term care services to parts of the needy population.

The Ministry of Labor and Social Affairs, by means of the social services bureaux of the local authorities, provides domestic help services and personal care to nursing patients, as well as to the frail in the community. This assistance is given from the Ministry's budget when three prior accumulative conditions are fulfilled:

a. The need for long-term care and domestic help is supported by the social workers authorized for this purpose in the social services bureaux. The needs are evaluated in coordination with medical factors in the community (the family doctor, the sick-fund nurse or the Ministry of Health).
b. The needy person, whose long-term care requirements have been recognized, passes a means test, i.e., his income from all sources is less than the minimum fixed in the rules issued by the Director-General of the Ministry of Labor and Social Affairs.
c. The budgetary framework earmarked for this purpose permits the granting of the assistance. Every local social services bureau has an approved budgetary framework which does not adequately cover the recognized need of the applicants.

The Ministry of Health provides nursing care to part of the population. The service is given on the basis of an evaluation of needs by public health

nurses at the regional health bureaux. The granting of this service too is conditional on a means test and on the situation of the budget at the time of application.

The general Sick Fund grants partial long-term care services to its insurees. The Sick Fund's rules do not obligate it to grant this service to its insurees and it is given in varying forms in the different regions of the country. The scope and quality of the service largely depend on the regional policy of the Sick Fund's district management. As a result, considerable differences exist in the allocation of resources and manpower to the long-term care of needy insurees.

The Long-Term Care Insurance Law was intended first and foremost to establish the provision of long-term care services to those needing them as of right. The present situation does not guarantee the provision of appropriate treatment to every nursing patient in need of it. The aim of the law is to ensure that by means of the National Insurance Institute, the resources required for long-term care in the community will be allocated. In view of the limited amount of resources mobilized thus far and to be mobilized in the future from insurees in the framework of this insurance branch, it is a basic assumption that the budgets earmarked for this purpose in the past by the three organizations mentioned above will continue to be at the disposal of those who need them. The intention of the Law's initiators was to ensure the allocation of additional resources in the framework of a long-term care insurance program of the National Insurance Institute and not the replacement of the present limited budgets of the Ministry of Health, the Ministry of Labor and Social Affairs and the General Sick Fund by National Insurance Funds which themselves are insufficient to provide a suitable solution to the numerous needs of the population.

We shall examine below the law's contribution to solving the basic problems of the long-term care population by attempting to answer the following questions:

- Does the law guarantee additional budgets and not mere replacement of budgets?
- Does the law provide a solution to all the problems facing the needy or only to part of them?
- What type of assistance is an insuree whose needs have been recognized entitled to receive?
- Is this an ordinary social insurance program or a social welfare program?
- What are the procedures for determining recognition of entitlement for long-term care and adapting the service to the person in question?

3. *Additional Budget or Replacement of Existing Budgets?*

The Long-Term Care Insurance Law will make a significant contribution to society as a whole only insofar as the resources allocated by the National Insurance Institute from insurance contributions collected for personal care and services development are added to the resources of the government Ministries and the Sick Fund. Accumulation of resources means: those at the disposal of the National Insurance Institute from contributions to the long-term care insurance branch (including the funds already accumulated) plus those included in the present budgets of the government Ministries and the Sick Funds for this purpose.[5] On the other hand, if the aforementioned State and Voluntary authorities regard themselves as free to cut the resources previously directed to this purpose, following the implementation of the Long-Term Care Insurance Law and the entry of the National Insurance Institute into the arena, then the main target of the law will be missed since the sums that the long-term care insurance branch will place at the Institute's disposal will not be sufficient to meet all the needs of the nursing patients in the community and they are not at all intended to meet the needs of patients in nursing homes.

The law's provisions do not prevent a "budgetary flight" of the financial resources allocated by these factors in the past to finance personal care and domestic help. There is therefore real cause to fear that when financining of personal services commences under the Long-Term Care Insurance Law (as stated, on April 1, 1988), the government Ministries and the Sick Funds even more so will consider themselves free of the responsibility to continue to finance these services. Consequently, needy people, who received care services in the community financed by one of the three above-mentioned factors and whose entitlement under the Long-Term Care Insurance Law is not recognized, are liable to find themselves in a worse situation than before the approval of the law. This is the case, for example, with old people whose disability does not reach the degree determined in the law as a condition for recognizing entitlement,[6] but who, nevertheless, had received care services from one of the three factors in the past.

Moreover, it is to be feared that nursing patients in the community who have not yet reached the age of 65 (men) or 60 (women) will be adversely affected by this development. The arrangements that existed up to now enabled long-term care patients in the community but who had not reached

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5 See p. 2, recommendation 12, in the report of the Committee of the Public Council for the Aged (Hebrew).

6 The degree of disability of a nursing patient for purposes of recognizing entitlement under the law is defined in Section 127 (84)(a). The definition and its implications are discussed below.

old age as defined by the Law to receive treatment too but, as already stated, their situation is liable to worsen if a "budgetary flight" takes place.

The situation with regard to the sources allocated for treatment in long-term institutions is different. In this case, the law makes the allocation of resources from the Long-Term Care Insurance branch by the National Insurance Institute conditional on the government Ministries responsible for services in long-term care institutions (Health, Labor and Social Affairs) proving that an increase has taken place in the number of people treated there. The Institute is authorized by the law to transfer funds to the Ministries up to a fixed ceiling (15% of the estimated annual collection of insurance contributions to each of the two Ministries) only if it receives proof that the Ministry in question has increased the number of its patients treated in long-term care institutions in the relevant financial year.[7]

This guideline of the law has both positive and negative aspects. The positive aspect is that a price will be set on a government decision to reduce the number of nursing beds maintained by the government Treasury. Such a reduction would cancel the Ministry's right to receive funds from the National Insurance Institute to finance the maintenance of patients in nursing homes.[8] The negative aspect is that there is no positive incentive for government Ministries to increase their budgets for nursing beds in any year since they are in any case entitled to receive money from the Institute for every person maintained in a nursing home above the budgetted quota. This arrangement will lead to a freeze of the government effort to increase the number of nursing beds from its own sources and will place the entire financial burden of increasing the number of nursing beds (which are seriously lacking) on the inadequate budget of the Long-Term Care Insurance branch. This is a negative result not intended by the law's initiators. It would have been preferable to make the transfer of national insurance funds to government Ministries dependent on two accumulative conditions: (a) the requirement, contained in the law, regarding the increase in the number of nursing beds above the number financed in a certain financial year; (b) the matching of any additional finance from the long-term care insurance branch by a similar sum (or other sum to be determined) from the government Ministry in question. Such a condition would have encourged an increase of the government's budget to solve the severe problem of the lack of nursing beds instead of freezing it at the level that existed before the law's coming into force.

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7 Section 127 (97)(b).

8 Section 127 (97)(b).

4. The Target Population — Who Will be Recognized in the Framework of the Law?

The law contains three limitations with regard to the location of the target population: age, degree of disfunctioning, place of residence.

a. Age. The target population for purposes of receipt of long-term services is limited by the law to insurees aged 65 (men) or 60 (women) — the age of entitlement by an old-age pension, as long as the application of the Law is not extended to persons below this age (under regulations which the Minister of Labor and Social Affairs is authorized to enact with the consent of the Minister of Finance and the approval of the Knesset Labor and Social Affairs Committee).[9] This condition excludes from entitlement all those in need of long-term care who have not reached the qualifying age for an old-age pension. The only justification for this age limit on entitlement is budgetary since it is clear that the needs of a person incapable of looking after himself and therefore requiring long-term care are not a function of his chronological age but rather the severity of his illness. The fact that the rate of nursing patients rises with age does not justify non-recognition of the rights of a younger insuree whose condition of health is so severe that he is incapable of performing most daily activities himself.

The population of insurees whose entitlements will be recognized includes housewives and widows with a pension[10] who are insured by virtue of their husbands. In addition, entitlement of new immigrants (under the Law of Return) who came to Israel at an age above that which allows them to become insured for old-age and survivors insurance[11] is also recognized. These elderly new immigrants will be entitled to a long-term care benefit even if they arrived in the country whilst suffering from a functional defect due to which they are in need of long-term care. The only limitation regarding new immigrants which does not apply to other people is the condition that they live in the country for a whole continuous year before their entitlement to submit a claim for a long-term care benefit is recognized (qualifying period).

b. Degree of disfunctioning. The law requires the right to a long-term care benefit only in cases of severe disability, i.e., old people defined in the Law as having become, as a result of physical or mental impairement, dependent on others to a great extent for performing daily activities[13] (dressing, eating,

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9 Section 127 (94)(1).
10 Section 127 (83)(2) and (3).
11 Section 127 (83)(4).
12 Section 127 (86).
13 Section 127 (84)(a)(1) and (2).

control of excretorial organs, washing, moving about the home)[14]. A lesser degree of impairement, which causes partial dependence on the help of others and performance of part of daily activities, does not allow recognition of the entitlement to a long-term care benefit under the law.

According to an estimate of the Brookdale Institute, made on the basis of a survey of long-term care needs and submitted to the Knesset Labor and Social Affairs Committee in the course of its discussions of the draft law, entitlement to long-term care benefits undert he law will be recognized for less than one third of all the elderly in need of personal care and domestic help. According to this estimate, entitlement will be recognized in the case of 9,000 elderly patients whose disability exceeds the degree fixed by the law whereas the needs of nearly 23,000 aged with a lower degree of disability will go unrecognized. The granting of personal care and domestic help to this large population whose needs will not be recognized within the law's framework will continue to remain the responsibility of institutional factors as before the passing of the law. This does not take into account those nursing patients who are not entitled to benefits because they have not reached the qualifying age (65 for men and 60 for women). This situation increases the danger expected from the flight of budgets and shedding of responsibility on the part of those who bore it before the law came into force. The danger lies in the fact that the situation of part of the population needing long-term care services will deteriorate as a result of the law instead of improving, a negative result which is in contradiction to both the spirit of the law and to the aims set by its initiators.

c. *The Nursing Patient's Place of Residence.* The right to a long-term care benefit is restricted in the law first and foremost to elderly nursing patients living in the community. The law explicitly denies the right to insurees residing in nursing homes or in nursing wards in which frail or mentally infirm persons or persons in need of long-term care, are maintained and treated.[15] Old people in nursing homes or homes for the frail elderly will continue to be maintained in the future with finance from private sources or with support from the budgets of the Ministry of Health or the Ministry of Labor and Social Affairs.

Government aid to patients in nursing homes is given ex gratia and not as of legal right, as will be the case in the future with regard to insurees in need of nursing care in an institution.

What will happen to old people in institutions for independent elderly

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14 This definition of daily activities is to be found in Section 127 (83) — definitions.

15 Compare to provisions of Section 127(87) with the definition of a long-term care institution in Section 127 (83).

who become nursing patients while in the institution and are not yet transferred to a nursing home or nursing ward? It appears that the law applies to them since it denies recognition of entitlement only to those insurees within a framework defined as a nursing one (including a nursing ward in a non-nursing institution). Nursing patients who continue to live in institutions for the independent elderly or even the frail (according to their classification and definition), will not be regarded as being in a nursing ward or home and will therefore be entitled to financing of long-term care services from the National Insurance fund just as will be insurees living in the community.

Entitlement of insurees in institutions for the independent and infirm to a long-term care benefit will be limited. First of all, old people who were nursing patients on their entry to such institutions will not be entitled to the benefit, because the regulations forbid acceptance of elderly nursing care patients to such institutions.[16] Secondly, entitlement will not be granted to old people who became nursing care patients in such institutions which have more than one hundred aged patients. The reason for this is that as from March 1, 1987 every institutions with one hundred or more old people will have to maintain a department for the frail aged and a nursing ward.[17] The existence of a nursing care ward in the institutions for independent elderly is intended to enable the transfer of an old person who has become a nursing patient from the independent ward to the nursing ward. The continued maintenance of such insurees in the former ward would be opposed to the purpose of the latter ward which, according to the regulations, must, as stated, exist in every institution with at least one hundred old people. It is doubtful whether artificial abstention from transferring old people who have become nursing patients to a nursing ward, which must operate in the institution according to the regulations, will lead to entitlement to a long-term care benefit for treatment of the old person in question.

Such a situation is liable to create discrimination between an old person who has become a nursing patient in the community and one who has become one in a home for independent elderly. The former will be entitled to a long-term care benefit to finance treatment services at home whilst the latter — or his family — will have to pay for the additional costs imposed on him as a nursing patient in the nursing institution or ward to which he has been transferred. This is because the law does not recognize, as stated, the right of a person in a nursing home or ward to a long-term care benefit. The right of those in homes for the independent elderly to the financing of long-term care

16 Section 30 (3) of the Supervision of Residential Homes (Maintenance of Dependent and Infirm Elderly in Residential Homes) Regulations, 1986 (Hebrew).

17 Sections 28(a) and 29 of the aforementioned regulations. These provisions came into force on March 1, 1987 (Section 62 of the same regulations).

services will be realized for a short intermediate period as long as the old person has not been transferred to a nursing ward. Transfer within the same institution or from one institution to another, from an independent framework to a nursing one, rules out the right to a long-term care benefit.

Discrimination is also created between an old person in an institution for independent elderly who has become a nursing patient and an old person in the community who has become a nursing patient and for whom it has been determined that no long-term care service is available. In the first case, transfer to a nursing ward is liable to lead to greater financial participation on the part of the old person or his relatives in the cost of his maintenance. In the second case, the financing of his maintenance in a State or State-supported nursing home is likely to come from the Long-Term Care Insurance funds of the National Insurance Institute.[18]

5. *The Nature and Scope of the Long-Term Care Benefit*

a. The nature of the benefit — in cash or in kind? The principle of payment in this program differs from that in other national insurance programs. Generally, an insuree is entitled to receive a cash benefit to the amount fixed by law. The Long-Term Care insurance program is based on a different principle. It grants a right to the financing of services in kind but not to a cash benefit paid to the insuree. An insuree whose right to a benefit has been confirmed will be entitled to coverage of the costs of his personal care up to the amount fixed by the law. The payment will be made to the supplier of the long-term care service but not to the recipient.[19]

An exception to this rule is when the local professional committee determines that an elderly nursing patient lives with a relative who takes care of him and that no long-term care services are available for him. In such cases, the National Insurance Institute will transfer the payment of the benefit to the entitled person in question.[20] In these special cases the long-term care benefit is reduced to 80% of the regular benefit paid under the law.[21] It should be noted that the elderly nursing patient who lives with family caregivers has no right to choose between a direct cash benefit and payment to an outside care worker determined by the local professional committee to be an available service for the insuree. If a local professional committee determines that there is an available service in the community for the elderly nursing patient living with relatives who take care of him, they will be faced with the difficult

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18 Compare Section 127 (85)(3) and Section 127 (95)(b) of the Long-Term Care Insurance Law.
19 Section 127 (85)(b).
20 Section 127 (85)(c).
21 Section 127 (84)(b).

choice of caring for him themselves without resorting to an external available service --- in which case they will not be entitled to the long-term care cash benefit — or agreeing to a service from an external factor which will be directly reimbursed by the National Insurance Institute.[22] This policy does not encourage family solidarity as a substitute for reliance on an external aid since refusal to resort to an available external supplier of services will abrogate the rightof the old person and his family caregivers to receive a long-term care benefit.[23] In reality, there are many cases of old long-term patients refusing aid from strangers towards whom they develop an attitude of suspicion and lack of confidence. In these circumstances the insuree is liable to be deprived of his right.

The wording of the law indicates the intention not to regard the relatives with whom the elderly nursing patient lives and who care for him as an available service.[24] Hence, an available service means an external one since if a relative who cared for an elderly nursing patient living with him could be regarded as an available service, then Section 127 (85)(c) would be superfluous. In particular, the closing passage of Section 127 (85)(c) would be meaningless since it states that a person who declines without reasonable cause the assistance of available long-term care services in the community and prefers the assistance of his family, loses his right to a long-term care benefit.

b. The amount of the benefit. The amount of the benefit to finance long-term care services is fixed according to two degrees of functional disability. An insuree whose handicap causes considerable dependence on the help of others in performing most daily activities or who is in need of attendance, is entitled to a full individual pension. The rate of the benefit is 25% of the average wage which is identical to the full individual benefit of a general disabled person.[25]

In severe cases, the rate of the long-term care benefit is higher.This refers to insurees suffering from very severe handicaps which cause absolute dependence on the help of others in performing all daily activities or necessitates continuous attendance. An insuree with a serious functional condition is entitled, as stated, to a benefit for the purchase of long-term care services at a rate of 150% of the full individual pension, which is equivalent to 37.5% of the average wage.

Calculations made reveal that an ordinary long-term care benefit will

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22 Compare Section 127 (85)(b) and (c).

23 The closing passage of section 127 (85)(c) states: If long-term care services were available but the entitled person refused to accept them without a reasonable cause, the long-term care services will be considered as having been supplied to him.

24 To strengthen this point, see the explanations in the draft law to Sections 127 (85) and (86) of the Long-Term Care Insurance Law, *Draft Laws of the State of Israel*, 1764, p. 67, January 1, 1986.

25 The amount of a full individual pension is defined in Section 127 (37) of the National Insurance Law.

suffice to finance personal care for 12 hours per week whilst an increased long-term care benefit will suffice to finance personal care for 18 hours per week. In both cases it is clear that the amount of the benefit is insufficient to cover the entire needs of the elderly nursing patient. In any case, it is assumed that the insuree receives treatment from relatives and other factors in the community. The practical conclusion of the aforegoing is that a solitary old person who is completely dependent on the help of others or is in need of continuous attendance cannot continue living for long in the community, relying on the insurance benefits which cover only part of his long-term care requirements (up to a maximum of 3 hours per day).

In exceptional cases a cash benefit is paid directly to the entitled person when, as stated, an elderly nursing patient lives with a family caregiver and the local professional committee cannot find available long-term care services for him. The cash benefit in such cases amounts to 80% of the full benefit determined by the law in accordance with the extent of dependence on the help of others in performing daily activities.[26] If available long-term care services cannot be provided for an individual who is not cared for by his relatives (whether they live with him or separately), his entitlement to a benefit will not be recognized. According to the law, the aim of the benefit is not to provide a financial compensation, but to finance the purchase of long-term care services.

An elderly nursing patient who is not cared for by a relative for any reason whatsoever and for whom the local professional committee did not manage to arrange available long-term care services, will be entitled, in constrast to the aforementioned case, to enter, in accordance with accepted rules, a State or State-supported nursing home. This maintenance in a nursing home in these circumstances will be financed by the budget fixed for such purposes in the framework of the Long-Term Care Insurance funds (Section 127 (97)(b)) as well as the approved budgets of the Ministry of Health and the Ministry of Labor and Social Affairs.[27] Preference for arrangements in nursing homes is meant to ensure a suitable solution for the elderly nursing patient who is not suitably cared for within the family or outside it. On the other hand, a family which shows solidarity and cares for the elderly nursing patient living with it will be entitled to financial compensation (80% of the benefit) only if there are no available long-term care services.

A special difficulty is liable to arise in cases in which relatives caring for an elderly nursing patient, or the latter himself, refuse to permit a stranger to enter their home and provide the long-term care services. In such cases the

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26 The reason for the reduction of the cash benefit in these circumstances is based on a calculation of costs which takes into account the absence of administrative expenses in the case of provision of services in a family. See explanations to the draft law (note 24).

27 Section 127 (95)(d).

insuree will not be entitled to a cash benefit (at the rate of 80%). An insuree who lives with his family does not have an option to choose between receiving services from relatives and receiving them from strangers. He, and the relatives with whom he lives, must agree to receive them from a stranger if the local professional committee decides that there are available long-term care services; otherwise the insuree is liable to lose the long-term care benefit to which he is entitled under the law. Decisions on such issues will take into consideration whether the insuree's refusal to accept the services offered to him is based on a reasonable cause. The law does not define a reasonable cause and therefore it is a matter of wide discretion given to the approving authority, i.e., the local professional committee.

6. *Means Test as a Condition for Recognition of Entitlement*

A key principle in the concept on which national insurance programs are based is that the conditions for recognition of an insuree's rights to a benefit on a contingency is defined by law as entitling him to such a benefit, do not include income tests or discretion based on morals or values. It is not necessary for the insuree to provide his economic need before being able to materialize his rights under the National Insurance Law to receive a benefit. Proof of economic need as a precondition of recognition of rights to a benefit is appropriate in welfare laws which place a stigma on the needy but not on social insurance laws under which benefits are granted as legally required and independent rights.[28]

The Long-Term Care Insurance program diverges from this general principle on which the other insurance programs are based. The actual right to a long-term care benefit and its rate depend on income tests to be determined by the Minister in regulations with the agreement of the Minister of Finance and the approval of the Knesset Labor and Social Affairs Committee.[29] In these regulations the Minister will state the rules and the tests for calculating the insuree's income in order to determine whether his right to financing the long-term care services he needs will be recognized. This fact lends the program the clear characteristic of a welfare program and at the same time eliminates characteristics of social insurance programs.

In one type of situation the Long-Term Care Insurance Law contains an income test whose requirements go even further than those of an income test in an essentially welfare law, such as the Income Support Benefits Law. The provision which deals with an elderly nursing patient's right to receive a

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28 For the characteristics of a social insurance system, as distinct from a welfare system, see: Abraham Doron, *The Welfare State in a Changing Society*, Magnes Press, The Hebrew University, Jerusalem, 1985 (Hebrew), Chapter VIII, p. 101.

29 Section 127 (84)(d).

benefit directly, whilst living with a family caregiver and in the absence of available long-term care services, lays down an additional condition which extends the income test to relatives and does not limit it to the insuree himself. In reckoning incomes, those of children are added to the insuree's income, if they exceed an amount equivalent to double the average wage. For purposes of comparison the Income Support Benefits Law, which is a clear welfare law (and not a social insurance law) limits the income test to the spouse of the benefit claimant alone[30] and does not extend it to adult children. The latter's income are not taken into account when calculating the resources of income support benefit claimants. The result of the aforegoing is that the income tests fixed in the Long-Term Care Insurance Law in the aforesaid circumstances (an insuree living with family caregivers and in the absence of available long-term care services) are more extensive in their scope than those in the Income Support Benefits Law which is an essentially welfare law.[31] This fact reinforces the conclusion at which we arrived, namely that the program's characteristics are more suited to a welfare program than to a social insurance program.

This unique provision, according to which the income of children who live with and take care of an insuree are added to the latter's income, also constitutes a negative incentive to family solidarity. This conclusion is based on the distinction made in the law between a relative who takes care of an elderly nursing patient who does not live with him and a relative who takes care of one who lives with him. In the former case (separate residence) the local professional committee may decide that the relative will receive a benefit at the full rate. Recognition of the insuree's entitlement to a benefit in these circumstances and determination of its rate will not be based on a means test of the relative supplying the service. On the other hand, in the latter case (common residence) the family caregiver's action may prove to be a double obstacle. First of all, the relative cannot be regarded as an available long-term care service and the insuree will receive a benefit of only 80%. Secondly, entitlement to a benefit will be conditional on a means test of the relative who supplies the service. This double stringency of the conditions in circumstances which should be encouraged is liable to have the opposite effect and send forth a negative message regarding the worthwhileness of family soldarity. The efforts of a relative who reveals a sense of family responsibility as reflected in his maintenance of the elderly nursing patient and his devoted care of him in his home should be accompanied by a positive incentive in order to encourage him and not by "sanctions" which will result in lack of solidarity in the future.

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30 Section 11 of the Income Support Benefit Law, 1980, 35 LSI 12.

31 Compare Section 127 (85)(a) of the Long-Term Care Insurance Law with sections 9-11 of the Income Support Benefit Law.

7. Procedures for Recognizing Entitlement and Supplying Long-Term Care Services to Insurees

The long-term care services for the target population in the law should be supplied as quickly and as efficiently as possible and with minimum bureaucratic difficulties and obstacles. The law deals with a weak population group which, due to its heavy dependency on the help of others, requires the relevant authorities to supply it with an immediate and flexible response to its needs. Nevertheless, we have already made it clear at the beginning of the article that the law will recognize an entitlement of only part of the population in need of others' help. A considerable portion of those suffering from incapacity in their daily functioning will not attain the degree of disability which the law defined as entitling a person to a long-term care benefit or will not fulfill the other conditions of entitlement fixed by the law (qualifying age, income test).

The National Insurance Institute estimates the number of applications for recognition of rights as 3-4 times the number that will eventually be approved. The number of applicants will thus be high — 30,000-40,000 a year — and will require an efficient and proficient classification and evaluation staff. Moreover, recognition of entitlement is not, as is known, the end of the process but only determines its further direction. Following recognition of entitlement, suitable long-term care services must be established in the insuree's home according to the personal plan adjusted to the needs and family circumstances in which he lives. To sum up, it is a complex process which requires extensive preparations with flexibility in organization and execution. The processes of decision-making and implementation in the law's framework will be able to be evaluated properly only after a trial period which will enable the drawing of conclusions. At this point of time, when the law's provisions concerning the granting of the benefit have not yet come into effect, only a speculative analysis of these provisions which deal with a most important issue can be made.

The procedures for dealing with an application for a long-term care benefit under the law consist of two main stages: Stage A, decision on the National Insurance Institute's attitude towards entitlement to the benefit and determination of the rate of the benefit recognized: an ordinary benefit (equal to a full individual pension), or an increased benefit (equal to 150% of a full individual pension); Stage B, decision on the services to be supplied to the insuree and concern that the ones decided upon are delivered according to the plan determined or alternatively, a decision that there are no available services for the insuree. Denying the entitlement to a long-term care benefit in Stage A cancels the need to continue to Stage B.

Stage A: Determination of Entitlement to a Benefit. This stage consists of

two separate elements. The first is essentially formal and administrative. Its purpose is to examine whether the prior conditions for recognizing entitlement as fixed by law have been fulfilled. In its course, it will be checked whether the applicant is insured under the law, whether he meets the requirements of age and qualifying period and whether he passes the income test to be fixed by the Minister in regulations. These technical enquiries can be undertaken by an administrative worker appointed by the Institute since no specific expertise or knowledge is required.

The second element is essentially professional and consists of an examination to determine the insuree's degree of dependence on the help of others. This examination is the basis for fixing the scope of the insuree's rights to a benefit. We have already seen that the actual right to a benefit and its rate are derived from an evaluation of the insurees dependence on the help of others in performing daily activities. An evaluation that the degree of dependence on others is less than the minimum fixed, means in practice a denial of the right to a long-term care benefit.

Despite the fact that this is a key function requiring specific skill and knowledge in the evaluation of an old person's functional capacity, the law does not state who will carry it out. On this matter, the law limited itself to an organizational guideline, according to which the National Insurance Institute will carry out the examination in accordance with arrangements to be made between it and the health and social affairs services.[32] A study of the law's wording clearly reveals that responsibility for examining the degree of dependency on the help of others has been left to the Institute alone. The nature of the coordination required on this matter between the Institute and the other two partners in the law's execution (the health services and the social affairs services) is not explained in the law and the matter has been left in fact to arrangements that will be made on both the State level and the local level.

Emphasis of the need for the functional test to be made in coordination between the Institute and the health and welfare authorities arises from the fact that the test's results are likely to serve as the basis for the decision of the local professional committee concerning the long-term care plan required for the insuree. In the absence of coordination, a gap is liable to be created between the functional test's results and the care program drawn up to meet the long-term care needs of the insuree.

An inquiry made by the author revealed that the National Insurance Institute intends to operate in each region a team of public health nurses who have specialized in holding evaluation tests of functional capacity to perform daily activities. The actual entitlement to a benefit as well as its rate will be determined on the basis of the results of the functional tests to be carried out

32 Section 127 (84)(c).

by the nurses. Such a procedure imposes a heavy professioal responsibility on the nurses appointed to this task. They will be required to reveal professional judgement as well as great skill in many decisions, day after day. A combined action of the National Insurance official who will examine whether all the prior conditions for recognition of entitlement have been fulfilled and the public health nurse who will test the degree of dependence on others' help in performing daily activities will enable rapid classification of the numerous applications expected and transfer of those cases which meet the law's criteria for continued handling in the local professional committee. In this way it will be possible to shorten and streamline the processes and ensure that the whole procedure will be completed within thirty days as required by the law.

Stage B: Determination of Long-Term Care Services for the Insuree. At the end of the first stage, the National Insurance Institute will notify the local professional committee of every insuree whose entitlement to a long-term care benefit has been recognized according to Section 127 (84). The tasks of these committees which will operate within a regional framework whose boundaries will be defined in the future, are: to determine the long-term care services to be supplied to the insuree; to decide on the supplier; to supervise the provision of the service determined or, alternatively, to decide that there are no available services that can be supplied to the insuree.

The decision of the local professional committee is essential not only to ensure that the long-term care services supplied are suited to the insuree's needs but also to enable cash payment to the insuree in exceptional cases, as defined in the law, as well as to secure a place in a nursing home maintained by the State for those insurees who are not supplied with long-term care services. In the first case, the committee has to decide that the insuree is living with a family caregiver and that he cannot be supplied with available long-term care services.[33] In these special circumstances the committee's decision will constitute an authorization to pay him a long-term cash benefit (at 80% of the full rate). In the second case, the committee has to decide that there are no available long-term care services and the insuree does not receive any from a relative, whether living with him or not. Such a decision by the committee grants the insuree the right to be received, according to the accepted rules, by a State or State-supported long-term care institution.

What is the composition of the local professional committee to which the Law has granted such extensive powers? It is charged. as already mentioned, with drawing up a suitable long-term care plan for each person entitled to a benefit, with making sure that a long-term care service infrastructure exists in

33 *Section 127 (85)(c).*

the region of this activity and with developing in case of need available long-term care services for those entitled to them. The teams will be multi-professional and will operate in a defined area of jurisdiction. The committee membership will consist of a health services nurse, a local welfare bureau social worker and a National Insurance Institute employee. The committee will consult the doctor on every matter it considers necessary. It is a model of an inter-discipilnary body which is required simultaneously to prove the professional qualifications of its members for purposes of suiting long-term care plans to insurees and to prove their organizational and administrative qualities for purposes of developing and operating available long-term care services in the region for which they are responsible.

In the absence of efficient and energetic functioning on the part of the local professional committees, the principal aim of the law is liable to be missed. The operative responsibility for supplying long-term care services rests on the local professional committee. Inefficient functioning on its part means lack of an appropraite response to the long-term care needs of the insurees who will not be able to materialize their entitlement despite the fact that it has been recognized by the law.

The wide distribution of local authorities throughout the country and the lack of uniformity in the standard of health and welfare services for the elderly in the various localities makes the task of the local professional committees especially difficult and complicated. On the one hand, there is no possibility of organizing, operating and supervising dozens of local professional committees which would function alongside each local authority due to the numbers involved and the resulting fragmentation, as well as the tremendous cost of maintaining such an extensive system. On the other hand, it is vital for the local professional committee to maintain close contacts with the health and welfare services of each settlement because they are charged with ensuring that the long-term care service infrastructure and the paid treatments (homemaking, community and family services) operate on a reasonable level in the settlement.

These organizational and professional considerations require comprehensive thought and planning when setting up a local professional committee, both with regard to its members' capabilities and with regard to defining its areas of jurisdiction, patterns of activities and organizational contact with the health and welfare services operating in the various settlements. In this early stage, it only remains to hope that the bodies responsible for implementing the Long-Term Care Insurance Law in the spirit of its aims (the National Insurance Institute, the Ministry of Labor and Social Affairs and the Ministry of Health) will arrange to find the appropriate solutions to this complicated issue. A decisive part of the program's success depends on finding fitting solutions to the operation of the local professional committees.

8. *Summary and Conclusions*

After the Long-Term Care Insurance Law comes into effect, Israel will serve as a model worthy of serious study, despite the criticism that has been expressed in connection with the law's numerous defects. Developed welfare states, such as England, Scotland, Holland and Norway already provide those of their citizens lacking full capacity to look after themselves with developed community and institutional health and long-term care services. Nevertheless, none of these countries has a social insurance law which recognizes the right of every elderly nursing patient living in the community to receive personal services in accordance with his recognized needs.[34] The law in England, for example, states that personal long-term care services in the community are the responsibility of the local authority. The scope of these services and the conditions under which they are granted are determined under the English law within the framework of the discretion granted to the local welfare authorities. In the absence of a definition of specific rights in the law, each local welfare authority is left with the discretionary authority to determine the order of priority in providing long-term care services. This situation is likely to encourage flexibility on the one hand, and lack of uniformity among the various local authorities on the other hand.

Israel's Long-Term Care Insurance Law is intended, as we have seen, to fill the vacuum left by the health and welfare authorities. In contrast to countries like England and Holland, Israel has not yet crystallized a long tradition of personal care of old people in need of help due to incapacity to perform daily activities. This fact turns the Long-Term Care Insurance Law into a principal lever both for developing direct services for personal care in the community and for expanding the infrastructure of nursing homes. Charging the National Insurance Institute with the responsibility for it ensures that there will be one state address for planning, development and operation of long-term care services for those in need of them.

The main problems in the future will focus on the fact that the law is not built to provide solutions for the entire population in need of long-term care. Such a comprehensive aim requires double or more the resources to be allocated to the program. The meager resources are the main reason that the services will be provided on a means test basis and to an extent that is incapable of satisfying all the needs. In the future, many people will discover that they are not entitled to assistance even after the law is fully implemented. Moreover, people in long-term care institutions will not be entitled in the

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34 See: Brenda Morgenstin & Perla Werner, "Long Term Care Services for Aged in England, Scotland, Norway and Holland", Survey No. 36, the National Insurance Institute, the Bureau of Research and Planning, Jerusalem 1982 (Hebrew).

future either to a long-term care benefit to finance full or part cost of their maintenance in an institution.

The arrangement determined in the law stresses the importance of cooperation between the health and welfare authorities responsible for providing services to the long-term care patient. Such cooperation is meant to ensure that recipients of a long-term care benefit will be able to obtain supplementary medical services (from the Sick Funds or the Ministry of Health) as well as domestic and social assistance (from the local welfare bureaux). Only such cooperation will be able to provide the person in need with the services he requires. The future also can tell us whether the necessary coordination among these authorities is actually achieved under the auspices of the local professional committees in order to enable the formulation of an appropriate care program for elderly long-term care patients. Parallel to this, it is necessary to ensure that handicapped persons whose right to a benefit is not recognized continue to receive suitable domestic help and personal assistance in the future. The contribution and importance of these services are considerable despite the fact that they are granted ex gratia and not as a defined legal right. Their absence would have a severe effect on the welfare of elderly nursing patients.

RESPONSE OF FORMAL SUPPORT SYSTEMS TO SOCIAL CHANGES AND PATTERNS OF CARING FOR THE ELDERLY

by Brenda Morginstin*

1. Introduction

One of the most acute and visible problems facing the health and social service sectors today is that of meeting the rapidly increasing needs of the disabled dependent elderly, especially those requiring long-term care. At the same time that western industrialized nations are under great pressure to reduce expenditures on welfare programs, the proportion of aged in the population, especially of the very old (75+), has been growing and is predicted to further increase over the next several decades (Rice, 1984). Demographic trends in the size and proportion of the elderly are compounded by epidemiological studies showing increasing rates of debilitating chronic disease and disability, particularly among the very old (Brody, 1982, Davies, 1984). Especially problematic is the growth of high-risk, hard-to-manage groups of elderly who suffer some form of mental disability and who require high-cost services.

Most relevant to long-term care planning are estimates of dependency in terms of activities of daily living. These estimates vary according to the definition utilized. Although the majority of elderly are not seriously dependent, even at advanced ages, at least 5% are institutionalized at any one point in time. Studies in Israel have shown that of the elderly living at home, approximately 7% require the assistance of others in performing daily activities (ADL) and 28% require household assistance (IADL) (Morginstin, 1984; Silberstein, 1981). Figures in U.S. studies range from 10%-18% for ADL dependency at home to about 40% for those requiring help with household chores (Factor *et al.*, 1982). These dependency rates increase with age (Table 1). Thus, the cost of health — primary, hospital and institutional — as well as

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Table 1. Proportion of Elderly Requiring Assistance with ADL and IADL* According to Age Group, Bene Beraq — 1979

	Age				
	Total	65-69	70-74	75-79	80+
absolute number	6,694	2,652	1,810	1,210	1,022
% requiring assistance with ADL	7.7	2.2	6.4	6.8	24.3
% requiring assistance with IADL	28.2	16.1	27.3	40.5	46.9

Source: Morginstin (1984), based on data collected by Silberstein (1981).

* ADL: includes mobility in home, washing, feeding, dressing, incontinence, attendance.
IADL: daily household chores.

of home and community personal care and support services spent on the elderly is beyond their proportion in the population. As a result there as been an overriding preoccupation in western countries with the growing, often unsupportable, cost of long-term care.

It is clear that meeting the long-term care needs of the elderly at home, in the community and in institutions will continue to require extensive funding. Although it may not be possible to reduce current expenditures significantly, many countries are searching for policy options for the provision of services in a more organized and efficient manner in order that funds be used to meet most acute needs. The questions for policy and planning are: What will be the order of priority in the use of funds? How should current funds be allocated, or new funds infused into the system in an effective, efficient and equitable manner which will meet needs while preserving imbalance in service provision and use? In other words, what kind of system are we aiming at that will provide an appropriate formal response to long-term care requirements?

It is important to recognize that while the design of a long-term care system should reflect the current magnitude of long-term care requirements, these cannot be defined only in terms of population data and dependency rates. Planning formal services requires a different approach in each society, based on its political structure, tradition of service provision, division of responsibility, program needs, desired short and long-term program goals and program constraints (Morginstin and Shamai, 1985). There are several factors, however, which are common to most societies and which ought to be carefully considered in planning a long-term care program:

a. informal care patterns;
b. current patterns of service use (institutional and non-institutional);
c. changing social conditions.

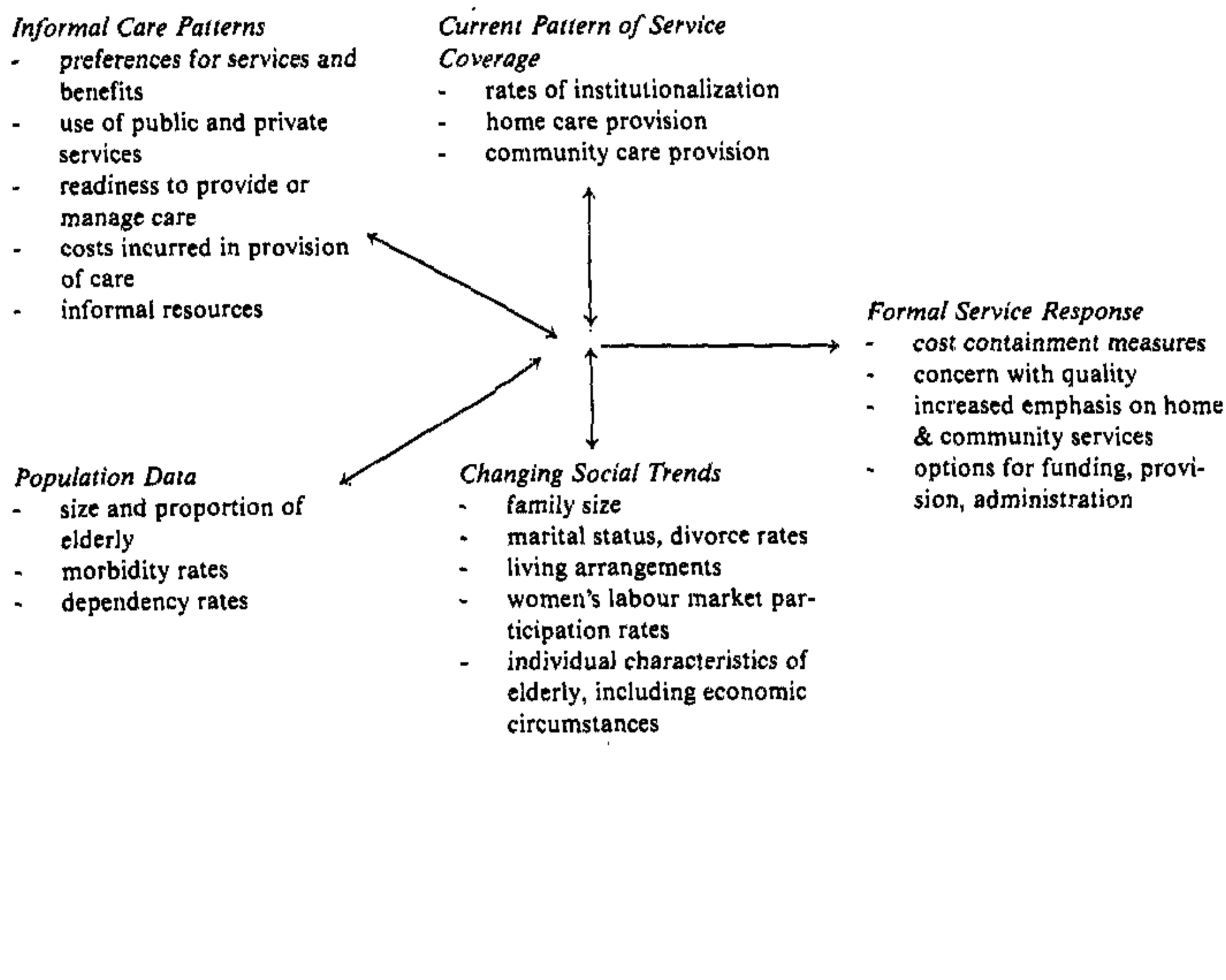
These interrelated factors are described schematically in Figure 1.

It is suggested that the very way in which a formal long-term care program is designed, funded and implemented should be related to these factors and will in turn affect the patterns of informal care and service use, and in particular the ability of the family to provide and manage informal care.

2. Informal Care Patterns

Research as well as experience continue to affirm that the family is the major provider of care for the elderly (Shanas, 1979; Shuval, 1982; Silberstein, 1981). Studies in Israel and abroad have shown that approximately 80% of the elderly, dependent in functional activities of daily living, are receiving care from family members. In Israel this figure reaches about 86% in some areas where research has been conducted. Formal services, provided by government and public agencies, cover a much lower proportion of the aged. In Israel, for example, about 14% of the non-institutionalized dependent elderly receive services for personal care and about 7% for home help. The

Figure 1. Some Factors Affecting Long-Term Care Planning



degree of overlap is very small — most persons receive help from family only, while only a small proportion receive both informal and formal services (Table 2). Thus there is a significant need for additional services from the formal sector — mostly to complement family care or to reduce overburden on the family.

Given the recognition of the increasing burden on the family, it may be expected that there be a shift in emphasis on target population from the elderly themselves to the older person *and* his family. The concern with family support services is one indication of the increasingly accepted approach that the family is indeed becoming a target in long-term care planning (Montgomery, 1984). This broadened view of the target population should be accompanied by a flexible approach in designing the kinds of benefits and services which will be included in a long-term care program. If we are to respond adequately to family needs and expectations, concern with the family should become an integral aspect of planning beyond the creation of the occasional seminar or self-help group.

In this context, however, it is important to expose a duality in professional thinking about family caregiving which is probably a result of the historical development of social welfare services for the elderly (Parker, 1980). These services have generally been provided on a selective rather than a universal basis. On the one hand, the existence of kin as potential and actual providers of care has repeatedly been documented as an invaluable resource, often the principal factor affecting the probability of institutionalization. In fact, family care has been and is viewed as the primary component of community care. On the other hand, while the growing burden of care is recognized by professionals, there is a tendency to consider family caregiving as a *free resource*. In fact, the family caregiver has in the past been neglected by the formal service system.

Table 2. Need for and Provision of Personal Assistance and Home Help Services Among Dependent Aged Bene Beraq, 1979

	% receiving services			% with needs	
Type of assistance	From family only	From community only	From family & community	% with unmet needs	% with need for alleviating family burden
personal assistance	76.6	3.6	9.7	26.0	12.1
home help	58.5	4.2	2.8	43.6	10.7

Source: Morginstin (1984), Silberstein (1981).

In planning programs for the elderly and their families at home, it is necessary to define carefully our concept of social policy in a way that closely reflects actual patterns of care, expectations and preferences of the family and expected family behaviour in the future as influenced by changing social trends. It is suggested in this paper that these changes, while they will not undermine or diminish the basic family willingness to continue fulfiiling its responsibility, will inevitably affect informal care patterns and the expectation on the part of the elderly and his family for government support. It is further proposed that response by the formal sector should be in the form of a flexibile universal program of long-term care which will provide a variety of in-kind services and cash benefits in order to enable and encourage the family to continue fulfilling its role as the principal manager and provider of care.

3. *Changing Social Trends*

Several changing demographic and social conditions that may affect patterns of care, family expectations and service usage have been documented in recent literature which has examined determinants of the magnitude of long-term care (Brody, 1981; Luce and Liu, 1984; Rice, 1984; Sang, 1983; Shanas, 1979; Vogel and Palmer, 1982). In general, the magnitude of need for long-term care has been discussed in terms of expected demographic changes in age/sex population structure and rates of chronic disease and disability.

Other demographic and social factors might not affect the basic level of need but have been identified as affecting the patterns of service response which have evolved in various societies, especially the balance of formal and informal care. These factors include: differential fertility rates among age cohorts, divorce rates (affecting the availability of children to provide informal care), marital status of the elderly (availability of spouse caregiver) and female labour force participation (availability of women to provide informal care at home) (Davis, 1985). To this we would add patterns in living arrangement and household composition trends, as well as economic status and level of education, all of which would affect not only patterns of care, but also expectations as to *kinds* of formal programs which might be made available.

Some of these conditions should be carefully examined in each society when describing current and emerging patterns of formal care. For example, although researchers have predicted an expected increase in the absolute number and proportion of old people in most societies (Rice, 1984), in Israel predictions indicate that we may expect a levelling off of growth at the turn of the century (Kop, 1981). This is one factor which should be considered in planning a program which might not respond to continued growing needs, but would be flexible enough to be modified periodically in terms of

changes in *kinds* of services required and the differential allocation of funds according to such changes.

In Israel the fact that informal care is in fact available in most cases is evidenced not only in survey findings, but also in data regarding living arrangements. Israel is distinguished from European countries in its much lower proportion of persons living alone and a higher proportion of couples. As pointed out by Achdut and Tamir (1985), single females, who are the most economically vulnerable group, comprise approximately 50% of all families in the 75+ age group in the U.S., Canada, the United Kingdom, Sweden, Norway and West Germany. In Israel, only 23% of all families in this age group are non-married females while the percentage of couples is 47% — double that of other countries. The percentage of single males is lowest in Israel and West Germany — 11%, as compared to 17%-18% in Sweden and Norway. This data, coupled with income trends, is significant for long-term care planning in Israel. Any program should be based on the assumption that in those cases in which family care is available, this care might be facilitated by a benefit to cover part of the expenses incurred in providing care. Other countries, however, having higher proportions of elderly living alone, might put greater emphasis on in-kind services rather than on cash benefits.

The changing role of women, who are generally the primary caregivers, will inevitably have an effect on caring patterns, expectations regarding kinds of services required and on the response of formal services to these patterns. In general, even when there are several siblings, there is a tendency for one person to assume caring responsibilities. In most cases this single caregiver is a daughter or a female spouse. An increasing proportion of women who have traditionally been the caregivers in our society are working outside of the home and are thus unable to fill the role of caregiver on a full-time basis. This trend, together with the smaller number of siblings to share the burden of caring, aggravates the already heavy burden of care.

Labour force participation rates are particularly interesting when we look at figures for age groups which are particularly vulnerable as potential caregivers. Experience shows that the problem of providing care to older parents or to a spouse is especially characteristic of upper middle age. Examining changes in labour force participation for persons aged 55+ according to sex, one finds that while other sex/age groups have experienced a *reduction* in labour force participation, in most countries the proportion of working women aged 55-64 increased significantly (Table 3).

However, Brody (1983) has pointed out that women's increased participation in the labour force will have an unknown impact on the caring situation in the family. The question is whether there will be a redistribution of responsibility among family members or an additional burden and strain on the working woman, thus aggravating the "woman in the middle" syndrome.

Table 3. Labor Force Participation Rates in Several Countries*

Country	early 1960s	1980	% change	early 1960s	1980	% change
	men 65+				men 55-64	
U.S.	33.1	19.0	-14.1	86.8	72.1	-14.7
Canada	30.0	14.7	-15.3	86.7	76.2	-10.5
Japan	56.5	40.8	-15.7	85.6	85.2	-0.4
France	24.0	9.0	-15.0	76.2	69.9	-6.3
Germany	24.9	7.5	-17.4	81.8	67.8	-14.0
G. Britain	23.4	8.9	-14.5	94.4	83.0	-11.4
Italy	25.2	8.4	-16.6	73.5	57.7	-15.8
Sweden	34.8	11.6	-23.2	91.1	79.2	-11.9
Israel	35.4	27.9	-7.5	84.6	82.4	-2.2
	women 65+				women 55-64	
U.S.	10.8	8.1	-2.1	37.2	41.3	4.1
Canada	5.6	4.3	-1.3	22.0	33.7	11.7
Japan	24.4	14.9	-9.5	44.4	43.6	-.08
France	9.0	4.3	-4.7	36.9	38.3	1.4
Germany	7.7	3.0	-4.7	27.2	28.8	1.3
G. Britain	5.7	2.9	-2.8	29.3	39.0	9.7
Italy	7.0	1.8	-5.2	20.2	14.0	-6.2
Sweden	8.6	2.5	-6.1	40.5	55.6	15.1
Israel	6.1	6.6	0 5	17.9	26.0	8.1

Source: Rojas-Pakas, *et al.*, 1985

Based on *Monthly Labor Review*, U.S. Department of Labor, Bureau of Statistics. February, 1983.

*Proportions for Japan, Germany and Great Britain include institutionalized population. Data for France are for 1979.

The burden of care, if it is not relinquished, will be compounded. However, it should be emphasized that increased labor force participation rates for women may have a dual effect: while the time available for caring may be reduced, the improved economic situation of women, accrued pension rights, savings, etc., may enhance their position as consumers of services. There seems to be evidence that families in which the wife works are more likely to purchase care (Luce, 1984). In other words, the tendency to acquire services from the formal sector will increase.

In view of studies that, despite predictions to the contrary, families are not relinquishing their responsibility as caregivers, the implication of this trend is twofold: a greater proportion of women will expect to be able to exercise greater independence in the way in which they manage care and in their choice of acquiring services; and as their earning power increases, women, who are traditionally the managers of care, will be able to purchase more services.

Thus, trends in labour force participation for women might be expected to affect the *expectation* of caregivers that the kinds of formal assistance available in long-term care programs permit them to make more *independent choices* in service acquisition while, at the same time, some groups of caregivers may enjoy somewhat improved economic circumstances which will enable them to cover at least some part of the cost of caring.

It would seem then that an important determinant of long-term care requirements and, by implication, patterns of care and service use, is the economic resources available to older people in the future. In the United States, for example, the average income of the elderly is expected to continue to increase, even in real terms, although at a lower rate than in the past. Moreover, traditionally large differences in income between men and women living alone are expected to narrow as more women enter the labor force and as men continue to leave the labor force earlier (Luce et al., 1984).

Certainly, cross-national comparisons of long-term care programs and attempts to learn or extrapolate from one society to the next should be based not only on a good understanding of demographic and cultural differences and of differences in tradition of service provision, but also on reliable comparative data which describe the economic circumstances of the aged in relation to demographic factors. Long-term care policy and planning should take into consideration the changing economic circumstances of the elderly population, especially in terms of retirement and earning patterns, capital income, public transfers and occupational pensions. One would expected, for example, that the relative proportion of public and private expenditure on long-term care, the emphasis on public or private service development, be related to the income available to groups of elderly. That the economic circumstances of the elderly may have an effect on long-term care needs and the concommitant response of formal services to these needs is evidenced by the example of Switzerland. Gilliand (1983) has reported that in Switzerland a significant increase in old age pensions in 1966 significantly reduced the number of admissions to old people's homes which were primarily funded by the government.

The analysis and comparison of long-term care development requires reliable comparative data over time. A good beginning has been made in generating and analyzing this kind of data in the Luxemberg Income Study (LIS) which has collated data from seven countries: Canada, Israel, Norway, Sweden, West Germany, the United States and the United Kingdom. From preliminary findings presented at the first LIS conference (July 1985) one finds some interesting differences in the economic well-being of the elderly at the beginning of the present decade (Table 4).

Thus, for example, comparison of the extent of poverty in different age groups shows that the risk of poverty is generally higher amongst those aged

Table 4. Poverty* Rates in Several Countries for Persons Aged 65+ and Total Population

Country	Aged 65-74	Aged 75+	Total Population
Canada	11.2	12.1	12.1
Germany	*12.7*	*15.2*	7.2
Israel	22.6	27.1	14.5
Norway	2.7	7.3	4.8
Sweden	0.0	0.0	5.0
U.K.	16.2	22.0	8.8
U.S.A.	17.8	25.5	16.9
mean	11.9	15.6	9.9

Source: Hedstrom and Ringen (1985).

* *Defined* as persons belonging to families with an adjustable disposable income below half the median for all families in the specific country.

75+ than those aged 65-74. Significant differences are found between countries, with Sweden having virtually no poverty for these groups. The authors (Hedstrom and Ringen, 1985) point out that this is due to reform in public pension benefit levels. Between 1952 and 1976 the average Swedish pension increased by over 300% in real terms, as compared to a 97% rise in average income among full-time industrial workers.

Longitudinal data of this type for future cohorts, coupled with projected labor participation rates, income from universal flat rates and occupational related pensions, should be considered when estimating the kinds of resources which will be available for long-term care. The elderly are still characterized by low incomes and a relatively high incidence of poverty. This seems to be especially true of Israel where almost half of the retired population receives income supplements. Long-term care strategy should reflect this data just as does income maintenance policy. Although individual differences will remain, some groups of elderly, such as working women, may be expected in coming years to enjoy better economic conditions with a greater sense of independence. This economic independence might, for example, be reflected in greater ability to purchase day care in the community or to participate in sheltered housing arrangements where long-term care services would be available if necessary. The proportion of public funding for these and other long-term care services, in the home, community or in institutions should reflect trends in income level. Thus planning for services and public allocation of funds should be based not only on forecasts of magnitude of needs but also on a projection of the various groups who will be the consumers of

services in the future, their preferences and their ability to acquire services from the formal sector.

It is not suggested that improved economic circumstances means a reduced need for publicly-funded benefits and services. However, some groups of elderly will be able to pay for a part of their service requirements. On the other hand, for low-income groups a cash benefit would constitute an important compensation for expenses incurred in direct service provision by the family. A benefit calculated to cover part of the costs, in order to share the cost of caring with the older person and his family, might therefore meet needs in those cases where informal care is already available.

The point is that increased awareness of changing social conditions and of demographic and income trends is crucial not only for estimatng the *scope* of services required, but also for designing the *kinds* of benefits — cash and in-kind — which would be made availabe, the procedures whereby these formal services could be acquired by the individual and his family and the *flexibility* of a long-term care program to adapt to individual differences and expectations and to growing expectations for making *independent choices* in care management. Trends in labor force participation of women, data regarding living arrangements and the availability of informal care, improved economic circumstances for some groups, as well as expected higher education level among the elderly would seem to indicate that caregivers will expect to be able to make more independent choices in service acquisition within a program of formal services based on the concept of shared responsibility/-shared cost between the caregiver and the formal service sector.

4. Current Patterns of Formal Service Provision: Institutional and Non-Institutonal Care

A basic policy goal in long-term care then is the need to develop a broadly diversified system of benefits and services to meet a continuum of changing needs, from need in the home to the need for institutions. On the one hand, the long-term objective is to assist the family and to develop services so as to enabe the disabled, dependent individual to remain at home and in the community for as long as feasible and to confine the use of nursing home beds to the most seriously disabled and to those living alone. On the other hand, an acute and most visible need in most countries is the current demand and waiting lists for nursing home beds. The issue behind these two seemingly conflicting goals becomes a practical question of priorities in allocation of limited funds in a model where cost containment is in itself a basic issue.

We find a great degree of variation among societies in the form and extent of institutional response to long-term care needs. However, the differ-

ential rates of institutionalization which have evolved in various countries cannot be attributed to demographic factors alone. A recent ISSA report (Davis, 1985) which sought to estimate the effect of demographic variables such as population age/sex structure on cross-national institutionalization rates found great variation when actual use rates were compared to protected use rates, using U.S. age/sex specific institutionalization rates as the comparative standard. It was found that whereas population characteristics alone would suggest similar use rates in the U.S., Sweden and Netherlands, both latter countries use institutional services at almost twice the rate of the U.S. In the Netherlands, however, rate of use of medical institutions is one-third less than the U.S. rate, while the use of non-medical institutions is almost seven times greater (Table 5).

In the same study, reported institutional rates vary from a low 3.6-4.5% in the Federal Republic of Germany to 8.7-10.5% in Sweden. A striking finding is the difference in medical and non-medical institutionalization rates. There is a much higher use of non-medical residential care in Western Europe than in Canada and in the U.S. The Swedish use of medical institutionaliza-

Table 5. Comparison of Projected Versus Actual Institutional Use Rates 1980

	Projected rate*			Actual rate		
Country	Medical facilities	Non-Medical facilities	Total	Medical facilities	Non-Medical facilities	Total
United States	4.5	1.2	5.7	4.5	1.2	5.7
Australia, 1981	4.2	1.1	5.3	4.9	1.5	6.4
Belgium,'81-83	4.5	1.2	5.7	2.6	3.7	6.3
Canada	4.2	1.1	5.3	7.1	1.6	8.7
Costa Rica, 1980	3.7	1.0	4.7	N/A	1.5-2.0	1.5-2.0
Denmark	4.5	1.2	5.7	N/A	N/A	7.0
France, 1982	4.8	1.3	6.1	5.3	1.0	6.3
Fed. Rep. of Germany, 1980	4.3	1.2	5.5	1.2-3.6	0.9-2.4	3.6-4.5
Greece, 1982	4.2	1.1	5.4	N/A	0.5	0.5
Israel, 1981	3.5	0.9	4.4	1.4	2.6	4.0
Japan, 1981	3.9	1.0	4.9	3.1	0.8	3.9
Netherlands '82-83	4.6	1.2	5.8	2.9	8.0	10.9
Spain, 1982	4.2	1.1	5.3	N/A	2.0	2.0
Sweden, 1980	4.5	1.2	5.7	4.6	4.1-5.9	8.7-10.5
Switzerland '82	0.5	1.2	5.7	2.8	5.0-7.2	7.8-9.0

N/A + Not available

* Based on a U.S. age/sex specific institutional use rate (measured by the 1977 National Nursing Home Survey).

Source: Davis, C.K., Long-Term Care Provided Within a Framework of Health Care Schemes, ISSA/MSC/XXI/2, Provisional Report, 1985.

tion is similar to that of the U.S., but its use of non-medical facilities is almost five times greater (see Table 5).

In other words, it would seem that factors other than need defined in terms of population characteristics are responsible for institutionalization rates. Given the fact that current data regarding need for beds based on waiting lists and rates of institutionalization reflect exigencies of the existing system, defining future need for nursing home care on the basis of extrapolated data alone would seem to be misplaced in view of long-term goals. This has been the experience in the Netherlands, where during the last few years one finds a contradiction between forecasts of the *increasing* need for institutionalization based on current practices and national policy norms which call for a *reduction* in the proportion of aged in nursing homes and other institutional settings (Morgenstin and Werner, 1982). In fact, the aforementioned ISSA report notes that on the basis of responses to its questionnaire, most advanced industrial countries perceive their rate of institutionalization as higher than necessary or desirable. "Most of these countries are currently pursuing deliberate policies to expand home and community-based long-term care services in part as means of reducing the need for institutionalization" (Davis, 1985). At the same time, however, some of these countries report experiencing considerable pressure to expand bed capacity to meet current unmet needs. In a broad sense, the need for institutionalization is not only a reflection of current requirements, but also becomes a question of long-term goals versus short-term pressures.

The costs of existing long-term care services point out the importance to Israel and to other countries of formulating clear-cut policy regarding the optimal balance between community and institutional long-term care, and the role of whatever program is developed in promoting such policy. Experience in other countries (Doron, 1978; Morginstin and Werner, 1982) as well as findings for Israel (Factor *et al.*, 1982) indicate that although community and institutional services are theoretically part of a single continuum of care which should reflect differential population needs, there is, in fact, a trade-off between community and institutional services which may be the result of emphasis placed on one aspect of care at the expense of, or to compensate for, a shortage of the other.

The issue of allocating resources between institutional and non-institutional sectors of long-term care has raised much discussion among professionals and policymakers. On the one hand, institutional care should be available for that group of chronically ill who, for various reasons, will inevitably be unable to remain living at home. On the other hand, recent developments in social policy increasingly emphasize the importance of assisting the family and of developing services for as long as possible. In some cases, inevitable institutionalization may at least be deferred for some time.

Examining long-term care schemes in other countries indicates some imbalance between the two sectors. In England, for example, where there is some overlap between acute and long-term care, chronically ill disabled aged are hospitalized due to the lack of sufficient long-term care services in the community. Since nursing homes are, in effect, hospitals, residential homes which were originally meant for the independent aged are slowly becoming transformed into nursing homes which are not always suited to the needs of residents from the point of view of physical condition, manpower, budget, etc. In Japan as well, much medically oriented long-term care is provided in acute care facilities. In the Netherlands, one of the results of the ABWZ Law, which had originally provided reimbursement primarily for institutional long-term care, is that there have been insufficient resources allocated to the community care sector. Indeed, the question that should be raised is whether the increase in institutionalization has been a result only of the increase in the number of chronically ill, or whether it is also a result of policy which makes it easier and more efficient for the family, and especially for professionals, to institutionalize an individual in a government-funded nursing home rather than provide services in the community.

Experience has shown that state policy and especially *funding practices* give rise to increased demand and use of services which are publicly financed. Countries which did not suffciently consider the desired balance between community and institutional long-term care have overemphasized the institutional end of the continuum of care, in terms of both policy and funding. In practice, such policy has constituted an incentive to the continued growth of costly institutional services at the expense of service provided by the community and the family. Much criticism has been voiced in recent years regarding the reduced role of the family and community as compared with the expanded role of institutions. Today the U.S. and several European countries are increasingly supporting the financing and growth of the community sector while attempting to reduce the role of institutions. For example, the Netherlands has pursued a policy of reducing institutionalization over the past few years by expanding benefits under ABWZ to include reimbursement for services provided at home and in the community. In Norway, too, policy in the past decade has encouraged a growth in community long-term care by making available reimbursements for such services.

5. *Formal Service Response Toward a Flexible Program of In-Kind Services and Cash Benefits*

Current trends emphasizing the growing importance of home and community long-term care have developed primarily as a result of pressures for cost-containment, although there is no clear evidence that home and commun-

ity services are less expensive than institutionalization when one inputs economic costs to informal care and includes opportunity costs. One could argue, however, against this type of conceptual approach to cost analysis of care provided in different settings which gives the same weight to economic cost of formal service provision often funded by the public sector and to the cost of informal care. It is unclear, for example, whether institutional care is less expensive if one looks only at public costs — the cost to the state of providing total care in an institution as compared to supplementing the informal care provided at home.

It is important to point out that increasingly the trend toward communty care reflects not only cost considerations but also growing sensitivity to the preferences and needs of the dependent older person and his family and the desire to improve the *quality of life* and *well-being* of the chronicaly ill individual and to create more alternatives for care prior to institutionalization. Moreover, sufficient non-institutional services would make it possible to view nursing home care as only one option within a range of communty services, an option which is not necessarily final and which ban be utilized for short periods of time. For this reason, it is essential to emphasize the importance of coordinating between the two sectors in order to maintain a continuum of care. Such coordination would view the process of professional and family decision-making regarding a suitable long-term care plan as a single process in case management which includes *all* options of institutional and non-institutional care. Today, the lack of coordination between professionals and organizations involved in care planning has resulted in separate and often duplicate procedures of need assessment and decision making for the two sectors. The literature today, especially that originating in the U.S., abounds with discussion of policy options for long-term care planning and funding (Callahan and Wallack, 1981; Gottesman and Cohen, 1985; Grana, 1983; Kane, 1985; Rossiter, 1984; Vogel and Palmer, 1982).

Whatever program is chosen, the basic question for each society is, given its specific population data, changing social conditions, cost considerations and existing modes of service provision, what is the *desired* pattern of care aimed for? What balance, what mix of benefits and services, against the background of current practices and expectations, will sustain the continued provision of family care, which seems to be the preferred vehicle in all societies? What program will facilitate the important link between formal and informal care, between public and private expenditures, and will build on the resource of family care while reserving formal services for hard-core need and for complementing family care?

It is important to recognize the fact that the kind of program developed, and especially its funding structure, will inevitably affect the pattern of care. As Gottesman (1985) has pointed out, by creating a service we make a deci-

sion on how the service will be used. By building a nursing home bed we make the decision that it will be occupied. Proposals for various kinds of programs vary from reimbursement, to fees for service programs, to block grants to universal insurance programs providing benefits and services. Most programs are based on government funding with some role left for the private sector. In general, the trend is for more and better services.

As already stated, common to most approaches is the tendency to consider family care as a free resource and to plan for services in-kind when family resources are inadequate or unavailable. This approach has not sufficiently considered the effect of family preferences on current patterns of care. We are not referring to the danger of families relinquishing responsibility for care. However, the incentive to substitute formal for informal care is strong if this is the only alternative being offered, just as institutionalization has been the preferred alternative if it is the only service being funded by government. Thus, social goals calling for more and better services, while important in themselves, cannot but constitute an incentive to *overutilize* these services, if a cash benefit is not included as an alternative within a range of services being offered to the families.

It seems that while some recent literature has seriously weighted the pros and cons of cash versus in-kind transfers, or insurance-based versus other selective programs (Callahan and Wallack, 1981; Grana, 1983), none has addressed itself to the possibilities of incorporating a statutory cash benefit within a broad spectrum of long-term care. Unfortunately, in fact, the two possibilities have generally been regarded as mutually exclusive, perhaps based on the assumption that the two types of benefits cannot be effectively organized under a single program. This remains a challenge to professional planners.

Proposals for Long-Term Care Insurance in Israel (Morginstin and Shamai, 1984) are based on the hypothesis that, in order to design a more flexible response to need, one that will most effectively utilize existing informal resources, including some private expenditures for services, Long-Term Care Insurance measures should incude as one benefit option some form of cash benefit to the older person and his family which has made the decision to provide care on its own or to purchase some of the services on the open market. This type of benefit would be one option within a range of services provided to older persons and their families who are capable of making decisions about care and who provide adequate care. Experience and research (Gottesman, 1985) has shown that a good proportion of those families requiring long-term care are capable of managing this care, or in other words, of being their own case managers, and would probably prefer exercising independence in case management.

Some of the trends described earlier would seem to support this

approach. It is believed that in the long run a program which would include a cash benefit as one option will on the one hand be more flexible to changing conditions which on the other hand indicate that the family cannot indefinitely be considered a free resource of care, and on the other hand take into consideration that caregivers may prefer to exercise independence in choosing services. The emphasis is on *partial* compensation for informal services in constrast to more expensive formal service provision under government funded programs, if we consider the enormous administrative costs involved in a program that would provide services.

It is hoped that cash benefits provided to some families will also constitute an impetus to the development of private or non-profit services which can be purchased by the older person. Needless to say, those receiving inadequate care, or the more isolated elderly, would be eligible for in-kind services.

A universal, insurance-based program which provides cash and in-kind benefits would take into account not only the needs of chronically ill dependent individuals, but also the needs of their families who are the primary providers of care. It is important to point out that this approach recognizes the principle of personal entitlement within an insurance program and does not exclude from eligibility individuals who are receiving adequate care from informal sources. Under Long-Term Care Insurance in Israel eligibility to benefits will be based on the principle of personal entitlement according to the degree of functional disability, irrespective of whether the family is providing care. The existence of family might affect whether there is a need for in-kind services and of what type. For example, persons living alone might be eligible for a higher benefit which would reflect the higher cost of services they must obtain; persons receiving no, or inadequate, family care might be eligible for in-kind services; those receiving help from family would indeed still be eligible for a benefit which would in fact be a form of partial compensation for services being provided or being bought on the open market generally at a significant cost to the family.

What this means is moving toward a concept of shared responsibility/-shared costs in long-term care. By providing a benefit which will cover part of the cost of service provision, it will be possible to help meet family needs as well as encourage family responsibility. This type of program would enable the individual and his family to acquire services in the community, if they so desire, thus facilitating the link between formal and informal support sectors.

An argument against an insurance program which would include a cash benefit has been that this type of program will be costly since all eligible persons would be entitled to some benefit — cash or kind, whereas under a program providing only services there would be individuals who are already receiving adequate informal care and would therefore opt not to receive a service. It is argued that those who are currently being adequately cared for

by the family, at none or little public cost, will become eligible for publicly funded benefits. The concern is that if large numbers of older people apply, the ultimate cost of this type of insurance-based program might be unpredictable and possibly unsupportable (Gruenberg and Pillemer, 1981).

Proponents of a cash benefit as part of a comprehensive program of long-term care visualize Long-Term Care Insurance as a social policy response to alleviate a given social condition, i.e., the increasing burden of dependency borne primarily by families, whether they receive additional services or are already providing adequate informal care. This approach makes a case for further strengthening the family's role in a long-term care program by enabling it to make decisions regarding the utilization of public resources according to personal preferences (Sager, 1983). In the long run, in-kind services or cash benefits, both of which can meet only part of the cost of service provision, will alleviate the burden of caregiving. One might go further by suggesting that provision of flat-rate cash benefits in some cases would be less costly than the involvement of expensive service structures. Indeed, it is believed by some professionals that defining social policy response to meet needs primarily in terms of expensive public services would lead to increased demand and spiralling costs of services. Moreover, one may point out serious problems of equity: limiting benefits to persons who do not receive adequate family care means "punishing" families who are currently meeting heavy responsibilities.

By providing a benefit to the eligible person living at home, and at the same time expanding the network and variety of community services, a flexible program of this type would, it is hoped, enable the disabled person to remain in his home and community for as long as feasible. It must be emphasized that the role of the benefits is not to replace family functions and responsibilities. The family will continue to have primary responsibility for the care and welfare of the individual. Therefore, the benefit will be calculated to cover only part of the costs incurred in caring for the functionally disabled, but will be high enough to enable the acquisition of some services, according to the older person and his family's choice and order of priorities.

6. *Community Services*

As part of a long-term care program which provides a mix of cash and in-kind benefits, it would be necessary to develop a network of public and private services in the community, one that would allow the family flexibility in service acquisition and would enable it to continue performing its caring role. Some of the services which are being advocated are:

a. Center for Long-Term Care. This service will provide a single address for

the family in need of consultation, services or referral, especially given the multitude of services and regulations faced by the family searching for assistance.

Experience shows that families do not apply for services until they are near the exhaustion point or in the midst of a crisis, at which time the potential effect of the service might be minimal. A center for long-term care providing case management would make it easier for the already overburdened family to apply for assistance.

b. Case Management or Service Coordination. Case management, a much discussed and examined service in the U.S., should be the focus of the center for long-term care. The primary responsibility of case management should be the coordination of a continuum of care, from the home to the institution if necessary. Although case management might be made available to all families, it has been shown to be most cost-effective for multi-service high-risk groups requiring intensive home care and professional involvement in introducing formal support services into highly personal, highly emotional caring situations. The role of the case manager, coupled with the family's feeling of "belonging" and trust, facilitates the provision and acceptance of services.

c. Day Care/Psychogeriatric Day Care. The importance of immedate day care for the dependent elderly has been increasingly recognized over the past decade. This service seems to be insufficiently utilized for high-risk groups, however, because of the difficulties and costs involved in transporting and caring for these individuals. Given the increase in labor force participation of women, this type of service should receive higher priority in planning if we desire to enable working families to continue performing the caring role. An important group requiring day care is the growing group of elderly suffering from some form of mental deterioration and living at home.

d. Services for the Caregiver. Some services geared to family caregivers themselves which have been more available, especially in the U.S., are:

- *Family study and support groups* organized by service agencies which provide practical information instrumental to the caring task as well as the opportunity for generally isolated caregivers to meet and exchange views with others in the same situation.
- *Respite service* both voluntary and paid, in the home or for short periods in an institution.
- *Organization of self-help groups* usually by families who have common problems in caring — such as those of Alzheimer victims.
- Services to families whose elderly relatives reside in *institutions* should not be neglected. Such services would be geared at counseling for placement and increased family involvement in the institution, including family

representation on public committees responsible for monitoring quality of care in institutions.

- *Volunteer services* — visits by volunteers which have generally been provided to isolated elderly should be extended to older people with caring families.
- *Congregate housing facilities* — should be extended to provide adequate long-term care so as to enable dependent residents to remain in their homes for as long as possible without having to move to a different facility.
- Finally, providing *medical services* at home is of the utmost importance. Often the decision to enter an institution is based on experience of the difficulties of receiving the care of a doctor at home. Unfortunately, whereas other sectors have recognized the importance of extending home services, home visits by doctors are still hard to come by. This remains one of the weak links of the home care system and deserves more extensive examination and discussion.

7. *Coordinating Long-Term Care — The Administrative Framework*

One would be remiss to present an outline of formal service response to caring patterns without referring to guidelines for implementation. Many countries report a lack of coordination in long-term care, whether at the stage of referral and need assessment, gate-keeping functions, professional decision making regarding care plans and case management, or with procedures for service provision, reporting and monitoring. Although there have been several attempts at coordinating the administration of long-term care in the U.S. and Europe, this is being done primarily on an experimental basis, as in the U.S. Channeling or Access projects. There are useful examples of informal attempts at coordination on a local level in Europe, some of which center around a hospital geriatric unit. However, although some countries have regulations for coordinated planning or allocation of funds on the central level, there seem to be few statutory provisions which set forth regulations for use of resources and administrating case management functions on the local implementation level.

Most experiments at coordinating the administration of long-term care constitute attempts to provide a continuum of adequate care at home and in institutions in a more cost-effective program. Issues most often addressed relate to the following functions:

- Short-term and long-term planning, goals and program strategy;
- Efficient allocation of resources according to regional and population needs;

- Overall need identification on basis of data-gathering;
- Individual need assessment;
- Defining and implementing criteria of eligibility for benefits;
- Case management and coordinated service provision, including inter-agency coordination;
- Institutionalization;
- Effective utilization of manpower and other resources;
- Reporting and monitoring of service provision.

At the heart of these functions is the basic and controversial issue of centralizaton versus decentralization of long-term care. This issue, which has implications for program design and administration, relates to the importance of decentralization in terms of service provision versus the necessity for centrally defined regulations and tools for determining eligibility, need assessment procedures, monitoring, etc.

In general, there seem to be two main trends in the reassessment of long-term care administration currently being undertaken by various countries. On the one hand, there is a trend for preferring increased decentralization at the level of service provision, primarily due to growing recognition that population needs as well as needs for service development are best understood and dealt with at the local professional level. On the other hand, however, the importance of centrally defined criteria and procedures for determining eligibility and monitoring has been emphasized in order to ensure regional and personal equity in service provision, as well as the efficient use of funds in meeting needs. In addition to the need to determine eligibility criteria, there is a need for centrally defined guidelines for resource allocation, which will ensure that funds are utilized for their designated purposes at the operational level of program implementation, thereby complying with national goals and orders of priority for service development.

In Israel the problem of allocating central and local functions has generated much debate on the aforementioned issues. How can these various and equally important goals be reconciled in order to assure equity and uniform implementation of an insurance program based on the principle of personal entitlement, while at the same time leaving the responsibility of professional decision-making to the local level?

The main question for policy and planning an administrative framework is, how can the various elements of a flexible program, which include cash benefits and in-kind services, be incorporated into a unified, comprehensive and effective system?

Under Long-Term Care Insurance in Israel, central functions, including determining eligibility for benefits and level of benefits, will be the responsibility of the National Insurance Institute, according to centrally defined

guidelines and tools. Determining care plans, provision of services, monitoring and reporting will be the responsibility of local professional committees, coordinated by the Ministry of Labor and Social Affairs. It is hoped that in order to ensure a continuum of home, community and institutional care according to the changing needs of the chronically disabled individual and his family, these local interdisciplinary committees will be able to coordinate Long-Term Care Insurance provisions being provided by other frameworks (Morginstin and Shamai, 1985).

The main functions of the committees will be as follows:

a. Designing a comprehensive care plan for those individuals eligible under law. The care plan will be designed after the National Insurance Institute has determined the level of eligibility for benefit, on the basis of degree of functional disability.
b. Determining whether there are available services according to law, who will provide the services and the level of provision. In those cases in which benefits are to be granted as a service in-kind, i.e., not in the form of a cash benefit provided directly to the eligible individual, the committee will determinine *which* services will be covered by the benefit and which will be funded by other agencies. The benefit will be transferred directly to the stipulated service provider.
c. Setting up uniform procedures for service and case monitoring as well as for need reassessment at the local level.
d. Determining required changes in the care plan or in the form of benefit provision. For example, in those cases in which an eligible individual receiving a cash benefit is receiving inadequate care from informal sources, the committee might recommend changing the benefit to a service.
e. Recommending nursing home care.
f. Ensuring the individual's continued rights to benefits *other* than those provided under Long-Term Care Insurance.
g. Gathering data, proposals and requests for aid for local service development projects to be submitted to a Central Development Fund.

8. *Summary and Discussion*

This paper has examined several issues related to the response of the formal service sector to patterns of long-term care provision against the background of changing demographic and social conditions. A flexible approach in policy planning and implementation is advocated, in a universal Long-Term Care Insurance program which includes, as one option, a cash benefit to the older person and the family which provides direct care. Recognizing the fact that the family can no longer be regarded as a free resource and that

some groups of elderly may be able to purchase some services, a cash benefit to cover part of the cost of caring would be effective in assisting some caregivers, while others would require services in-kind to complement informal care provision. This type of program recognizes the need to support the continued provision of family care while enabling the older person and his family to choose the kinds of services they require.

At the same time, it would seem that there is growing awareness of the need to develop and expand a network of support services which would enable the older person to remain at home for as long as possible. These services should be made available to older people and their families before severe crisis sets in, at which time services become least effective and institutionalization becomes imminent.

In any case, a flexible approach to program planning should be predicated on an understanding of family expectations and patterns of care. Services should be designed to facilitate and encourage independent caring as much as possible while providing supports as a complement to family care. Some questions are: How can we achieve an optimal balance, both in terms of cost-efffectiveness and social goals, in the linkage between informal and formal services networks? What kind of services should be developed that are geared directly to family caregivers rather than to the elderly themselves? What is the role of a cash benefit to the family in a caring situation which is by definition non-static and often deteriorating, and which therefore requires some form of professional involvement in the form of monitoring, counselling, etc.? What long-term care services are required by the modern care-provider (e.g., case management, support groups, respite care, day centers, home helps, volunteers)? What will be the impact of these services? What are the issues of equity that arise in a program which recognizes the family's eligibility for cash benefits and services? Is it justified to provide high cost services for high-risk groups when they could be cared for more efficiently in institutions? How and when would families utilize these services? Can some services be more efficiently provided by the private sector? These questions must be addressed in policy discussion and in applied research.

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DEVELOPING SERVICES IN THE FRAMEWORK OF THE LONG-TERM CARE INSURANCE LAW

by Dr. Uri Laor*

1. To What Will Insurees be Entitled Under the Long-Term Care Insurance Law?

In contrast to the schemes of other National Insurance Laws, the Long-Term Care Insurance Law guarantees, first and foremost, a "long-term care benefit" to be paid "wholly or partly, to whoever supplies the long-term care services...and not to the entitled person" (Section 127 (85)b of the law). "Long-term care services" are defined as services intended to help in the performance of daily activities or household management (Section 127 (83)). Daily activities are defined as dressing, eating, control of excretional organs, washing and mobility at home as well as attendance aimed at "prevention of harm or danger to himself (the insuree) or others" (Section 127 (83)).

Hence we see that the main purpose of the law is to finance the provision of help in the insuree's home or in suitable day centers to whoever, for reasons of physical, mental or intellectual impairment — no matter what its source — has difficulty in performing daily tasks to a full or large extent and is consequently in need of assistance in carrying them out. The benefit funds are also intended to finance attendance services for those for whom being alone constitutes a danger to themselves or others, i.e., the mentally infirm or people suffering from defects due to which they are not responsible for their actions and are liable to harm themselves or others.

The benefit funds will be transferred "wholly or partly" to whoever supplies the service. Only in exceptional cases, which are detailed in the law, is it possible to transfer the benefit to the entitled person himself, and particularly in cases where the "local committee" does not succeed in providing him with "long-term care services" within sixty days "from the day on which entitlement to a long-term care benefit was established" (Section 127 (85)(c)).

In addition to the direct services to be supplied to the entitled person (an insuree who fulfills the conditions of entitlement for receipt of the benefit and for our purposes, after providing full or considerable disability in performing daily activities), the law provides for the allocation of resources for "activities

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intended to develop community services for functionally disabled persons in need of long-term care and to develop services supplied in nursing homes and improve their quality" (Section 127 (97)(a)).

The services to be developed are not necessarily identical to those to be received by disabled insurees under the law, but are intended for "the functionally disabled in need of long-term care." For instance, the law does not permit the provision of physiotherapy or rehabilitation in any form, but it is possible for physiotherapists to be trained with the funds accumulated (see below).

According to Section 127 (97) of the law, a total sum of NIS 40 million[1] will be budgetted during the years 1986-1995 for developing community and institutional services as mentioned above. Following discussions among the government Ministries, it is proposed to earmark two-thirds of the above-mentioned sum (approximately NIS 26 million) to developing institutional services and improving their quality and one third (approximately NIS 14 million) to developing community services and training manpower.

In addition, approximately NIS 9 million of the law's funds will be budgetted each year (during 1986-1995) to financinging "maintenance of an additional number of "people being treated in nursing homes". Half the sum is intended for the Ministry of Health and half for the Ministry of Labor and Social Affairs. These resources will make it possible to finance additional places for 650 patients in various types of long-term care institutions.

In 1986 and 1987 alone, the National Insurance Institute will allocate about NIS 6 million annually to the two aforementioned Ministries for "expanding the scope of services for assistance in personal care and help in household management" (Section 127 (98)(a)). This sum too will be divided equally between the two Ministries. The way in which these funds are to be distributed is not detailed in the law and they will possibly be distributed according to today's accepted criteria, to the provisions of the law or in any other way.

2. The Number of Insurees Who will be Entitled to Receive a Long-Term Care Benefit

In order to know the extent of the expansion required in the capacity to supply personal care, domestic help and attendance services, it is necessary to estimate the number of insurees who will be entitled to the long-term care benefit. This number depends on the rules and regulatons to be enacted and the size of the budget to be placed at the disposal of these services. The right

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1 At the time of preparation of this article, the rate of exchange was $1.00 + NIS 1.6.

to the benefit is absolute and independent of the budget, but obviously, in the long run, there is a connection between the rules of entitlement and the amount of contributions collected under the law. Collection is estimated at NIS 30 million annually.

The long-term care services are intended for disabled people living in the community. At the present stage of the law's implementation only the aged (men of 65 and over and women of 60 and over) will be entitled to receive them. Accordingly, estimates have been made of this population group only.[2]

Approximately 31,500 disabled aged (8.6% of the total aged population) live in the community. According to the intention of the law's planners, only those handicapped in daily activities and in need of more than twelve hours of assistance per week will be entitled to help. Their number is estimated at 8,800. An insuree in any kind of institution whose maintenance cost is mainly borne by public bodies will not be entitled to a long-term care benefit (Section 127 (86) of the law).

For purposes of comparison it is worthwhile examining the number of recipients of personal care and domestic help services. According to data of 1984, approximately 11,700 aged received domestic help services (mainly cleaning of the house) and 5,100 received personal care services from public bodies. The annual expenditure on these two types of assistance amounted to approximately NIS 8.4 million.

Hence, following the full implementation of the Long-Term Care Insurance Law, its funds will enable to almost triple the number of personal care recipients and simultaneously to raise the sums earmarked for these purposes. There is no doubt that in the field of personal care and domestic help a minor revolution can be expected on the completion of the organizational and professional network required to implement the law according to its letter and spirit.

These data are valid for today's reality. Toward 1995, following the increase in the number of old people, and especially the great increase in the number of those aged 80 and over,[3] an increase of some 50% is expected in the number of handicapped persons entitled to assistance from the law's funds.

If the present insurance contribution rates will not lead to an increase in

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2 The following data have been taken from "Selected Data on Disability Among the Aged in Israel — Today and in the Future," February 1986 (Hebrew). The document was drawn up by the National Insurance Institute and the Brookdale Institute of Gerontology and Adult Human Development and was submitted to the Knesset Labor and Social Affairs Committee.

3 The number of those aged 80+ among the Jewish population will reach about 109,000 in 1995, compared with about 52,000 in 1983, i.e., more than double (see: H. Factor, "Forecast of the Need for Long-Term Care Beds," The Brookdale Institute of Gerontology and Adult Human Development, Jerusalem. February 1985, Table 2 (Hebrew).

incomes (due to economic growth), it will be necessary to raise them from 02.% to 0.3%, or, alternatively, to tighten the rules of entitlement or reduce the amount of assistance given to those entitled.

The latter alternative is not reasonble, since it is in complete contradiction to the demographic trends and their implications in terms of additional needs, trends which led to the passing of the Long-Term Insurance Law despite our difficult economic situation — this *before* the extension of the law to younger groups of the population.

It should be stressed that all the services to be supplied as a result of the law are meant to be in *addition* to the aid given today and financed by budgetary funds. It should not be forgotten that the law cannot meet the needs of a number of important needy groups such as those who require less than twelve hours of personal care per week, or those who will need assistance exceeding the maximum permitted by the law, or those who will require assistance in domestic help only and who cannot be assisted by the benefits guaranteed by the law.

3. Implications of the Assistance Guaranteed to Entitled Persons on Care Manpower Needs

The Matav Association supplies approximately 38% of personal care services in Israel. It employs approximately 1,000 workers who supply about 85,000 hours of care on a budget of NIS 4 million annually.[4] On the basis of these data it may be estimated that with organizational patterns such as those prevailing in Matav, it will be necessary for another 5,500 caregivers (!) in order to provide the services to which the insurees are entitled. Needless to say, new ways must be found to mobilize manpower for the supply of domestic help and personal care. There is no doubt that the private sector will play a far more significant role than today in the field of assistance to the handicapped. The challenge which will fact those responsible for the law's operation will be to develop tools for following up the quality of care and for supervising the private suppliers of services in order to prevent misuse of National Insurance funds which will be given "to whoever supplies the long-term care services." Special responsibility lies on the "professional local committee" which will be established under the law and which, among other things, "will determine the supplier of services and concern itself with the supply of those services...(long term care services) that are to be supplied to the insuree" (Section 127(2)).

Other sources for the supply of long-term care services are housewives,

4 From the address of the Chairman of the Executive of Matav at its general meeting on February 2, 1985.

neighbors and other who do not belong to the labor force at present but who can be trained within a short period of time to supply these services to persons living near them, without any large staffs or unnecessary overloads. This will necessitate flexibility on the part of the professional committee and the National Insurance Institute with regard to adjustment of payment and accountancy procedures as required by the nature of these workers. Moreover, one should be wary of over-professionalization and aspiration to create lengthy and expensive training systems for such workers.

Without flexibility and variety there is no chance of finding the manpower needed to supply services, especially since during the next decade needs will growth by an additional 50%. Without this manpower the law will be unable to achieve its goal and there will be no alternative but to grant cash benefits due to the inability to supply services.

The attendance service mentioned in the law is a new one and barely exists today. The attendance can be supplied at home or in a community framework such as a day center. It is important for attendance services to be able to be given at unusual hours such as in the evening and at night as well as on weekends and during holidays. Experience in this field is little and it will be necessary to determine which type of worker is suitable for caring for "confused" or "mentally infirm" old people and which training they should undergo.

The implementation of the law necessitates the establishment of a "roof organization" to include a professional local committee which will specialize in adjusting care programs and the supply of services to those entitled to them and supervising services' suppliers; professional teams (nurses, social workers and doctors) who will specialize in estimating functional limitation; a system of manpower training which will arrange courses and further training at various levels and distribute guidance material and professional literature to the various types of workers; follow-up evaluation and research of the manner in which the law is being implemented — whether the assistance provided meets the needs, whether there are groups in need of assistance who are not receiving it, whether the assistance is adequate[5] and the like.

True, the law does not guarantee assistance for patients in institutions but considerable sums will be allocated to the development of institutional services. The law also enables an increase in the number of patients hospitalized in institutions (see above).

A joint committee of the Ministry of Health, the Ministry of Labor and Social Affairs, Eshel, the General Sick Fund and Mishan has prepared a

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5 On this point, see "Summary of Recommendations of the Committee of Information in Preparation for the Implementation of the Long-Term Care Insurance Law," submitted to the Director General of the Ministry of Health. June 1986 (Hebrew).

program for the development of institutional services in the next few years. According to this program, approximately NIS 57 million will be invested in the period 1985-1990 in order to add 2,800 beds for frail, mentally infirm and nursing patients. The law's funds will be one of the sources of financing this program. In addition, there are about 200 beds being planned by other public factors — altogether about 3,000 beds. This addition of beds necessitates, according to the present situation, 1,800 additional posts, of which 1,250 are of care manpower[6] (nurses, non-professional auxiliary manpower, doctors, physiotherapists, social workers, etc.).

At the same time, a plan should be drawn up for the extension of the network of day centers caring for the physically and mentally impaired. Today there are approximately 50 day care centers in various stages of operation, construction and planning. These centers will serve 4,000 handicapped living in the community. It is necessary to draw up criteria for determining needs and dispersal of day centers in a form similar to that of the long-term care institutions, as a basis for creating additional development plans in the future.

4. What Does the Law Not Guarantee?

The approach of the Long-Term Care Insurance Law is essentially preservative, passive-maintenance rather than active-rehabilitative. The aim of the assistance to be given from the funds is to make it easier for the handicapped to lead their daily lives at home and by doing so to make it easier for the families.

However, the law does not provide for the supply of active rehabilitative services which would improve the functional capacity of the handicapped and make them less dependent on the help of others.

The development of such services necessitates the employment of manpower with a higher level of professional skill (physiotherapists, occupational therapists, rehabilitation doctors). Emphasis on rehabilitation can also be achieved by increasing the family's involvement in care, under the close guidance, advice and aid of professional workers.

The development of systems of care for the handicapped at home following the implementation of the Long-Term Care Insurance Law will lead to greater equilibrium in the continuum of services placed by society at the

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6 See: H. Factor, "Forecast of the Required Additional Manpower in Long-Term Care Institutions in 1990", The Brookdale Institute of Gerontology and Adult Human Development, Jerusalem, May 1985 (Hebrew).

disposal of the handicapped, and in the first stage — for the handicapped aged. However, for this purpose it is essential to reinforce the system of services aimed at increasing the handicapped's own capacity and at rehabilitating and increasing his capabilities. A considerable part of the resources earmarked for developing services in the community should be directed to this purpose.

EVALUATING THE NEED FOR LONG-TERM CARE SERVICES AND THEIR COST

by Haim Factor, Dr. Jack Habib, and Shmuel Be'er*

1. Introduction

In Israel in recent years there has been a growing awareness of the gaps between needs and services for the disabled elderly. The first estimates were made at the end of the 1970's. They pointed to rapid growth in needs as the population aged 75 and over was forecast to rise by 52 percent, from 119,000 to 181,000 between 1983 and 1995.

In the face of this new reality, efforts have been made to expand public investment in services for the elderly. The Ministry of Social Affairs, the Ministry of Health, the Joint Distribution Committee and, in particular, ESHEL (The Association for the Planning and Development of Services for the Elderly in Israel) appreciably expanded their activities. After much intense activity, the Nursing Care Insurance Law, created in order to meet the needs of the disabled elderly and their families, was formulated and passed.

Alongside increased activities in the field, expanded research efforts, intended to provide an information base for planning purposes have been initiated by ESHEL, the JDC, and the National Insurance Institute.

In this article we present a summary of current needs and projected future needs, for both community and institutional services in 1983, and forecasts for 1990 and 1995. 1983 is used as a base year because census data that provide detailed information on the characteristics of the elderly, are available for that year.

We first present data on the extent of functional impairment that creates the need for assistance, and then discuss the need for specific services. We examine needs, existing services, and the gap between them. Data of this kind are not available for all types of services. Consequently, we limit ourselves to a quantitative assessment of a number of principal services and to general remarks for other services. It must be emphasized from the outset that there is no simple, clear-cut relationship between an elderly person's need for assist-

* JDC-Brookdale Institute of Gerontology and Adult Human Development.

ance and the services required to provide this assistance. There is more than one way to meet needs. For example, it is possible to meet the needs at home or to transfer the elderly to a protective framework such as sheltered housing or an institution. For elderly persons who live at home, services can be brought into the home or, with respect to some of the needs, the elderly can be brought to the service (day centers, etc.). This factor significantly complicates the problem of evaluating service needs.

2. *Functional Impairment Among the Elderly*

A distinction is generally made between personal care needs — bathing, dressing and eating — and homemaking needs, such as laundry, meal preparation and housecleaning. Determination of impairment with respect to personal care is not related to the availability of assistance; however, the need for home help must take the elderly person's living arrangements into consideration. In other words, elderly who are unable to perform homemaking tasks for themselves, but who live in households where there is someone who can perform these tasks and would anyway without excessive additional hardship, are not included among the impaired. For example, an elderly person who eats with his family does not require separate food preparation and will not be defined as requiring assistance in meal preparation.

Table 1 presents data on the elderly population with ADL limitations in 1983 and 1985, and projections for 1990 and 1995.

The estimate of the population of impaired elderly in ADL was based on the number of disabled elderly living in the community, plus elderly in institutions, in the wards for those elderly with impairments in personal care. On the basis of the survey conducted in Bnei Brak, an estimated 27,000 elderly with limitations in ADL were projected to live in the community, representing 8.3 percent. It should be noted that preliminary estimates of ADL limitations from the new National Survey of the Elderly conducted in 1985-6 by the CBS show similar estimates of disability when adjusted to the 1983 population distribution. In 1983, 7,000 disabled elderly resided in long-term care institutions. Consequently, the total number of disabled elderly was esimated at 34,000, or 10.1 percent of the elderly population in Israel.

We estimated the number of disabled elderly in the future by applying the current rate of disability according to age, sex and ethnic origin to the population composition in 1990 and 1995. According to this project, the number of disabled elderly will reach 47,500 by 1990 and 55,000 by 1995. The proportion of disabled in the total elderly population will increase from 10.1 percent in 1983 to 11.9 percent in 1990, and 13 percent in 1995.

The proportion of disabled elderly in the community with respect to homemaking tasks (IADL) in 1983 was approximately 30 percent. The pro-

Table 1. Elderly with Limitations in ADL, 1983 and 1985 and Projections for 1990 and 1995

Number of disabled	1983	1985	1990	1995
In the community[1]	27,041	29,597	37,107	49,925
In long-term care institutions[2]	6,998	7,837[5]	10,400[5]	12,114[5]
Total disabled	34,039	37,434	47,507	55,039
Rate of disabled				
(percentages)				
In the community[3]	8.3	8.6	9.8	10.6
In long-term care institutions[4]	2.1	2.2	2.7	3.0
Total disabled[4]	10.1	10.6	11.9	13.0

1 Including elderly living in the community who need partial or complete assistance in performing activities of daily living such as washing, dressing and/or eating. The disability estimates are based on the Bnei Brak Survey (Zilberstein *et al*, 1981).
2 According to a Census of Residents in Institutions — 1983, Brookdale Institute.
3 Total disabled elderly in the community out of total elderly in the community.
4 Total disabled elderly out of total number of elderly in the community and in institutions.
5 Total impaired elderly who will be in institutions in the future, if the specific 1983 patterns of institutionalization according to age, sex and ethnic origin are maintained.

jected increase is however relatively moderate; the rate will rise to 32 percent of the elderly population in 1995.

In addition, almost all those in institutions (4.2% of the elderly population) would be unable to perform homemaking tasks in the community on their own.

3. Community Services

In this article we focus on three principal community services — personal care, homemaking and prepared meals — that address the needs of disabled elderly.

The extent of available services is presented in Tables 2 and 3, for 1984. This is the last year for which accurate data are available.[1]

1 The data on the extent of existing services for personal care include the main agencies that provide services or participate in financing them: Matav, the Ministry of Health, Kupat Holim, and the Ministry of Social Affairs (see Table 2). Data for home help and prepared meals were provided by the Ministry of Social Affairs.

Table 2. Extent of Personal Care Services in 1984[2]

	Recipients	Hours of Care	Annual Cost ($ thousands)	Weekly Hours Recipient	Hrly Cost ($)
Total	5,084	1,558,485	4,603.8	6	2.95
Referred by (%):					
Ministry of Social Affairs	28	17	18	4	3.11
Ministry of Health	19	21	20	7	2.79
Kupat Holim	50	53	51	6	2.89
Private Referrals	3	7	8	16	3.41
Referred by Others	1	2	2	7	3.42
Of these provided by "Matav"[1]	1,937	708,061	2,414.3	7	3.41
Referred by (%):					
Ministry of Social Affairs	33	25	25	5	3.42
Ministry of Health	16	15	15	6	3.39
Kupat Holim	40	41	41	7	3.41
Private Applicants	7	16	16	16	3.41
Others[5]	4	4	4	7	3.42
Of these provided by other sources	3,147	850,424	2,189.5	5	2.57
Referred by (%):					
Ministry of Social Affairs[3]	24	11	11	2	2.55
Ministry of Health[4]	20	26	26	7	2.49
Kupat Holim[4]	56	63	63	6	2.61

1 Matav — National voluntary organization providing homecare services.
2 Some data are based on estimates.
3 Primarily by aides to the elderly (*mataz*) employed by the local authorities and local non-profit associations.
4 Primarily services purchased in the private sector.
5 Referred by the Ministry of Defense, Neighborhood Rehabilitation, National Insurance, Jewish Agency, Cancer Association, and Kupat Holim Leumit.

Table 3. Selected Community Services in 1983 Compared to Current and Projected Needs

	Existing Services 1983			Needs 1983			Needs 1990			Needs 1995		
	P.C.	H.M.[3]	P.M.	P.C.	H.M.	P.M.	P.C.	H.M.	P.M.	P.C.	H.M.	P.M.
No. of recipients	5,084	11,671	3,500	11,361	57,873	14,035	16,000	70,506	17,156	18,262	76,058	18,638
As percentage of elderly in community	1.6	3.6	1.1	3.5	17.8	4.3	4.2	18.6	4.5	4.5	18.8	4.6
Total annual hrs(ths)	1,558	512	—	5,258	12,037	—	7,571	14,665	8,642	—	15,820	—
Weekly hrs per recipients	5.9	0.84	—	8.9	4	—	9.1	4	—	9.1	4	—
Annual cost ($ths)	4,604[2]	993	1,656	16,141	23,352	6,641	28,451	23,243	8,118	26,530	30,691	8,819

Symbols: P.C. = Personal Care, H.M. = Homemaking, P.M. = Prepared Meals

1 In this table, "needs" means the assistance required from formal services to supplement the assistance provided by the family or other source of informal care so that the elderly's complete needs are met.

2 Including participation by the family in the cost of the service (estimated at less than 10 percent)

3 The data here are in terms of the number of elderly who receive the service. These elderly live in approximately 8,000 households. Each household received on average 1.3 hours of home assistance per week.

A monthly average of 5,084 elderly, or 1.6 percent of the total population of community-resident elderly, received personal care services at an annual cost of $4.6 million.

Approximately 8,000 households, including 11,700 elderly, or 3.6 percent of the elderly population living in the community, received homemaking services at an annual cost of about one million dollars.

In 1983-84, some 3,500 elderly benefitted from home prepared meals financed by the Ministry of Social Affairs. The estimated public cost (after deducting the recipients' participation fee) was about $1.6 million annually.

It should be noted that the recipients do not participate in the costs of personal care and homemaking services, beyond a nominal 10 percent fee. This reflects the low income level of those eligible for these services within the framework of the Ministries of health and Social Affairs, as well as the tendency in practice not to charge the recipients for these services.

We will now examine the estimate of needs for these services in order to compare services with needs. In determining service need, several steps were required. Firstly, there was a need to determine which service would best meet the need. Secondly, the number of service "units" (hours, numbers of meals) had to be determined. Together, these two factors made it possible to estimate the total assistance required to maintain a reasonable level of daily functioning and home management. At this point, a third factor was taken into consideration: Would the service be provided by a family member or other informal source, or by a formal source (i.e., is it provided or financed by the public services).

Each of these three decisions involves professional judgement. Our estimates are based on the judgements of professional assessment teams who reviewed the data collected for every elderly person included in the survey and were required to decide the extent of formal services required to fully address needs and to supplement the assistance provided by the family.

4. *Findings*

If only formal services were used to meet all the needs, it would be necessary to spend approximately $32 million annually on personal care and $38 million on homemaking services. However, these sums are much smaller due to the family's role.

Table 3 presents and estimate of the need for formal services for the above three services in 1983 and Table 4 presents the gap between the recommended needs for formal services and existing services. These estimates are based on a combination of data from the Bnei Brak survey (Zilberstein *et al.*, 1981; Habib, Factor and Shmueli, 1986) and from the survey on recip-

Table 4. Gaps Between Needs and Services in 1983 and Projects for 1990

	Gap between needs and services in 1983			Gap between projected needs in 1990 and existing services in 1983			Growth in needs 1983-1990		
	Personal care	Home making	Prepared meals	Personal care	Home making	Prepared meals	Personal care	Home making	Prepared meals
Number of recipients									
Absolute	6,277	46,202	10,535	10,916	58,835	13,656	4,639	12,633	3,121
Percentage	123	396	301	215	504	390	41	22	
Percentage of recipients									
Absolute	1.9	14.2	3.2	2.6	15.0	3.4	0.7	0.8	0.2
Percentage	119	394	291	163	417	309	20	4	5
Total hours annually (ths)									
Absolute	3,700	11,525	—	6,013	14,153	—	2,313	2,628	—
Percentage	237	2,251	—	386	2,764	—	44	22	—
Weekly hours per recipient									
Percentage	51	357	—	51	357	—	2	0	—
Annual Cost ($ thousands)									
Absolute	11,537	22,359	4,985	18,639	27,458	6,462	7,102	5,099	1,477
Percentage	251	2,251	301	405	2,764	390	44	22	22

ients of community services that was conducted in Jerusalem, Beersheva and Tel Aviv (Habib *et al.*, 1986).

The data base for the number of elderly in need of formal assistance is based on the Bnei Brak survey. With respect to the number of hours of formal assistance required for personal care, the estiamtes of need found in the Bnei Brak survey are much lower (2.5 weekly hours of formal personal care per elderly) so that the total assistance according to this survey does not exceed *that provided today by the system. Examining the results of the three-city* survey on community service recipients, it was found that the recommended number of hours for formal personal care was much greater (Habib *et al*, 1986). We tend to favor this latter data, especially because the elderly and their families (also interviewed during the survey) corroborated the needs estimate given by the professional caregivers. Consequently, the number of hours recommended that were used are based on the survey of community service recipients. There were no differnces between the two surveys with regard to the required hours of homemaking assistance.

Table 4 presents the gap between needs and existing solutions. In order to close the gap in personal care, it is necessary to add 3.7 million hours of assistance and 6,300 recipients. The cost of this addition is approximately $11.5 million, or an increase of 251 percent compared to present cost. With *respect to homemaking help, a significant expansion is required to meet the* needs: an additional 11.5 million hours of care and 46,000 new recipients at the cost of an additional $422 million, representing an increase of 2,250 percent.

The need for homemaking services was determined under the assumption that the need for prepared meals is met. Consequently, the expert determinations for these two services must be taken together. The experts recommended providing meals to 4.3 percent of the disabled elderly population, meaning a 300 percent rise in the number of recipients and the cost of service provision.

More than a quantitative addition will be required to meet the needs of *the disabled elderly. A change in the patterns of service provision, primarily* with respect to personal care, is required. In particular, there is a need to introduce flexiblity in the tasks of home aides and in the provision of care hours so that it will be possible to provide services 24 hours a day, on weekends and holidays. There are those who claim that the role definition of home aides (*matavit*) should be re-examined with the aim of combining some of the activities of personal care with homemaking tasks.

So far we have considered the elderly's need for formal services. These services which constitute only part of the assistance extended to the elderly are supplemented by the family. According to expert estimates in the Bnei Brak survey, families can continue to give 85 percent of the hours required for

personal care and some 74 percent in the sphere of homemaking, without being overwhelmed by the burden. As mentioned above, we used the estimates in the survey on community service recipients which reflects a more balanced division between formal and informal assistance. For example, the expert recommendations with respect to personal care indicated that the families need to provide some 60 percent of the total assistance.

With respect to other services, we have no basis for a general estimate of needs. However, we can point to a number of partial indicators that indicate the existence of additional need, if not the actual extent of this need. The survey of community service recipients revealed that a significant number of elderly are in need of services that are not provided today, such as non-professional attendance in the day or at night, or housing adaptations and renovations (Habib *et al.*, 1986).

5. *Institutional Services*

In 1985 there were 14,821 licensed long-term care beds in Israel. Of these, 6,684 were designated for semi-independent elderly (limited primarily in home-making capacity), 2,280 for frail elderly (limited primarily in bathing or bathing and dressing), 5,487 for nursing cases (dependency in bathing, dressing and feeding, usually bedbound and incontinent, and often cognitively impaired) and 370 for mentally frail (cognitively impaired but ambulatory, closed ward often necessary) (Table 5). These figures include beds in old age homes, hospitals for the chronically ill, geriatric centers and nursing wards in general hospitals. In addition, there were 4,511 units of sheltered housing with 4,699 elderly residents (see Table 8).

As well, there were 766 beds for long-term geriatric rehabilitation (in Kupat Holim's rehabilitation institutions and Fleeman, Pardes Katz and Tel Hashomer hospitals) and 507 beds for short-term rehabilitation, diagnosis and acute geriatrics. These beds represent a ratio of 2.2 and 1.5 (respectively) per thousand elderly. We are concerned here primarily with beds for long-term care and sheltered housing.

The available long-term care beds represent a rate of 41.8 per 1,000 in elderly in Israel. Thirty-two percent of all long-term care beds were in private institutions and 45 percent of beds for nursing care and the mentally frail (Table 6).

Nineteen eighty-three survey data indicate that the bed occupancy rate of those in long-term care institutions was 89 percent. Of the remaining 11 percent, 5 percent of the beds were occupied by persons under age 65 and 6 percent were unoccupied. This 6 percent represents temporary non-occupancy caused by resident turnover through death or departure. The occupancy rate varies between types of beds. In practice, due to the shortage

Table 5. Development of Beds in LTC Institutions, 1981-1985 and the Need for Beds in the Future (1990-1995) in Order to Maintain Existing Patterns According to Demographic Groups

	Existing Beds				Need for Beds*		Required Growth Rate	
	1981	1983	1985	Growth Rate between 1981-85	1990	1995	1985-90	1985-95
Beds								
Total	12,557	13,858	14,821	18%	20,320	23,568	37%	59%
Indep.	6,502	6,769	6,684	3%	8,555	9,863	28%	48%
Frail	1,636	2,154	2,280	39%	4,388	5,152	92%	126%
Nursing	4,202	4,642	5,487	31%	6,337	7,347	15%	34%
Mentally Frail	217	293	370	71%	1,040	1,206	181%	226%
Rate per 1,000 of elderly in the population								
Total	39.5	41.0	41.8	6%	50.6	55.0	21%	32%
Indep.	20.4	20.0	18.8	-8%	21.3	23.0	13%	22%
Frail	5.1	6.4	6.4	25%	10.9	12.0	70%	88%
Nursing	13.2	13.7	15.5	17%	15.8	17.2	2%	11%
Mentally Frail	0.7	0.9	1.0	43%	2.6	2.8	160%	180%

* Based on the principal of maintaining the 1983 institutionalization patterns according to age, sex, and ethnic origin.

Table 6. Licensed Beds in LTC Institutions by Year, Types of Bed, Ownership and Geographic Region

Ownership and geographic region	Year and Type of Bed														
	1981					1983					1985				
	Total	Independent	Frail	Nursing	Mentally Frail	Total	Independent	Frail	Nursing	Mentally Frail	Total	Independent	Frail	Nursing	Mentally Frail
National															
Total	12 557	6 502	1 646	4,202	217	13 858	6 769	2 154	4,641	293	14 821	6,684	2, 280	5,487	370
Government/Municipal	2,589	794	902	806	87	2 609	767	889	857	96	2,665	767	917	86 4	117
Public	6,423	4,545	448	1 300	130	6,831	4 550	597	1 553	151	7 461	4,503	672	2,08 8	198
Private	3,545	1,163	286	2 096	--	4,418	1 452	668	2 252	46	4,695	1 414	691	2,53 5	55
Geographic Region															
Jerusalem District	1 256	727	85	444	--	1 526	810	126	557	33	1 633	802	126	643	62
Northern District	638	220	158	206	54	754	254	231	215	54	942	347	218	306	71
Haifa District	2 792	1 302	371	1,032	87	3 127	1 287	654	1 089	97	3 194	1,248	729	1 12 0	97
Central District	3,910	1 437	717	1 717	39	4 359	1 595	754	1 962	48	5 070	1 547	854	2,600	69
Tel Aviv District	3 691	2,764	236	691	--	3 806	2 787	290	705	24	3 694	2 702	254	704	34
Southern District	270	52	69	112	17	286	36	99	114	37	288	38	99	114	37

of beds for the frail, they often utilize beds earmarked for the independent. As a result, the occupancy rate for beds for the frail reaches 117 percent, compared to 79 percent for the independent elderly.

The first half of the 1980s witnessed a significant growth in the number of beds, so that the rate of beds in proportion to the elderly population increased — 39.5 beds per 1,000 elderly (12,557 beds). While the total number of beds increased by 18 percent, the increase in beds for the frail (39%), nursing care (31%) and the mentally frail (71%) was particularly high. Beds for the independent elderly increased by only 3 percent, reflecting the trend toward limiting the supply of beds to this group and using the same resources to build beds for more disabled elderly.

In addition to beds in long-term care institutions, there are a number of sheltered housing frameworks in Israel that are designed for elderly who are able to manage their households independently. These programs provide a partial substitute solution for the institutional needs of the semi-independent elderly population.

As stated above, some 4,700 elderly live in sheltered housing units, representing 13.1 residents per 1,000 Jewish elderly. One-third of the sheltered housing units are owned by "Mishan" and one-quarter by the Jewish Agency. Only 7 percent of the units are owned privately. About 60 percent of the units are located in the Tel Aviv region, where the rate of supply reaches 20 per 1,000 elderly. The number of residents in sheltered housing frameworks grew by approximately 6 percent betwee 1981-1985 (see Table 9).

There is no survey that can provide us with an overall evaluation of the need for institutional services. The matter is complicated and requires an estimate regarding persons in the community and in acute-care institutions who require an institution, and persons in institutions who should have remained in the community. In the absence of such assessments, we have used a number of partial indicators.

Despite the rapid growth in recent years in the number of beds for frail and mentally frail elderly, the gap between needs and supply of beds is expressed in occupancy rates that exceed 100% for these types of beds. Another indicator of needs in the institutional domain is the waiting list for institutionalization through the health and social affairs bureaus. In 1985, 186 independent elderly and 519 frail elderly were waiting for an institutional arrangement through the Ministry of Social Affairs. During the same period, 630 mentally frail and nursing cases were waiting through the Ministry of Health. Some of these elderly are waiting at home, but othes are waiting in acute-care and rehabilitative wards where costs are much higher. It should be noted that despite the increase in the number of beds as mentioned above, the size of waiting lists has not shrunk during the 1980s.

Another aspect of the need for beds is the percentage of beds defined as

sub-standard by the Government supervisors but that cannot be closed due to a lack of beds. In a 1982 survey seven percent of all the beds in the country were defined as substandard. Moreover, a significant number of beds were defined as low standard; deviating significantly from the standard in geriatric centers and ESHEL-sponsored institutions (Fleishman and Tomer, 1985). In any general overview of needs, this problem must be taken into consideration.

Some of the pressure on institutions stems from the fact that the community services that would make it possible for disabled elderly to remain in the community are not sufficiently well developed. A recent survey indicates that half of those elderly waiting for institutionalization through the health and social affairs bureaus could remain in the community with the assistance of appropriate community services. In the majority of cases, the cost of these services is lower than the maintenance cost in an institution (Habib *et. al*, 1986).

Hence, the solution to the current pressure on institutions does not necessarily lie in a rising rate of institutionalization, but rather in the expansion of community services. In the next section we will examine the reciprocal relations between the development of these two service areas.

6. Future Needs: A Look at 1990-1995

Any discussion of future needs must look at the development of community services and institutional services in conjunction. The hope is that the development of community services will relieve the pressure on institutions. On the other hand, the more disabled elderly that enter institutions, the less the need for community services. Thus, any changes in one domain will affect the needs in the others. There is, moreover, room for different approaches regarding how much emphasis to place on the development of these two types of services within the context of a comprehensive policy.

The estimates of future needs that we present here is based on the assumption that existing patterns of institutionalization will be maintained and that the community services will be expanded in order to meet the full residual growth in needs. Three variables are used to define the existing patterns: age, sex and country of origin. In other words, we assume that the rate of institutionalization and of receipt of community services by age, sex and country of origin will remain at their 1983 levels. We calculate the increase in need for beds that emerges from the changes in the total number of elderly and in the composition of the elderly by these characteristics. This assumption does not allow for any expansion in institutional services in order to cut back waiting lists or to diminish the prevalence of low standard beds.

The projected demographic changes in the near future point to rapid

growth of those population groups in which there is a greater need for both institutional and community services. While the number of elderly is increasing by approximately 18 percent between 1983 and 1990, the number of elderly age 75+ will rise by 43 percent and the 80+ group will increase by 71 percent. During this same period, the number of elderly women will increase at twice the rate of elderly men (23 versus 11 percent). The number of Asian-African elderly will rise by 30 percent during this same period, compared to a growth of only 14 percent among the elderly born in Europe, America or Israel (Table 7).

If we want to maintain the institutionalization patterns of 1983, then the change in the demographic composition of the elderly will necessitate a rapid increase in the institutionalization rate. To maintain the existing service level, 20,320 long-term care beds will be needed in 1990, or 50.6 beds per 1,000 elderly (Table 5). It will be necessary to add 5,500 beds to the supply existing in 1985, an increase of 37 percent. The required increase varies according to type of bed. In order to meet the emerging needs, it will be necessary to build 2,100 beds for the frail — an increase of 92 percent compared to 1985. An additional 670 beds will be required for the mentally frail, representing a growth of 180 percent. Due to the increase in the number of nursing beds built between 1983-85, only a 15 percent expansion should be required by 1990. An increase of about 28 percent is required for the independent elderly.

The development of beds for the independent elderly raises many questions. Some agencies have frozen any expansion of this type of bed in the belief that this population could be referred to community services or sheltered housing frameworks. Consequently, we should examine the need for these beds in conjunction with the projections of the need for sheltered housing. In order to maintain the 1983 level of sheltered housing, and assuming that the development of beds for the independent elderly will proceed according to projected demographic growth, it will be necessary to increase the number of units by approximately 20 pecent between 1985 and 1990, or 190 units. These figures are based on the assumption that 1,800 beds for the independent elderly will be built during this same period. If the tendency to freeze the building of beds for the independent elderly persists, then the number of additional sheltered housing units required will be greater.[2]

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2 Sheltered housing is only alternative to entering an old age home. Another alternative is remaining in the community and receiving additional community services. One study of elderly awaiting institutionalization (Habib *et al.*, 1986) concluded that only 20-30 percent of the independent elderly waiting to enter an institution had to leave their apartments due to poor housing conditions. This could be viewed as the minimum rate of need for sheltered housing stemming from a freeze on beds for the independent. Of course, entry into a sheltered housing framework can result not only from housing problems, but also from a need for a more protective environment. Therefore, if beds for the independent elderly are not built, it will be necessary to provide even more sheltered housing, possibly as

Table 7. Developments in the Composition of the Elderly Population 1983-1995

				Percentage of Growth		
	1983[1]	1990[2]	1995[2]	1983-1990	1983-1995	1990-1995
Total	337,834	397,683	424,413	18	26	7
Aged:						
65-74	219,141	227,799	248,837	4	11	7
65-69	109,054	132,759	129,690	22	19	-2
70-74	110,087	95,040	114,147	-14	4	20
75+	118,693	169,884	180,576	43	52	6
75-79	66,759	81,180	72,369	22	8	-11
80+	51,934	88,704	108,207	71	108	22
Sex:						
Men	157,620	175,527	181,071	11	15	3
Women	180,214	222,156	243,342	23	35	10
Ethnic Origin:						
Asia-Africa	82,779	107,613	125,532	30	52	17
Europe-America	255,055	290,070	298,881	14	17	3

1 Source: Population census, 1983.
2 Based on elaboration of Central Bureau of Statistics; projections adapted to the results of the 1983 Population Census.

Today, there is growing interest on the part of commercial bodies (private contractors, mortgage banks, etc.) to invest in projects of this type (See table 8).

The number of elderly in Israel is expected to grow by 7 percent between 1990 and 1995. The change in age composition of the elderly population will be relatively moderate: the young-old (ages 65-74) will rise by 7 percent and the old-old (aged 75+) by 6.3 percent. However, the 80+ age group will increase by 22 percent. Similarly, the rapid rise in the percentage of women (10%) and Asian-African elderly (17%) is expected to continue. As a result, the overall institutionalization rate will continue to rise, but at a reduced pace. In order to maintain the current institutionalization levels for these specific groups, it will be necessary to add 3,250 beds to the 1990 needs projections, which would lead to a ratio of 55 beds per 1,000 elderly in 1995 (for details, see Table 7). With respect to nursing cases and mentally frail elderly, the pace of required growth falls from 4.7 percent annually for the period 1985-1990 to 3 percent annually for the period 1990-1995. Regarding the frail elderly, the rate of required growth reaches 14 percent annually during 1985-1990. The growth rate is particularly high due to the necessity to build additional beds for those frail elderly who are currently occupying beds officially designated for the independent elderly. A more moderate growth of 3.2 percent annually will be required between 1990-1995.

We will now examine the implications of projected demographic developments on community services. There are two aspects to the growth in demand for community services: (1) the implications of demographic changes for the development of needs; and (2) the expansion of community services in order to close the gap between needs and solutions. The expansion of community services to meet the demographic changes will keep the situation from deteriorating further. However, it will not reduce the present gap between needs and services or help to reduce the waiting lists for institutionalization. Only the development of services beyond the minimum necessary to meet projected demographic growth will make it possible to reduce these gaps.

The estimates of the growth in need for formal services is based on the further assumption that the degree of informal support will remain constant within groups defined by age, sex and country of origin. Thus changes in the need for formal community services can in our calculations arise from changes in the compositions of the population which affect both the degree of disability and the availability of informal support.

If existing institutionalization patterns are maintained, the elderly population living in the community will rise by 18 percent during 1983-1990.

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much as another 1,500 beds. It will be necessary to examine the possibility of referring to sheltered housing those elderly who would otherwise be placed in beds for the independent elderly, and the relative cost of the alternative solutions.

Table 8. Sheltered Housing Units and Resident Utilization by Ownership and Geographic Region, 1985

Ownership and Geographic Region	Housing Units	Number of elderly residents	Utilization rate per 1,000 elderly
National			
Total	4,511	4,699	13.1
Ownership			
Municipal/government	216	204	0.6
Jewish Agency	1,033	1,100	3.1
Eshel	557	606	1.7
"Mishan"	1,498	1,649	4.6
Other public ownership	891	860	2.4
Private	316	280	0.8
Geographic Region			
Jerusalem District	483	504	16.6
Northern District	176	175	6.5
Haifa District	560	570	9.0
Central District	254	256	3.6
Tel Aviv District	2,651	2,782	20.0
Southern District	387	412	14.5

However, the changes in this population's composition (the rapid increase of the old-old, of women, and Asian-African elderly) will raise the number of elderly needing formal personal care from formal services by 41 percent. The percentage of elderly requiring such services will rise from 3.5 percent in 1983 to 4.2 percent in 1990. With respect to other services, the growth in needs stemming from demographic changes is much more modest because the variation in the rates of need between the different population groups is not as sharp as with personal care. The number of elderly needing homemaking and prepared meals will increase by 22 percent, or about 5 percent more than that required by the growth in the elderly population. It is interesting to note that while the number of elderly needing personal care will increase by 41 percent, the annual cost will rise by 44 percent, indicating that the amount of assistance (number of hours per recipient) is also projected to increase. With respect to the other services, the cost will grow at a comparable rate to the number of needy.

Table 9. Development of Sheltered Housing, 1981-1985 and the Need for Future Expansion in Order to Maintain Existing Patterns According to Demographic Groups

	Housing	Number of Elderly Residents
Existing situation in:		
1981	--	4,438
1985	4,511	4,699
Rate of growth between 1981-1985	--	5.9%
Forecast of future need:*		
1990	5,429	5,656
1995	6,029	6,280
Required rate of growth		
Between 1985-1990	20.4%	20.4%
Between 1985-1995	33.6%	33.6%

* Based on the assumption that the 1983 utilization patterns for sheltered housing according to age, sex and ethnic origin are maintained.

As noted, the rapid pace of growth which characterizes the period 1983-1990, stems from changes in the demographic composition of the elderly population. Between 1990-1995, these changes will be more moderate and as a result the growth in needs will also slow down. In the sphere of personal care, the growth rate will fall from 5.0 percent to 2.7 percent annually. With regard to homemaking assistance and prepared meals, it will drop from 2.9 percent to 1.5 percent annually.

We now turn to the evaluation of the growth required to move from the 1983 situation in which needs were only partially met to a situation of successfully meeting all the needs in 1990. In other words the increase that is required to address the needs implied by demographic changes and to close the gap between present needs and services availability.

With respect to personal care, it will be necessary to increase the number of recipients of formal services by 215 percent (by 1990) and the number of weekly hours of each recipient by 51 percent. As a result, the cost of personal care services would have to increase by 405 percent, from an expenditure of $4.6 million in 1983 to $23.2 million in 1990.

We would again like to emphasize that in presenting the estimates of the growth in needs we assumed that institutional services would be increased by

the amount required to meet the demographic changes. The expansion of community services may make it possible to expand institutional services by less than that implied by demographic change. In this case, it will be possible to lower the target number of institutional beds presented here. It is difficult to assess at present how realistic this option is. At the same time, any reduction in the amount of institutional expansion will necessitate a greater expansion of community services to meet the needs of the additional elderly who remain in the community.

7. Summary

This paper does not present a complete picture of the needs of the elderly, or even of the disabled elderly. Despite the rapid development of information in recent years, hard data is still missing in many areas. We have concentrated on those areas for which it is possible to make more informed estimates. These estimates should be viewed as approximations. They provide, at least, a partial basis for making decisions with respect to the resources allocation and priorities.

We conclude with several comments about the relationship between the new Nursing Care Insurance Law and the needs described here. Within the framework of this Law, resources are allocated for the development, financing and maintenance of elderly in institutions and for the financing of personal care and homemaking services.

The sums allocated in the Law for service development represent a significant addition to the funds already available in the system. They cannot, however, be viewed as replacing the need for the continued allocation of development funds outside of the framework of the Law. Moreover, it is very important that there be close coordination between the allocation of development funds within the Law with the present channels.

The sums allocated for maintenance of the elderly in institutions are tiny compared to the current expenditure and projected increment. Thus in this sphere the financing of these needs in the years ahead needs to be addressed outside the framework of the Nursing Care Law.

The most significant change under the new Law is in the sphere of community services. The projected total current expenditure for 1990 is approximately $24.1 million,[3] an increase of 330 percent compared to the sum allocated in 1983/84 for personal care and homemaking services.

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3 The estimated expenditure of the Law is approximately $18.5 million in 1990. We estimate that the sums spent today by Kupat Holim and the Ministries of Health and Social Affairs totaling $5.6 million, will be maintained in the future.

However, the relation between these amounts and the estimates of needs projected here are complex for a number of reasons.

The estimate of needs presented in this paper relates to the needs for personal care and homemaking assistance to all the disabled, including the personal care needs of frail elderly who are partially impaired, and the home help needs of the elderly who are independent with respect to personal care but need assistance with homemaking. Under the Law, by contrast, eligibility is limited to the severely disabled elderly (primary nursing eldery). Thus the needs of the semi-independent elderly and a majority of the frail elderly will not be met within the Law's framework. Thus other sources of financing will be needed to meet the growth in the needs of the excluded groups and to reduce the gaps between needs and available services. If the sources of financing required to expand the services for these populations are not found, the pressure on institutions for the independent and frail elderly will increase.

If we focus only on the eligible, the sums allocated constitute an even greater increment compared to the sources available today for the population which will be eligible under the new Law. We estimate that the increase will be about 500-550 percent. Thus, it is likely that the funds will match or even exceed the amount estimated to be required to meet the needs for services from formal agencies in the sphere of personal care and home help.

The estimate of the need for formal services presented in this article is based on the assumption that the families on average will continue to provide some 60 percent of the required assistance. This is less than the 90 percent which they currently provide, but it is still significant. This percentage was based on the evaluations of professional caregiving teams and has two components. It assumes that many families will not apply at all for public support and many of those who apply will request only partial support. If the Law or other factors induce a still larger decline in family participation, then the planned expenditure within the framework of the Law may fall well below that required to meet needs.

Finally, it is important to emphasize that the possibility, within the framework of the Law, to receive cash benefits if services are not available, makes it more difficult to compare the projected cost within the framework of the Law and the needs as defined in terms of formal services.

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THE QUALITY OF INSTITUTIONAL CARE FOR ELDERLY IN ISRAEL: A STUDY AND ITS APPLICATION*

by Rachel Fleishman**, Miriam Bar-Giora***, Jenny Mendelson***, Adrian Tomer**, Robert Schwartz**, Revital Ronen**

1. Introduction

Studies[1] and examinations by public commissions[2] have indicated a number of areas in which the quality of institutional long-term care in Israel is deficient. Among the shortcomings identified are: quantitative and qualitative manpower problems, deficiencies in physical structure and planning, shortcomings in social and occupational services, inadequate nursing care, inadequate care of the mentally frail, failure to provide rehabilitative care, inadequate provision and insufficient variety of food, insufficient privacy and autonomy, isolation of the institution from the community, and lack of social interaction among the elderly. Further, government supervision has been found to suffer from insufficient manpower and to lack appropriate methodology and tools for carrying out ongoing supervision and follow-up of the correction of deficiencies.

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* The study "Measuring Quality of Care in Long-Term Care Institutions in Israel" (Fleishman *et al.*, 1985) also included a multi-disciplinary team that included: Shmuel Wartski (physician), Ruth Merchav (nurse), Esther Nelken (occupational therapist), Dov Peles (Oral Epidemiologist) and Arnold Rosin (Geriatric Advisor). The findings were published in *Social Security*, No. 27 (1985). The "Experimental Program for Implementing the Tracer method in the Home Supervision System" (Fleishman *et al.*, 1986) was published in *Social Security*, No. 29 (1986).

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1 The studies dealt mainly with structural dimensions of quality. For example: physical conditions (Weihl & Gether, 1973); manpower rates, training and turnover (Katan, 1976; Bergman *et al.*, 1980); and in addition, resident adjustment to institutional life (Cibulsky, 1976) and nursing staff drop-out rates (Bergman *et al.*, 1983).

2 The *Silverstone Committee* (1981) submitted recommendations regarding required services, manpower, admission procedures and resident protection, payment principles, supervision and licensing procedures and contacts with the community. The *Darbassi Committee* (1981) examined the needs and costs in nursing homes; the Eshel committee (1981) presented guidelines for planning the construction of old age homes in Israel. A Brookdale Institute working group on quality of long-term care, led by Prof. Rivka Bergman (1982) set criteria and prepared a scheme for measuring quality of care instruments for institutionalized elderly.

In recent years, special efforts have been made to improve the quality of care in institutions for the elderly. Noteworthy among these are increased financing for institutions and closure of poor quality homes.

In light of the growing interest in improving the quality of care, the Brookdale Institute initiated a study aimed at developing appropriate methods and instruments for examining the quality of care in homes for the elderly. The intention was to develop tools which could both determine shortcomings in the provision of institutional care and identify causes for these shortcomings. The study was financed with the assistance of the National Insurance Institute. Its steering committee was headed by Prof. Arnold Rosin, director of the Geriatric Ward in the Shaarei Zedek Hospital. Members of the committee included representatives from the Ministry of Social Affairs, the Ministry of Health, the Ministry of Finance and the National Insurance Institute.

Upon the publication of the study findings (Fleishman, Tomer *et al.*, 1986), the Service for the Aged in the Ministry of Social Affairs decided to work towards improving their surveillance methods and instruments, based on the method proposed by the study. Consequently, a joint working team was established by the Service for the Aged and the Brookdale Institute, and a five year plan prepared (Fleishman *et al.*, 1986).

This paper will present a summary of the study, and the program for its application. The paper begins with a review of the methodology and the main findings of the study followed by a discussion of the major factors effecting the quality of care. The paper concludes with a description of the application of the study method to the governmental system for supervising institutions for the independent and frail elderly.

2. *Conceptual Framework and Methodology*

The study was designed to test an innovative method for examining the quality of institutional care, namely the tracer method (Kessner & Kalk, 1973). A tracer is a well-defined medical, nursing or psycho-social problem which occurs frequently, has a defined diagnosis, has a significant impact on the elderly, has a known treatment, and that can be used to represent the general quality of care provided in the same area of care.

Eleven tracers were selected. The medical tracers included hypertension, vision difficulties, hearing difficulties and oral health problems. The nursing tracers included mobility problems, difficulty in washing, difficulty in dressing, difficulty in brushing teeth and urinary incontinence. The psycho-social tracers included feelings of loneliness and lack of autonomy. Poor quality of care was defined as unawareness by staff of the existence of problems, or lack of treatment or unsatisfactory.

The study is unique in that it encompasses a wide range of areas, and in that it considers processes and outcomes as well as structural indicators. The data were collected through in-depth examinations by a multi-disciplinary team that included a physician, a nurse, an occupational therapist and an oral epidemiologist. Data were collected about the elderly residents and about the institutions themselves from four sources. First, interviews and examinations were conducted with a sample of residents. Second, the staff were interviewed about the same sample of residents and about the institution's policies. Third, observations were conducted, and fourth, the residents' records were reviewed.

The study was conducted in nine units, four in private institutions and five in public institutions. Two of the sample units were for independent elderly, three were for frail elderly, and four were nursing units. The sample included 136 residents — a 36% sub-sample of the units' total population. Since no independent evaluation of the quality of long-term care facilities existed at the time of the study, national supervisors from the Ministries of Health and of Labor and Social Affairs were asked to evaluate the quality of all long-term care institutions in Israel. Such an external evaluation was necessary in order to draw up the study's sample and to enable the researchers to test the validity of the new instruments. The units were selected for the study based on these evaluations. Five of the units included in the sample were chosen from units assessed as providing good or very good quality of care ("good" units) and four from units assessed as being of mediocre quality or poor quality ("poor" units).

3. *Findings*

The study revealed many shortcomings in the quality of care provided in the sampled units. Some of the more outstanding findings are described below.

(a) Prevalence of problem. The starting point in the evaluation of quality of care using the tracer approach is the prevalence of the problem. Prevalence, although not a direct measure of quality, may reflect the adequacy of preventive efforts and care.

The prevalence of functional problems may indicate that residents with lower levels of functioning reside in units designed for a more independent population. For example, 50% of the independent and frail elderly were found to require help in washing, 41% needed help in walking, and 31% suffered from partial or full urinary incontinence. As expected, the prevalence of functional problems was higher among the nursing elderly. Between 80 and 100% of the nursing residents needed help in washing, dressing and mobility.

Many residents were found to suffer from vision problems — 60% in the "good" units, and 70% in the "poor" units. Similarly, high percentages of hearing problems were found — 61% in the "good" and 47% in the "poor".

The high prevalence of oral health problems is noteworthy, especially the problem of defective dentures. Fifty-four percent of denture wearers in the "good" wards and 95% of denture wearers in the "poor wards" had defective dentures.

Almost half of the residents in the "good" wards and nearly three-quarters of the residents in the "poor" wards suffered from feelings of loneliness. Ten percent of all the residents suffered from lack of autonomy in the "good" wards, as opposed to 46% in the "poor" wards (for definitions of these tracers see Fleishman *et al.*, 1986(a)).

(b) Staff awareness. The rate of awareness was found to be high (about 50% or more) for a number of tracers in both "good" and "poor" wards. Especially noteworthy is that physicians and nurses in the "poor" wards were unaware of 54% of the vision problems and 70% of the hearing problems.

No consistent relationship was found between unawareness rates and the supervisors' assessments of ward quality. Only regarding unawareness of mobility and oral health problems, physicians in "good" units showed lower rates of unawareness than physicians in "poor" units (mobility, 10% versus 40%; oral health, 58% versus 99%).

A lower rate of unawareness of hearing difficulties was found in nursing units than in independent and frail units; in 68% of the cases the physician was unaware of hearing difficulties among the nursing patients, as opposed to 82% of the cases among the independent and frail residents. The nurse was unaware of feelings of loneliness among the nursing residents in 59% of the cases, as opposed to 82% of the cases among the independent and frail residents.

(c) Treatment. Awareness of a problem is a pre-condition to care provision. In light of high rates of staff unawareness, it is to be expected that a large proportion of required care is not provided. Therefore, the indicator for some tracers was the existence of any type of care or treatment (rather than the quality of provided care).

High rates of lack of treatment or lack of adequate treatment were found for the various tracers. For example:

- Follow-up of hypertensive residents was found to be inadequate in 34% of the cases in the "good" wards and in 75% of the cases in the "poor wards".
- Of residents with vision problems, 63% in the "good" wards and 87% in the "poor" wards either had no eyeglasses or had eyeglasses which did not improve their vision. The situation was particularly critical in the "poor"

nursing wards, where 94% of all residents with vision problems had no eyeglasses or had unsuitable eyeglasses.

- Sixty-eight percent of the residents with hearing problems in the "good" wards did not visit an ear specialist during the past year, as opposed to 98% in the "poor" units. Seventy-four percent of the nursing and frail residents suffering from hearing problems had not been seen by an ear specialist during the past year.
- Over 96% of the residents in need of oral health treatment in poor wards had not received appropriate treatment. Practically no differences were found between the different units.
- About 40% of the residents with mobility problems in the "good" units, and 95% in the "poor" units, had not received the necessary rehabilitative treatment (physiotherapy).
- Although about 90% of the residents received help in washing, cleanliness was found to be inadequate in 27% of the cases in "good wards and 75% in "poor" wards.
- Poor oral hygiene was found among 22% of the residents in the "good" units and among 75% of those in the "poor" units.
- Rehabilitation programs for incontinent residents were generally unavailable. Seventy-four percent of the incontinent elderly in the "good" wards and 94% in the "poor" wards had no such programs available to them.
- Forty-six percent of the residents in the "good" nursing wards and 64% in the "poor" wards suffered from restrictions on their autonomy.
- Staff only partially dealt with the problem of loneliness. Sixty percent of lonely residents in "good" wards and 79% in "poor" wards did not receive any care in this respect.
- In the "good" wards, 25% of the residents did not participate in activities organized by the institution, as opposed to 66% in the "poor" wards.
- Institutional staff did not maintain meaningful and ongoing contacts with residents' families in 69% of the cases in "good" wards, and 40% in "poor" wards (for specific definitions, see Fleishman *et al.*, 1986a).

d. Structural indicators. Serious deficiencies were found in a number of structural components of care. (1) Staffing levels were generally below government requirements. (2) Medical, nursing and social recording procedures were not followed. (3) Living conditions were sub-standard in some of the units, with regard to room density and furniture. (4) Safety conditions in some of the institutions were unsatisfactory, for example: there were no railings in the halls, insufficient lighting in the bathrooms. (5) Facilities had no fixed arrangements with eye, ear and oral health specialists.

4. *Summary Evaluations*

The study findings, according to a general summary index constructed as an arithemetic average of the indicators for each tracer, correlated highly with the previous evaluations by government supervisors. However, summary evaluations by area (medical, nursing, psycho-social and structural) do not always correlate with the supervisors' evaluations. There were deficient areas in units judged as "good" by supervisors, and areas with adequate care in "poor" units.

5. *Factors Affecting the Quality of Care*

Figure 1 shows the main factors that affect the quality of care: (a) There are four main structural factors: (1) Effectiveness of government supervision; (2) Reimbursement policies, payment rates and terms; (3) Staff training policies in long-term care institutions; and (4) Referral policies; (b) These structural factors in turn influence various institutional factors, such as administration, recording, staffing, physical and structural conditions, lack of family involvement and inadequate placement.

(a) Structural Factors

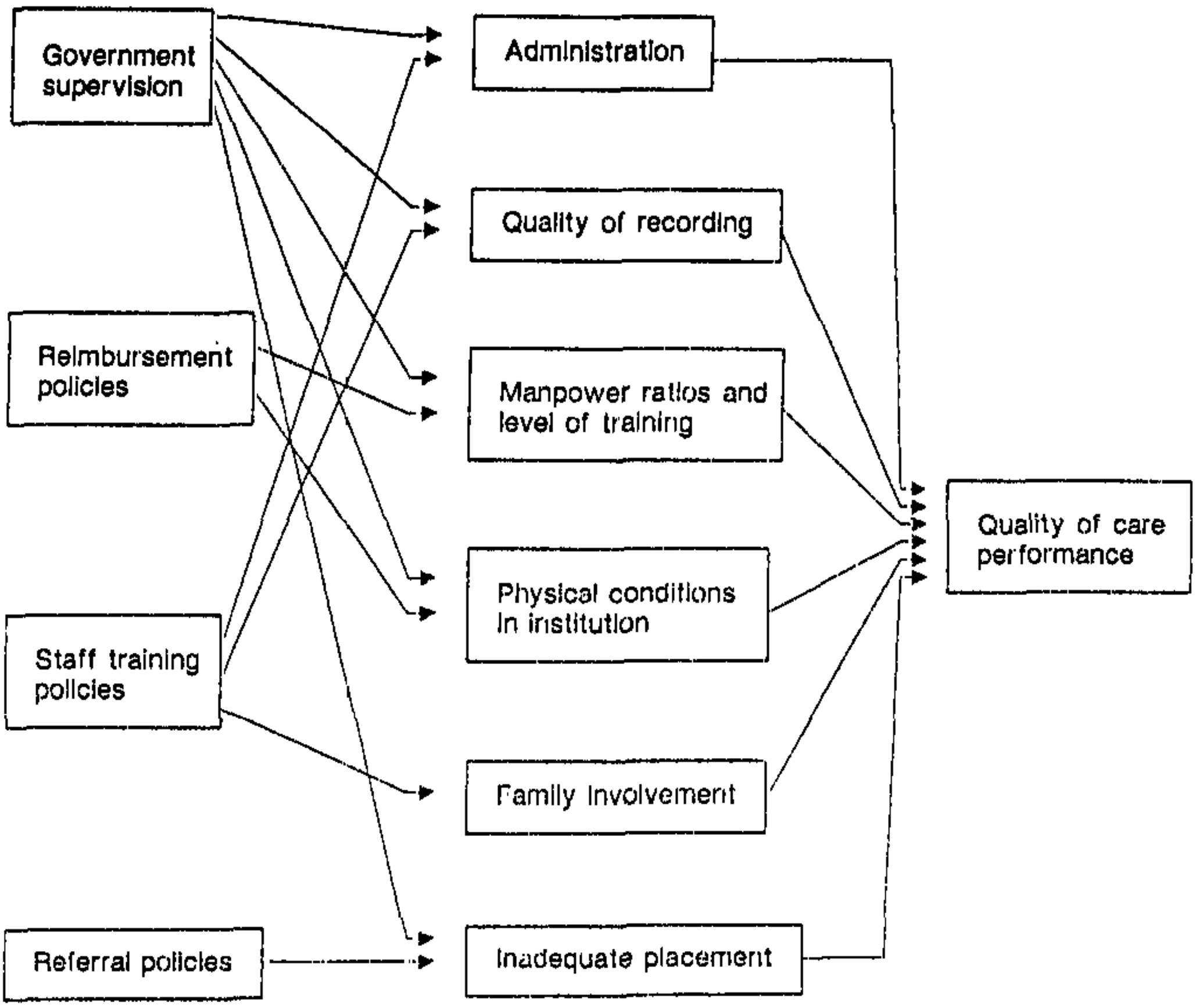
(1) Government supervision. Among the important causes for shortcomings in care are a number of areas that are related to government supervision of institutions. For example: lack of clarity as to the institution's areas of responsibility, partial enforcement of existing rules and regulations, and existence of institutions operating without a license. Supervisory methods are neither uniform nor methodical, there is a lack of reliable and comprehensive supervision instruments, and supervisors have little access to various enforcement measures.

Although good supervision does not ensure good quality of care, a supervisory system may play an important role in improving the quality of care provided. A supervisory system can upgrade the quality of care by enforcing the rules and raising the requirements.

(2) Government reimbursement policies for residents referred by various government ministries is an important factor in influencing the quality of institutional care. For example, reimbursement may affect the physical conditions in an institution, the manpower rates, and the skill and training level of the workers.

(3) Staff training policies. Institutional staff training policies also affect the quality of care. Some institutions have no registered nurse or trained social workers. Most workers do not undergo any special training for working with

Figure 1. Factors Affecting the Quality of Care



the elderly. Suitable training programs could alleviate some of the administrative problems, as well as improve the level of recording and encourage family involvement. Training is needed mainly to update professional knowledge and to ensure a concept of rehabilitative and supportive care of the residents, instead of the "maintenance" concept that views an elderly person as someone nearing the end, in need only of a roof over his head in his remaining years.

(4) Referral policies when inadequate may create unnecessary concentrations of residents with a particular functional level in some kinds of institutions, or simply result in inadequate placement of residents.

These four structural elements have a direct effect on a number of other

important institutional elements that were identified as causes for shortcomings in the quality of care study.

(b) Institutional Factors

(1) Poor administration. Most institutions have administrative problems such as: a lack of job descriptions and unclear division of responsibilities, lack of written work procedures, little internal supervision and lack of ongoing in-service training for staff. In addition, there are no special incentives for attracting and motivating workers.

(2) Deficient recording. Shortcomings in follow-up and recording in medical and nursing records, as well as social records, were found in all the institutions.

(3) Inadequate staffing. In most institutions, the staffing ratios and skill levels were below the required standard. There is a serious shortage of nursing staff at all levels (nurses, aides) and of staff for psycho-social care (social workers and recreational workers).

(4) Poor physical and structural conditions. The physical conditions of some units detract from the quality of life and the quality of care provided to the residents. For example, a lack of hot water around the clock, a shortage of toilets and overly crowded rooms may have an adverse effect on the residents' medical, nursing and psycho-social condition.

(5) Lack of family involvement. Families of residents were not sufficiently involved in supervising the institutions. In most institutions there were no organizations representing the families, and there were no established procedures for registering complaints.

(6) Inadequate placement. In some units, placement did not correspond to the residents' functional status, the consequence being inadequate treatment.

6. *Application of Study*

The Service for the Aged in the Ministry of Labor and Social Affairs was in the process of preparing new regulations for homes for independent and frail elderly when the study's findings were published. The new regulations cover a wide range of institutional care issues, and specify the institutions' areas of responsibility. In conjunction with the preparation of new regulations, the Service for the Aged expressed interest in introducing changes in the supervisory method. A plan was developed to use the study findings in an experimental five year program aimed at improving the supervisory system

for homes for the independent and frail elderly in Israel (see Fleishman *et al.*, 1986).

(a) The Experimental Program

The program attempts to improve the supervisory method within the context of a number of practical constraints including: (1) shortage of supervisory manpower (4.5 positions for more than 90 homes); (2) budgetary limitations, for example, low reimbursement rates that limit the supervisory system's ability to demand changes that involve significant increases in the cost of care; (3) Shortage of beds for frail and independent residents, which limits the possibilities of closing homes that do not meet the supervisors' requirements, or of ceasing referrals of residents to substandard homes.

The program includes the development of scientific and reliable supervision instruments, based on the tracer method. Tracers that in the opinion of the joint staff are relevant to the quality of care of independent and frail elderly, have been selected for examination. These include vision problems, hypertension, urinary incontinence, difficulty in washing, mobility difficulties, loneliness and lack of autonomy. A number of structural, process and outcome indicators relevant to residents' health and general well-being, such as safety, resident-staff relationship, cleanliness and equipment are also examined. The instruments include a series of questionnaires and forms, to be completed by each one of the regional supervisors, the social worker supervisor and the nursing supervisor, and by institutional staff. The surveillance process includes an examination of the records, observations and interviews with residents and staff members regarding the tracers under examination.

Under the new surveillance process, both the regional social work supervisor and the nursing supervisor visit the home together. The questionnaires and forms they fill out are sent directly to the Brookdale Institute, where they are computerized for processing and producing a concise report. Finally, the social work supervisor and nursing supervisor together decide on the necessary steps to be taken in order to correct the shortcomings they discovered, and follow up the corrections.

These surveillance instruments are intended to overcome the lack of objectivity in the existing governmental surveillance method, and the lack of uniformity among the different supervisors. The joint visit will ensure better coordination between the social work supervisors and the nursing supervisor, and a more effective follow-up of how the homes respond to the supervisors' demands for changes.

Computerizing the data from the questionnairs and forms will enable the Service for the Aged to receive an overall picture of the quality of care in an institution and the extent to which their demands are being met. It will also

facilitate setting care standards, and follow-up of changes in the quality of care. These data will form a basis for further research and for better understanding of institutional care in Israel.

Implementation of the program has already begun. The stages include: a seminar for supervisors on advanced supervision methods with a head supervisor from New York State; training sessions for institutional directors on the new regulations and on quality of care; training sessions on the new supervision instruments and on good record keeping.

Table 1 presents the stages for implementing the program.

Table 1. Stages of the Program

a. Preparation of instruments.
b. Training sessions for supervisors
c. Training sessions for directors and senior institutional staff.
d. Pre-test of surveillance method, drawing conclusions regarding the instruments and information-gathering method.
e. Implementation of method throughout institutional system.
f. Improving the method and instruments by analyzing the surveillance data and by developing standards based on the information collected by surveying institutions.
g. Implementing the revised method.
h. On-going evaluation of the experimental program.

The experimental program is expected to yield the following results:

- Improvement in the supervisors' ability to detect shortcomings.
- Improvement of supervisors' ability to monitor compliance with corrections requested of institutions.
- Determination of the effectiveness of the tracer approach as a method of supervision.
- Improvement of the basis for planning and policymaking, through analysis of the computerized data.
- Improvement in the recording system of the institutions.

These changes could contribute a great deal to the improvement of the quality of care in old age homes for independent and frail elderly.

b. Program evaluation

To measure the extent to which the program will be successful in achieving its goal of creating an effective regulatory system, a baseline evaluation was conducted before the program's inauguration. An annual follow-up over a five year period will be conducted. The initial evaluation employed data collected in the course of surveillance, as well as interviews with government supervisors, institutional directors and staff.

The evaluation is based on six general criteria:

1. *Program implementation* — whether or not the supervisors carried out all the activities included in the new method according to the instructions they received. Data will be examined annually.

2. *Reliability* — variability between supervisors will be examined in the first year of implementation by a second survey visit to the same institution after a one week lapse.

3. *Validity* — institutions surveyed with the new instruments will receive independent ratings based on additional tracers and areas of care in order to determine the validity of the instruments. Examination will be carried out after the first year of implementation.

4. *Effectiveness of the regulatory system* — the system's ability to detect deficiencies, and the degree to which the institutions comply with requests for improvement will be examined before and after the implementation of the program.

5. *Quality of institutional care* — the improvements in treatment of various medical, nursing and psycho-social tracers, as well as some of the outcomes of care are considered. The examinations will be carried out annually by independent third-party observers.

6. *Perceptions of the experimental regulatory system* — the responses of the supervisors and directors will be compared before and after the inauguaration of the program in order to understand the problems in: (1) detecting deficiencies; (2) compliance of instittuions to the demands for change; and (3) program implememtation.

7. *Summary*

The program presented here is an attempt to improve one of the major determinants of the quality of care in institutions for the elderly — the governmental surveillance system. In order to ensure a more general improvement in the quality of institutional care, some complementary action is called for. There are additional areas that need attention at the national and at the institutional level.

a. At the national level:

1. Enrichment and expansion of the ongoing training system for institutional staff. The study indicated shortcomings in professional know-how, espe-

cially in the nursing and occupational care. Further, most workers in the institutions had no training in Gerontology.
2. Introduction of a reimbursement method, which would encourage the upgrading of the quality of care.

b. At the institutional level:

1. Improvement of management: Many institutions need to improve their internal supervision and their recording systems, and to introduce a more efficient use of resources. Also in need of improvement are the handling of residents' complaints, enforcing adherence to clear work procedures, formulation of personal care plans, and more adequate human resources management (staff recruitment, job descriptions, performance evaluation, motivation incentives and in-service training).
2. Encouragement of family involvement in the institutional life of their elderly and creation of channels for processing complaints by residents and their families.

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THE ORGANIZATION OF LONG-TERM CARE SERVICES IN ISRAEL — AN EVALUATION

by Jenny Brodsky, Marc Cohen, Dr. Jack Habib and Tamar Heron*

1. Introduction

Most long-term care systems are characterized by a division of responsibility among a variety of service providers who have different funding sources, eligibility criteria and types of service.

The system of long-term care for the elderly in Israel is no exception. Today elderly clients may receive services from a variety of agencies that operate according to a clear division of financial responsibility. The elderly are classified by disability level: The semi-independent, who are independent in the area of personal care but need homemaking help or supportive social services; frail elderly need partial help in personal care as well as homemaking assistance; nursing elderly need help in bathing, dressing and eating, and of course homemaking assistance; a fourth group is composed of the mentally frail elderly who are confused and disoriented but ambulatory and need help in personal care and homemaking services, depending on the severity of their condition.

Care provision is divided among the various agencies on the basis of the elderlys' functional status and the type of assistance required:

The Social Services Bureau is responsible for financing homemaking services for all disabled elderly and for financing personal care assistance (help in bathing, dressing and mobility) and institutionalization for semi-independent and frail elderly. The Bureau also finances other services such as transportation, home equipment, home repairs for those lacking in means, and day centers.

Kupat Holim (Sick Fund) is responsible for financing personal care services for nursing elderly who are fully insured Kupat Holim members. It participates in the cost of medical equipment, and finances institutionalization for rehabilitation and complex nursing cases requiring a medically oriented setting.

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The Health Bureau is responsible for financing personal care assistance for nursing elderly who are not fully insured Kupat Holim members. It supplies medical equipment, and finances institutionalization for nursing and mentally frail elderly.

In addition, there are other agencies that service a more limited population or specific need mostly on a volunteer basis, such as "Yad Sarah" which provides medical equipment.

A number of problems may emerge from the fragmentation of the system of care provision and finance.

In most systems, agency responsibility is limited to specific problems and focuses on providing solutions to these problems. As a result, the client's problems and needs are not seen as part of a comprehensive picture. Sometimes, because this overall picture is lacking, clients are not referred to other agencies for supplementary services. Other researchers cite the absence of established procedures for transferring information between the different agencies as a major problem in the process of service delivery and organization. This leads not only to a lack of uniformity in the treatment of clients with similar problems, but also to the implementation of inappropriate care plans (Sherwood, Morris & Bernhart, 1975; Gottesman, 1980; Willemain, 1979). Furthermore, this division creates a discontinuity in the provision of care, if and when there is a change in the client's condition. The lack of clear-cut procedures for dividing responsibility among the agencies can result in situations where the elderly "fall between the cracks" and are overlooked by all the agencies (Beatrice, 1979; Greenberg *et al.*, 1980; Habib & Pakes, 1982; Raymond & Carter, 1983). Another result of the division of responsibility for service provision is wasted resources — assessments for the same client are duplicated by different agencies and there is no coordination in the implementation of care and follow-up plans (Morgenstein *et al.*, 1982; Mueller & Hopp, 1979; Steinberg & Carter, 1983). The clients themselves find it difficult to find their way in so complex a system; and are often unaware of the options available to them.

In Israel there has recently been a new impetus given to improving the organizational system following the passage of the new Home Care Services Insurance Law which will introduce major changes in resource allocation for home care services for the elderly. This Law opens the way for far-reaching changes in the systems' organizational structure.

This paper** presents the principal findings of a study designed to exam-

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** This article is based on the findings of a comprehensive study conducted by the Brookdale Institute with a joint funding of the National Insurance Institute. Our thanks to the study's steering committee who provided many constructive comments throughout the project: Yissachar Ben Haim, Batya Vashitz, Shlomo Cohen, and especially, Brenda Morgenstin. In this article we also used data from

ine in detail the way the system functions in providing care to the elderly. The study attempted to identify the dominant patterns as well as the major differences within the agencies, among the agencies, and between different areas in Israel. The aim of the study was to create an information base to facilitate the planning of these changes.

2. *The Conceptual Framework*

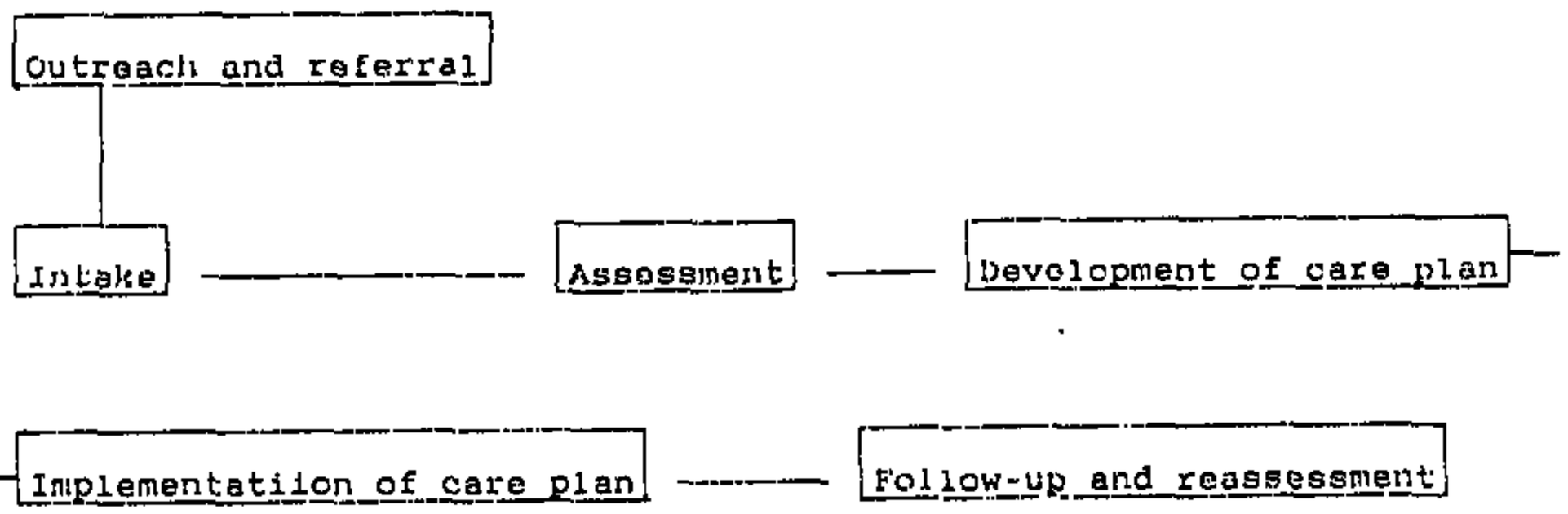
In recent years, increasing attention has been directed toward the organizational structure of services as awareness has grown that the care of the elderly is determined not only by an objective assessment of their needs, but also by the system's organizational and administrative structure. Various organizational models have been developed in an attempt to address the problems described above.

To create inter-agency links, there must be coordination on three levels: the ministerial level, the managerial level and the field level.

One of the approaches to coordination at the field level is based on the development of the role of case manager. Case management is a technique designed to: (a) assure accessibility to services and provide information through a central address; (b) assure overall responsibility for implementation of the care plan; (c) ensure adequate follow-up and provide an address for solving problems that may arise during the care process; (d) document the care process in a standard and systematic manner to create an information base for service planning.

This paper will focus on the process of case management as practiced in Israel considering each of the specific tasks facing case managers on the individual level. These tasks are, in fact, stages in the course followed by any individual entering the system, as described in the figure, below:

Stages in the Care Process



the study "Disabled Elderly in the Community: Development of Appropriate Community Services *and Their Implications for the Need for Institutional Services,"* (J. Habib. H Factor, D. Naon, J. Brodsky and T. Dolev. 1986) which was funded by ESHEL.

For each of these stages, we will describe how professionals in the field perceive their responsibility, how this responsibility is implemented in practice, and the problems that arise during implementation. We will also examine inter-organizational links: The frequency and type of contact among the various service organizations; staff perceptions of the most common problems in inter-agency coordination, as well as their recommendations for improving coordination.

3. Methodology

Elderly clients receiving long-term services (community services or institutional services) enter the system through a number of agencies: the Social Services Bureaus, the Health Bureaus, and general and rehabilitation hospitals, the Kupat Holim Continuing Care Units and clinics. Kupat Holim's clinic staff provide acute care for all its elderly members at the clinics or in the elderly's home. With respect to the chronically ill elderly, Kupat Holim established a special unit: The Continuing Care Unit. The staff of the unit are seen as specialists and they advise and train the nurses from the clinics in the areas of assessment in how to provide special treatments such as catheter, colostomy, etc. In addition the staff of the unit is directly involved or responsible for the care of some of the cases. The staff of the unit are also the decision-making body with respect to special services to the elderly such as personal care, medical equipment and para-medical treatments. It was decided to examine the case management techniques used in each of these 4 settings. The study was conducted in four areas: Jerusalem, Tel Aviv, Beersheba and Haifa.

Two complementary methods were employed: (1) Interviews with the social workers and nurses on the staff of the major agencies providing services for the elderly. The interviews included a description of work procedures in each step of the case management process, the main implementation problems, and recommendations for improvements; (2) Data on the actual care of clients was collected from their files. Information that did not appear in the files was supplemented through staff interviews.

The professionals interviewed included:

1. All the social workers who work with the elderly and their supervisors from the Social Services Bureaus (a total of 97).
2. Care teams in the Kupat Holim Continuing Care Units (a total of 10).
3. Social workers and head nurses in geriatric, internal, surgical and orthopedic wards in hospitals serving the areas included in the study: Hadassah Ein Kerem, Hadassah-Mt. Scopus, Shaarei Zedek, Tel Hashomer, Ichilov, Asaf Harofeh, Hasharon, Rambam, Rothchild and Soroka. The

heads of the geriatric wards in the Shaarei Zedek and Mt. Scopus hospitals were interviewed as well. Also interviewed were social workers and head nurses in rehabilitation hospitals in the areas included in the study: Ezrat Nashim, Beit Rivka, Shmuel Harofe and Fleeman, as well as the rehabilitation ward in Hadassah Scopus (a total of 109). Altogether 220 staff members were interviewed. The data was collected between May and September, 1983.

Analysis of the files was based on the following populations:

1. All elderly clients on waiting lists for long-term institutional placement (including semi-independent, frail, mentally frail and nursing elderly) through the Health Bureaus and Social Services Bureaus in Jerusalem on 15.6.83, in Beersheba on 10.10.83, and in Tel Aviv on 1.1.84.
2. A sample of elderly who received personal care or homemaking help (or both) financed partially or completely by the Ministry of Labor and Social Affairs, the Ministry of Health and Kupat Holim Klalit, and were not on waiting lists for long-term institutionalization. The sample was based on clients who received these services in Jerusalem in April 1983, in Beersheba in September 1983, and in Tel Aviv in December 1983.

Analysis was based on 663 elderly clients awaiting institutional placement and 2,289 not on waitng lists, for a total study population of 2,952 elderly.

The data, as gathered from staff descriptions of their work procedures and perceptions were integrated and compared with the data taken from the clients' files.

4. *Stages in the Care Process*

As stated in the Introduction, the care of the elderly can be divided into a number of basic stages. This chapter will describe how each of these stages is carried out. The findings will be presented for each of the major organizations. The primary differences in the care process among the four areas studied will also be presented.

(a) Referral and Entry

One of the most common problems preventing many elderly from receiving the services they are entitled to, is the absence of established referral procedures among the various agencies.

In most cases, elderly clients approach the Health Bureaus and Social Services Bureaus on their own initiative. However, they are usually referred to the Continuing Care Units by some other agency, primarily the Kupat

Holim clinics. Among the care-providing agencies, the Family Health Station received the lowest rating as a referring agency. This reflects the as yet limited involvement by public health nurses with the elderly.

(b) Intake and Assessment

Intake. During this stage, the basic data on the client's condition are collected, and the client's compatibility to the services offered by the agency approached are examined.

In the literature there is some disagreement over the question of who is the most suitable person to carry out this first assessment. Some claim that this preliminary screening does not require a highly skilled professional, and that it is therefore possible to separate screening from the more professional aspects of care management and care (Gottesman, 1980). The main advantage of this division is that it eases the work load of the professional caregiver. However, the disadvantage is that the information received through direct impressions, which is difficult to "translate" onto forms, is lost. Another disadvantage is the resulting lack of continuity between the client and caregiver. Therefore, there are those who claim (for example, Donabedian) that the screening stage is critical, and should be carried out by the most highly skilled professionals.

In Israel, intake and screening are carried out by all staff members of the Social Services and Health Bureaus. There is a social worker on duty at the Social Services Bureau, and a nurse on duty in the Health Bureau. They usually receive new clients and refer them to the staff member responsible for their catchment area. In some areas (for example, in Beersheba) there is a permanent staff member, called an "Intake Worker", who is responsible for receiving clients, carrying out a preliminary assessment of their condition, and referring them to another staff member for the continuation of care. It appears, therefore, that generally there is no continuity in the client-caregiver relationship although professionals do generally undertake initial screening.

Assessment. After intake, the staff member assigned to the case proceeds with a more in-depth assessment. The assessment is aimed at defining the client's status and needs, and determining which resources are needed to meet these needs.

Assessment may be carried out by a single professional, who consults, as necessary, with other professionals, or by a multi-professional team. Researchers differ in their opinions as to the most efficient method of carrying out an assessment. Beatrice recommends using a multi-professional team composed of a nurse and a social worker, in order to create a balance between the social assessment model and the medical-nursing assessment model (see Beatrice, 1979). Gottesman claims that the multi-professional team method is expensive and not always efficient (Gottesman, 1980). There is, of course, the

possibility of employing a multi-professional team for only part of the population.

Data on assessments in the four areas examined are presented below. Table 1 presents the percentage of staff members participating in assessment teams.

In the health agencies, most assessments are carried out by teams. In fact, almost all the staff members interviewed in the Health Bureau and hospitals reported that assessments for the majority of clients are carried out by teams. By contrast, in the Kupat Holim Continuing Care Units, 22 percent of the staff reported that in most cases they do not carry out team assessments. These staff members claimed that the assessment and decision regarding service provision are carried out at times by a single person and at times by a team, depending on the complexity of the case and the services required. The Social Services Bureaus require team-assessments for all cases, as specified in the Regulations. These regulations also specify the composition of the team: A social worker from the Bureau, a nurse, and if possible — a physician from the local health services. But it turns out that 33% of the respondents never participated in team assessments, and that 13% only participated with regard to a small number of cases under their care.

The composition of the assessment teams differs according to agency. In the Health Bureau, the team is usually composed of a social worker, nurse, and geriatric physician; in hospitals the team included a physician, a nurse, a social worker and often a physiotherapist; in the Kupat Holim Continuing Care Units the team was composed of a social worker, a physician, a nurse, a physiotherapist, an occupational therapist and the clinic nurse.

The multi-professional team in the Social Services Bureaus is of special

Table 1. Participation in Assessment Teams (Percentages)

Assessment Team	Care Agency			
	Health Bureau	Social Services Bureaus	Hospitals	Continuing Care Units
Team discussions of all cases	89	20	74	44
Team discussions of most cases	11	33	11	33
Team discussions of a minority of cases	----	13	3	22
No team discussions	----	33	13	----

interest because it includes staff members from other organizations, which calls for a high level of coordination. Eighty-six percent of the teams included a Kupat Holim nurse, and 65% included a public health nurse. Twenty-nine percent of the teams included both nurses. There were some differences by area. It seems that a high proportion of the Tel Aviv and Beersheba Social Service workers do not participate in teams, while in Jerusalem and Haifa 70 percent of the staff take part in team deliberations regarding most of their cases. There were also differences by area in the composition of the teams. The public health nurse always participated in the Beersheba teams, and in 86% of the Haifa teams. In fact, in Haifa the public health nurses and the Kupat Holim nurses participated equally. Forty percent of the Social Services staff in Haifa reach decisions regarding assessment of the client's condition as part of a team which includes both types of nurses. In Jerusalem and Tel Aviv, on the other hand, 85% of the social workers reported that Kupat Holim nurses mostly participate.

The findings regarding the composition of the teams are consistent with the findings on existing inter-agency arrangements. The Social Services Bureaus in Haifa and Beersheba maintain closer contacts with the Family Health Stations than in Jerusalem and Tel Aviv. The Bureaus in Jerusalem and Tel Aviv maintain close contacts with the Kupat Holim clinics, while the Haifa Bureau maintains close contact both with the clinics and the Family Health Stations.

Problems in the Assessment Process. The assessments rely on information from clients, the client's family, and other care agencies who know the client. Inter-agency transfer of information is most important because it allows staff members to carry out more comprehensive assessments and reduces duplication.

Transfer of information on clients may be done formally (by filling in forms) or less formally (by telephone or informal conversation). Table 2 summarizes the main problems related to obtaining information as reported by the staff.

Seventy percent of the workers mentioned at least one problem in obtaining information from other care agencies. Staff in various agencies who are responsible for intake of clients referred from the Social Services Bureaus, reported difficulties in contacting the Bureau staff. Another frequent problem is delays in receiving information. Forty-four percent of all the staff members in the system said that information received from Kupat Holim is frequently incomplete.

Problems in Client Classification. In the Israeli system the classification of the elderly by disability level is very important, because the amount of services provided, as well as the agency responsible for financing them, are determined by this classification. The classification stage is problematic,

Table 2. Problems in Obtaining Information from Referral Sources (Percentage of Respondents in Each Agency who Cited this Problem)

Referral Source	Problem				
	No Problems	Delays in Obtaining Information	Difficulty in Reading Handwriting	Incomplete Information	Difficulty in contacting staff
Kupat Holim	36	22	28	44	28
Hospitals	39	26	26	32	21
Health Bureau	58	17	4	7	28
Social Services Bureaus	33	32	7	20	53
Family Health Station	72	12	5	14	11

because many clients do not exactly fit the criteria (See Table 3). Ninety percent of the caregivers reported having problems classifying clients who are, in their opinion, in need of institutionalization; eighty-six percent reported having problems classifying clients in need of community services.

These difficulties may cause delays in service provision, shuffling of clients back and forth between agencies, and clients being overlooked (clients "falling between the cracks"). A change in a client's functional status which entails a change in the client's classification, may require that the client be transferred from one organization to another, potentially disrupting the continuity of care. To ensure continuity, close cooperation and coordination among the different agencies is required.

Recommendations for improving the assessment process. Staff members were presented with the question: How, in their opinion, could the assessment process be improved? Twenty percent of the staff of all the agencies, with the exception of the Kupat Holim Continuing Care Units, recommended having

Table 3. Percentage of Staff who Have Problems in Client Classification

	Health	Social	Hospitals	Kupat Holim	Total
For clients needing services	89	90	86	65	86
For clients needing institutionalization	100	94	88	83	90

formal links with other organizations. The intention was to establish and maintain regular contacts, including regular meetings where staff could report on specific cases. The Continuing Care Units staff recommended that information be transferred in writing at the time of referral (at present much more information is transferred by phone).

(c) Development of Care Plans

Theoretically, it is possible to differentiate between the care plan development stage and the assessment stage. In fact, however, in most cases, the care plan is developed during the assessment process. The care plan, which is constructed jointly by the client and the caregiver, is aimed at determining, first, the client's problems and needs, and then, the assistance needed to meet these needs (Gottesman, 1980).

Some researchers recommend developing assessment instruments that directly link the functional assessment (i.e., the collection of information) with the determination of disability level and the decision about service allocation). Others (Kutz, 1979) claim that assessment instruments are a standardized and structured data-collection method for ensuring that all the relevant information is available to the care-planner, but that the decision regarding type of care and service allocation must be left to the professional.

One of the difficulties in translating disability level into practical assistance is the lack of agreement over the meaning of "need". Actually, the definition of "need" is a question of policy. Studies have shown that there is no consensus among various professionals treating elderly clients about the level of required care and the extent of services (Sager, 1980)

The assessment instruments used in Israel do not determine the level of disability according to a disability scale, and do not translate the disability into the need for practical assistance. Thus the professionals are left considerable discretion in deciding the extent of assistance and the services to be provided.

Another point for consideration is who should do the care planning. Gottesman, for example, recommends that the same person carry out the assessment and care planning (Gottesman, 1980) in order to avoid duplication (for example, home visits by both the assessor and the care planner, since designing a care plan requires direct client contact).

Differences were found among the agencies in this regard. In the Health Bureau, the nurse frequently relies on the functional assessments done by nurses in other agencies. In the Social Services Bureaus, the social workers who carry out the social assessments also work out the care plans. However, these plans are submitted for authorization to their supervisor, who can introduce changes. When a functional assessment is required, the social worker relies on the assessment done by the Kupat Holim nurse or the

Ministry of Health nurse. In the Kupat Holim Continuing Care Units, both patterns are practiced. Sometimes the nurse uses assessments carried out by the clinic nurse; at other times, the Unit's nurse herself carries out home visits, makes an assessment and establishes a care plan.

Another key question is whether care planning is comprehensive. In other words: Do the staff at the differen agencies perceive their responsibility as comprehensive, and do the plans cover all the services that the client might need, or only those services that their agency can provide.

An analysis of the types of services recommended by the different agencies shows that the Health Bureau staff recommend only those services which they supply. On the other hand, staff in other organizations recommend services that are not provided by their own agency. It is possible to say, then, that staff members in the Social Services Bureaus, in Kupat Holim and in the hospitals perceive their role as addressing the needs of the clients in a comprehensive manner.

Analysis of client files bears out the caregivers' reports. It was found that the caregivers at the Social Services Bureaus were involved in obtaining services from other agencies for 50 percent of their clients, as opposed to 40 percent at Kupat Holim and 25 percent at the Health Bureau. It is interesting to note, that in their general report the Health Bureau staff said that they do not recommend other services; however, in the analysis of specific cases, it was found that they assisted about a quarter of their clients to obtain services outside the Bureau. The question of comprehensive responsibility will emerge later in the discussion of the follow-up of care plan implementation when we consider whether caregivers follow up only those services supplied by their agency or services supplied by other organizations as well.

It has been hypothesized that caregivers try harder to obtain services provided by other agencies for clients who have no family who can assume this role. Most caregivers agreed but an examination of client files failed to confirm this. On the contrary, there was almost no difference in this respect between clients with families and clients without families, and if there was a difference, it was in favor of those with families. Apparently, family pressure on the caregiver may considerably affect the efforts made by professionals. Proof of the positive effect of family on service utilization was also found in Norway (see Daatland, 1983).

(d) Family Involvement in the Development of Care Plans

Family involvement — or informal support — is a primary factor in ensuring adequate care to the elderly client. Professionals need to take into consideration the family's ability and willingness to help. The process of developing a care plan involves negotiation with the family to determine how

the assistance that the client will receive should be divided among the various possible providers.

The case analysis reveals that the Health Bureau staff have contact with 35% of their clients' families; Social Services Bureaus, with 53% and Kupat Holim staff with 70% (these data include only clients who have families).

Both the Social Services Bureaus staff and the Health Bureau staff maintain contacts with family members of clients on waiting lists for institutionalization more than with families of clients who are not on waiting lists.

Among other variables that were found to be related to the existence of or lack of contact between caregivers and families, are problems related to the provision of care by the family. When, in the caregiver's opinion, caring for the client causes stress in the family, or when care constitutes a heavy physical or mental burden on family members, there is a greater tendency among caregivers to maintain contacts with the family.

Two-thirds of the respondents reported that they consult with the family frequently about the care plans. A small number of staff in all agencies reported that they never consult with the family. The various organizations differ from each other in the extent of consultations with the family. In the Social Services Bureaus the rate of staff who consult with the families on a regular basis is relatively low.

A further question that was examined was staff attitudes toward the balance between formal and informal services. We examined to what extent staff members are willing to withhold provision of a certain service to clients whose families are able, but unwilling, to help (Table 4).

It appears that the staff do not usually prevent service delivery to clients whose families refuse to help. Thirty percent of the staff are prepared, at times, to withhold services, but only 5% consistently refuse services to clients whose families refused to help. The rate of staff members in the Health Bureau who are prepared to withhold service provision is even lower. However, 90% of the caregivers reported that they try harder to obtain services for clients whose families show a greater willingness to provide care.

Table 4. Responses to the Question "Do You Provide Services to a Client Whose Family is Able but Unwilling to Help?"

	Care Providing Agency			
Provides Help	General	Health Bureaus	Social Services Bureaus	Kupat Holim Units
Yes	70	87	65	72
Not always	25	13	32	28
No	5	0	3	0

With regard to the assistance provided families, we asked "What prevents families from providing more help to their elderly?" The staff pointed to the many problems facing the families. About 80 percent of the staff cited poor relationships between family and client, and almost three-quarters mentioned family members' health problems.

Many studies in Israel and abroad have shown that it is the families, rather than the formal services, who provide most of the help to the elderly (Silberstein, 1981; Sussman, Shanas, 1981; Cantor, 1980). Reports of family burden, and of the need for services to ease their burden are frequent.

Most caregivers suggested that the family's burden could be lightened by adding personal care and homemaking services. A considerable percentage thought that additional emotional support and guidance would also be helpful.

(e) Implementation of the Care Plan

Implementation of the care plan requires contact with service providers, negotiating the delivery of the required services to the client and follow-up, to ensure that the services have indeed been provided.

The implementation stage is highly complex, especially in a fragmented system. We asked the professionals to address the problems that arise in care plan implementations.

Problems in the Provision of Community Services. There is a connection between the services that are actually available and the care planning process. When there are problems in obtaining certain services, the planners will avoid recommending them, even if they think that the client needs them. Cumbersome organizational procedures may also cause implementation problems. Finally, it is possible that the family or the client may not be interested in the services recommended by the caregiver.

We examined staff attitudes with regard to the quality of eleven different community services. The staff were asked to specify the problems which arise in each service.

Table 5 presents the main problems which arise in each service in each of the four areas. In addition to budgetary problems which preclude the provision of services, qualitative and organizational problems were also found.

Difficulties of finding suitable manpower is a central problem for personal (care) services, homemaking services and paramedical services. In the area of home care, a flexible approach to the needs of the elderly is required. Elderly clients need assistance throughout the day, and not necessarily during the morning hours when this service is generally provided. Bureaucratic difficulties are especially acute with respect to home repairs and apartment adaptations. With regard to mental health services, a high rate of staff members noted problems in the way this service is provided. This service has virtually

Table 5. Main Problems in Each Service, by Area (Percentage of Respondents who Mentioned the Problems)

	City			
Service	Jerusalem	Tel Aviv	Beersheba[1]	Haifa
Social work aides	Budget problems (55% Manpower problems (57%)	Manpower problems (57%)	Service does not exist (82%)	Budget Problems (44%)
Personal care	Manpower problems (73%) Budget problems (62%)	Manpower problems (66%)	Budget (53%) Service delivery problems (53%)	Budget problems (46%) Manpower problems (35%)
Meals on wheels[2]	Service delivery problems (30%) Client refusal to accept service (28%) Service unavailable in all the areas (26%)	Service delivery problems (31%) Client refusal to accept service (34%)	Service delivery problems (13%) Client refusal to accept service (25%)	Service delivery problems (31%) Client refusal to accept service (31%)
Mental health service[3]	Service delivery problems (47%) Client refusal to accept service (31%)	Client refusal to accept service (36%) Service delivery problems (43%)	Service delivery problems (21%) Families refuse to accept service (21%) Bureaucracy (21%)	Service delivery problems (32%) Client refusal to accept service (20%)

Home-making services	Manpower problems (78%) Budget problems (67%)	Manpower problems (78%)	Manpower prolems (76%) Budget problems (70%)	Manpower problems (70%)
Laundry services	Budget problems (40%)	Service does not exist (26%)	No problems	Budget problems (37%) Service delivery problems (20%)
Clubs[4]	Budget problems (22%)	Service unavailable *in all areas* (12%)	Service delivery problems (19%) Service unavailable in areas (19%) Client refusal to accept service (50%)	Client refusal to accept service (18%)
Volunteers	Manpower problems (60%)	Manpower problems (42%)	Manpower problems (64%)	Manpower problems (56%)
Para-medical services	Manpower problems (41%)	Manpower problems (29%)	Manpower problems (64%)	Manpower problems (56%)
Home repairs	Budget problems (55%) Bureaucracy (43%)	Bureaucracy (46%)	Bureaucracy (46%)	Budget Problems (44%) Bureaucracy (41%)

Notes:

1 The problem with the Matav (home aides) service in Beersheba is that the aides do not work the full quota of hours they agreed to, and do not carry out all the required activities.

2 The problem with the meals-on-wheels service is that the elderly do not like the food.

3 In the mental health service, there is a service delivery problem: the psychiatrists do not treat the problems of the elderly adequately, *do not* maintain contact with other care agencies, and do not make home visits.

4 The problems in the club service are unsuitable staff, transportation problems and language problems.

no home visits, so that elderly clients who are unable to reach the service on their own are generally prevented from utilizing this service.

There are also those elderly who do not want a service. This is an important factor with respect to meals and clubs. It is important to examine whether these services are sufficiently adapted to meeting the requirements of the potential clients. It was found that a large proportion of the hospitals' staff are unaware of the problems in most of the services, due to the lack of contact with the community services.

Problems in Institutionalization. There are cases when the need for institutionalization arises.

There are a number of problems that may arise and hamper staff in arranging for institutional placement. Staff members were asked whether, and to what extent, they come across one or more of the problems listed in Table 6.

Almost all the staff members reported a shortage of beds. Staff in the health agencies, even more than in the social services agencies, said that the pressure exerted by the family has a great effect on the client's admission to an institution.

Table 6. Problems in Institutionalization by Type of Problem and Care Agency

	Care Agency				
Problems	General	Health Bureau	Social Services Bureaus	Hospitals	Continuing Care Units
Limited number of beds or institutions	92	80	89	95	89
Lack of inter-agency coordination, causing clients to "fall between the cracks"	33	30	30	31	56
Those who make the final decision about admission to institutions do not participate in the assessment process and are not sufficiently familiar with the cases	27	0	27	33	5
Institutional placement as a result of client or family pressure, and not because of the client's objective condition	32	30	18	42	44

Staff were asked to assess the quality of the institutions. Most staff members assessed the quality of institutions as mediocre, and only a minority as either very good or very poor. The institutions were divided according to ownership: State, public or private. Significant differences between the various institutions were found in staff assessments. Twenty percent of the caregivers thought that the quality of public and state institutions was high, compared to 7% who responded that the private institutions were of high quality. Relatively few professionals considered the state institutions to be of poor quality (10 percent). On the other hand, a high proportion of staff members said that the private institutions were of poor quality. In Haifa and Tel Aviv, where there are many private institutions, more than 40% stated that the quality of the institutions was poor.

The caregivers were asked how many clients they referred to institutions during the past year, and how many cases they would have referred if:

(1) There was no limitation on the availability of beds;
(2) The quality of the institutions was improved;
(3) The quality of community services were improved.

Twenty-four percent of the caregivers said that had there been no shortage of beds, they would have referred more clients to institutions. Forty-two percent reported that if the quality of the institutions had been better they would have referred more clients to institutions. Sixty-four percent of the staff claimed that if the quality of the community services were improved, they would refer fewer clients to the institutions.

The differences found between the various cities are of interest: In Beersheba, the bed shortage has the greatest effect: 43% of the staff there said that if there were more beds they would refer more clients to institutions, as opposed to only 15% in Haifa. It is interesting to note that the quality of institutions affects mainly the staff in Tel Aviv and Haifa: More than 50% of the staff in both these areas said that if the quality were improved, they would refer more clients to institutions. These findings are consistent with the fact that the caregivers in Haifa and Tel Aviv believe the quality of the institutions to be poor.

(f) Follow-up and Reassessment

The care of the elderly client does not end with the implementation of the care plan. Follow-up of the client after the client has received the services prescribed by the care plan is sometimes important. Such follow-up is not an integral part of the service set-up, and this undermines the effectiveness of the care (Gottesman, 1981).

Follow-up includes: (1) An examination of the extent to which the recommended services were indeed provided; (2) follow-up of the changes in the client's social, health and functional status, to determine the effectiveness

of the services and to what extent the client still needs them; (3) supervision of the service providers, to examine whether the service is provided as recommended and agreed-upon, with regard to the number of hours, range of services and quality of care.

In general, most staff members reported that there is follow-up of the way the services are provided. The Health Bureau follows up only the personal care services that it supplies. But the Social Services Bureaus and Kupat Holim staff members said that they also follow-up on services which they do not fund.

Staff in the Social Services Bureaus usually divide their clients into three categories: Intensive cases, regular cases and follow-up cases. Table 7 presents the distribution by category in the four areas.

The total number of cases handled by each caregiver varies from place to place. It ranges from an average of 152 in Beersheba to 105 in Haifa. We examined the standards for follow-up by category, and found some variation:

Intensive cases: Frequency of contact ranges from more than once a week to once every two weeks; the most common is weekly.

Regular cases: Frequency of contact ranges from once every two weeks to once in three months; the most common is monthly.

Follow-up cases: Frequency of contact ranges from once a month to once in more than three months. The most common is once every three months.

The frequency of contact for the sample of disabled elderly revealed that in the Social Services Bureaus and in Kupat Holim, the staff maintain more frequent contact with their clients than in the Health Bureau. In these two agencies, staff members are in contact with their clients not only for the preliminary assessment, but for on-going care as well (Table 8).

Table 7. Average Number of Cases Assigned to Each Staff Member By Categories of Care

	Jerusalem		Tel Aviv		Beersheba		Haifa		Total Average	
Category	No.	%	No.	%	No.	%	No.	%	No.	%
Intensive	30	22	28	25	7	4	20	19	26	21
Regular	39	28	52	47	21	14	31	30	40	32
Follow-up	69	50	30	27	124	82	54	51	59	47
Total	138	100	110	100	152	100	105	100	125	100

Table 8. Frequency of Contact Between Caregivers and Clients (Percentages)

	Health Bureau	Social Services Bureau	Kupat Holim
Total number of clients	693	1,822	436
In percentages	100	100	100
Less than once a month	72	31	35
Once a month	12	30	29
More than once a month (2-3 times)	5	19	17
At least once a week	6	12	14
Unknown	5	8	5

There is a connection between the frequency of contact with the client and his condition. In all three agencies contacts are more frequent with elderly who have a high disability level or need constant supervision (during the day or night). Unexpectedly, staff members do not have more frequent contact with clients who live alone; on the contrary, there is a tendency to maintain more frequent contacts with those clients who live with a spouse or children. It was also found that both in the Health Bureaus and the Social Services Bureaus, more frequent contacts are maintained with clients who are on waiting lists for institutional placement.

Follow-up in hospitals was examined through interviews with nurses and social workers in the different wards. It was found that about 60% of these caregivers conduct follow-ups after the patients are released from the hospital; 70% of the caregivers conduct the follow-up by contacting the staff treating the patient in the community or in the institution they were referred to; about half also contact the patient or the patient's family directly.

A comparison of the hospitals in the four areas shows that in the Haifa and Tel Aviv hospitals, relatively few caregivers tend to maintain contact with the patients after their release. In Beersheba and Jerusalem there is more follow-up after release from the hospital. In Beersheba the staff usually contact the community caregivers (nurses or social workers) rather than the patients or their families.

5. *Inter-Agency Links*

(a) Extent and Type of Inter-Agency Coordination

Coordination between agencies is required at several levels: On the general policy level at which the various agencies define their responsibilities

for provision of care; at the level of routine work procedures used by the field staff in performing their jobs.

We have examined the problem of coordination as reflected in the problems reported by the staff in each of the stages of the case management process. We now attempt to achieve a broken overview of the degree of coordination.

Inter-agency coordination within the service system is necessary for many reasons: For purposes of assessment. The Social Services Bureaus that are dependent on information from the health agencies in order to carry out medical-functional assessments. To ensure that clients assigned services from various agencies will receive them. To maintain the continuity of care for clients who, because of changes in their medical-functional status and in their health condition, are transferred from one agency to another.

In order to understand the extent of inter-agency coordination, staff were asked how often they have contact with other agencies, and to describe the type of contact. These contacts could take the form of an exchange of information about specific clients, including follow-up reports, or of regularly-held meetings to coordinate activities on a more general level.

Throughout the years, various types of inter-agency links have been established by the different agencies. One of the most common are the regular visits by social workers to Kupat Holim clinics treating their elderly clients. Another established link is regular meetings at the hospitals by a Kupat Holim nurse, who is given documents, requests and recommendations for the continuation of care in the community for an elderly patient about to be released.

Most of the staff in the four care agencies (Health Bureau, Social Services Bureau, hospitals and Continuing Care Units) reported frequent contacts with each other, with the exception of hospital and the Social Services Bureau staff. Links with other service provider agencies, such as rehabilitation hospitals, day-care units, clubs, mental health stations and the Family Health Station, were also reported.

The findings reveal that the most common inter-agency link is exchange of information on specific clients. Relatively few staff members reported holding regular meetings for policy coordination.

Most staff in the Kupat Holim Continuing Care Units reported that they maintained contacts with all the other agencies for purposes of information exchange. Most said that they do not have regular meetings with any agency.

Most of the Health Bureau staff reported holding regular meetings with the staff in other health organizations: General hospitals, Kupat Holim and rehabilitation institutions. This finding correlates with reports by the Health Bureau staff on their outreach activities to locate elderly persons.

Inter-agency contacts are a result of the particular practices followed by

each agency, and are also affected by the unique characteristics of the area they serve. The most notable differences in the inter-agency links in the four areas are described below.

The Health Bureau. The Health Bureau staff in Jerusalem and Beersheba reported more frequent contacts with the general hospitals than did the staffs in Tel Aviv and Haifa. In all areas, except for Tel Aviv, there are regular meetings between the hospital and Bureau staffs. With regard to the links between the Health Bureau and the Social Services Bureaus it was found that the Haifa staff, unlike those in othe areas, do not hold regular meetings but only meet when the need arises. The differences in the frequency of contact between the Health Bureaus and the Mental Health Stations in the four cities are notable: In Jerusalem and Beersheba, Health Bureau staff reported maintaining frequent links with the Station. In Tel Aviv the staff said that they seldom have contact with the Station, and in Haifa they have no contact.

Social Services Bureaus. The frequency of contact between the Social Services Bureaus and the Health Bureau is lower in Haifa than in the other areas. However, staff of the Haifa Social Services Bureaus reported having very frequent contacts with the Family Health Station, including regular meetings with its staff — a practice that was not reported anywhere else. In Beersheba, too, social Services Bureaus staff have fairly frequent contacts with the Station, but not regular meetings. Most Social Services staff in all locations, with the exception of Jerusalem, maintain regular links with the volunteer organizations. The staff of the Social Services Bureaus in Jerusalem, Haifa and Tel Aviv hold regular meetings with the Kupat Holim staff. This finding coorelates with the report on participation in assessment teams which include social workers and Kupat Holim nurses.

The Kupat Holim Continuing Care Units. The patterns of links between the Units and the other agencies are similar in all the areas. The one exception is the link between the Units and the Mental Health Stations. In Haifa, unlike the other areas, most staff members said that they had no contact with the Station. The most frequent contacts between the Unit and Station were in Beersheba. In Jerusalem and Beersheba, Unit staff maintain contacts with the Social Services Bureaus, but do not hold meetings with them on a regular basis. On the other hand, Unit staff members in Tel Aviv (mainly those in the Jaffa Unit) and in Haifa hold regular meetings with the Social Services staff and with hospital staff.

The patterns of hospital links did not reveal any outstanding differences.

(b) Problems in Coordination

Lack of coordination between the staff of the different agencies providing care for elderly clients derives from a number of sources. The problems

were divided into two groups: (a) Policy level problems, such as the lack of defined procedures and policy, or problems in division of responsibility in providing care for the elderly; (b) Problems at the field level, such as: Manpower shortages, lack of staff initiative to create contacts with staff members from other agencies; shortcomings in transfer of information regarding services provided by these agencies; and extra work due to excessive paperwork and forms.

The staff were asked to cite which problems hinder inter-agency coordination. Their responses are summarized in Table 9.

Almost all the staff members reported problems stemming from both levels.

A large proportion of the Social Services Bureaus staff (65%) emphaszied problems related to the division of responsibility. In the hospitals, 81% of the staff mentioned bureaucratic problems. This was as expected, since

Table 9. Proportion of Respondents Who Mentioned Problems in Service Coordination by Care Agency

Problems	Care Agency				
	General	Health Bureau	Social Services Bureaus	Hospitals	Continuing Care Units
No Problems	8	0	10	7	11
1. Problems in division of care responsibility	50	50	65	36	50
2. Sometimes there is no agency that is willing to take responsibility for service provision	35	40	30	36	50
3. Lack of coordination for policy setting on service developments for the elderly	41	50	40	39	44
4. Complicated procedures and bureaucratic problems	70	40	65	81	50
5. Shortcomings in transfer of information about services that clients are receiving from other agencies	31	20	28	37	17

hospitals are a transition point, from which clients are referred to continuing care in the community or to an institution.

In the Health Bureaus 40% of the staff complained that at times no agency is willing to take responsibility for elderly clients, and 50% of the staff point to a lack of coordination with respect to service development.

We compared the prevalence of inter-organizational problems reported by the staff of each agency in the different areas of the country.

With regard to problems of coordination between hospital staff and other agencies, no significant differences were found among the different areas. however, differnces were found in the extent of inter-organizational problems reported by the social service staff in the different areas. A higher proportion of staff members in the Haifa Social Services Bureau reported problems in the division of responsibility than did Social Services staff from the other areas. Fifty-five percent of the staff also said that at times no organization is willing to assume responsibility for providing the required services to the elderly. The proportion of staff in Haifa that mentioned problems of transfer of information about services received by clients from other agencies is twice as large as in the other bureaus, and three times as large as in Beersheba. This is surprising as in Haifa there is the highest degree of participation in assessment teams, and close links with other agencies. This indicates that the existence of inter-agency links does not necessarily prevent coordination problems. On the other hand, it is possible that the attempt to create comprehensive care plans in cooperation with other agencies brings out and illuminates the problems deriving from a fragmented system, and that therefore more problems are reported.

Differences were also found in the extent of problems reported by the staff of the Continuing Care Units in the different areas. The fewest complaints are reported by the Tel Aviv and Yaffo staff. In Beersheba all the workers complained that there are problems of division of responsibility, and that at times no agency is willing to take responsibility for elderly clients. In Haifa, a large proportion of the Continuing Care Unit (75%) staff emphasized that there is a lack of coordination with respect to service development.

(c) Recommendations for Improving Inter-Agency Coordination

The caregivers were asked to recommend ways of improving the coordination among themselves and the staff of other organizations in their area. The recommendations, given in response to an open question, were divided into three main groups:

1. Recommendations related to structural changes within the system: creating a single agency that would coordinate the care of the elderly at all levels;
2. Recommendations for formalizing existing procedures without changing

Table 10. Proportion of Staff in Each Care Agency by Type of Recommendation

Recommendation	Care Agency			
	Health Bureau	Social Services Bureaus	Hospitals	Continuing Care Units
No recommendations	10	24	25	11
Single care agency	30	8	7	11
Strengthen existing links	80	52	56	83
More information	0	4	7	5

the basic structure of the system: holding joint meetings of the care-providing agencies, employing inter-agency coordinating personnel.

3. Recommendations for improving the methods of transferring information and enhancing knowledge and awareness.

The findings are presented in Table 10.

A significant percentage of the staff in all the care agencies viewed a single care agency as the best solution for the coordination problems. However, the majority, between 50 to 85 percent, believe the solution lies in strengthening the links between the agencies through frequent and regular meetings of the professionals employed in the different agencies. These meetings are needed to coordinate activities in general and for discussion of specific cases. Only a small proportion of the staff in all the organizations recommended enhancing knowledge and information through seminars and training sessions.

Table 11 presents the precentage of staff by type of recommendation in each area.

Table 11. Proportion of Staff in Each Area by Type of Recommendation

	General	Jerusalem	Tel Aviv	Beersheba	Haifa
Single care agency	23	29	15	33	20
Strengthen existing links	68	67	65	67	73
Improve information transfers	9	4	20	0	7

Two-thirds of the staff in all the areas recommended strengthening existing inter-agency links. However, the percentage of staff in Tel Aviv who recommended improving the transfer of information is particularly high while one-third of the Beersheba staff recommended centralizing the care of the elderly at one address.

6. *Discussion*

One of the significant findings of this report is the considerable variability in case management methods across organizations, geographic areas and even among workers in the same organizations and area. The differences among staff may be due to differnces in time pressure and work loads, and not necessarily to different views of appropriate care.

Another issue examined was the quality of community services as perceived by the staff. We found a great deal of dissatisfaction. Alongside numerous complaints about insufficient funds and manpower recruitment problems, there were complaints about the procedures for accessing the services as reflected among other things in delays in service provision.

The differences in practices and attitudes could be a useful starting point for training field staff in order to arrive at a more uniform approach, not only within a given agency but within a broader, inter-agency context.

One central question we raised was with respect to how the different agencies perceive their responsibilities toward their clients. Today, clients can receive services from a number of organizations, which operate according to a clear division of financial responsibility. However, this division of responsibility entails the transfer of clients from one agency to the other when there is a change in their condition. If coordination is less than perfect, the continuity of care is disrupted during the transfer. The situation is complicated even further by the fact that the criteria for classifying clients, which determines agency responsibility, are also not clear-cut. In some cases, it is unclear which organization is responsible for providing care to the client.

It was found that the staff in several of the agencies feel responsible for providing care to their clients beyond the context of the services provided by their agency. The staff in Kupat Holim, Social Services Bureaus, and hospitals carry out a comprehensive assessment of their clients' needs, and also recommend services not supplied or financed by their organization, in order to give a complete response to their clients' needs. They also follow up on services provided by other agencies.

It would seem that this willingness to accept a broader responsibility, and the comprehensive approach to client assessment which characterize most of the agencies, would contribute to more adequate care for the elderly.

However, unlike the clear division of responsibility in the financial sphere, there is no clear division of this broader responsibility and of the case management functions among the organizations, and this can cause conflict or duplication. It can also cause some staff members to wrongly assume that other caregivers have assumed responsibility, and as a result clients may "fall between the cracks", i.e., be overlooked and not receive any services at all.

The complexity of inter-agency links is also affected by the fact that the agencies are dependent on each other for assessments and for implementation of care plans. For example, the social workers in the Social Services Bureau are dependent on the nurses from other organizations for functional asessments. The Ministry of Social Affair's regulations recommend the convening of a multi-professional team for assessment purposes, the intention being that a nurse from one of the health organizations takes part in the Bureau's evaluation team. The converse is true for the Continuing Care Units and the Kupat Holim clinics, who do not employ enough social workers to meet the needs for evaluation and follow-up of all the clients in their area, and therefore need the assistance of the Social Services Bureaus staff. Another example is the hospital's staff dependence on community or institutional agencies, in order to transfer the care of patients about to be released. In addition, all of the agencies, of course, depend on other agencies to approve their recommendations for provision of services which are outside their sphere of financial responsibility.

It appears, then, that no one agency can really implement a commitment to comprehensive care. For the system to realize this goal, a great deal of inter-agency coordination is required.

The problems caused by the network of existing links are reflected in reports about various difficulties related to exchanging information between agencies. Two-thirds of the staff reported problems in this area. However, the fact that a third of the staff did not report such problems indicates that some of the caregivers are capable of creating for themselves the necessary arrangements with the other agencies. Furthermore, about half of the staff mentioned problems in the division of responsibility for care (in some places the rate was higher, for example: 80% of the staff of the Haifa Social Services Bureaus and 100% of the Beersheba Continuing Care Unit), and 70% reported bureaucratic organizational procedures.

Despite these difficulties, a great deal of inter-agency coordination was found, but this coordination is heavily dependent on the initiatives of field staff and is not anchored in formal arrangements. This may explain the great diversity in the extent and type of inter-agency links maintained by different staff members in different areas. Against this background many staff members mentioned the need to formalize and strengthen inter-agency links.

Some of the caregivers recommend pooling entitlements and creating a

single agency. Undoubtedly, any reduction of the present fragmentation would simplify the problem of coordination. However, the main recommendation was to strengthen the existing coordination mechanisms by establishing multi-professioanl teams composed of a Kupat Holim nurse and a Social Services Bureau social worker who would work in cooperation with the public health nurses. As the findings indicate, this arrangement already exists in some places.

7. *Postscript*

Subsequent to the publication of the original research report major strides have been made toward resolving the problems identified by the study. A working group developed a national plan for a system of comprehensive health and social care based on the interorganizational nurse-social worker teams recommended by the professionals interviewed in the study.[1] A prototype of the scheme was tested in Jerusalem and the scheme was adopted as national policy by both the Ministry of Labor and Social Affairs and Kupat Holim.

The teams called TZOMET (intersection) are now being established throughout the country. In 5 areas the introduction of the teams will be carried out as a demonstration project sponsored by ESHEL and the Brookdale Institute in order to perfect the system and to evaluate its implementation and contribution.

The inter-ministerial committee planning the implementation of the Nursing Law has designated the teams as the primary care planning entity under the Law. Thus, the system in Israel is in the process of implementing a more coordinated system reflecting very much the recommendations of professionals in the field as they emerge from this study.

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APPENDIX

ISRAEL'S LONG-TERM CARE INSURANCE LAW

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

It should be emphasized that under Israel administrative and legal practice no translation of Israel legal measures is binding. The text presented here is given only for the information of the readers of this issue of Social Security.

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

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

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

Chapter Six "E": Long Term Care Insurance

Article One: Definitions

Definitions

127EEEE. In this chapter —

"insured person" — each of the following:

(1) a person insured under old age insurance and survivors' insurance;

(2) a housewife within the meaning of that term in section 8;

(3) a widow entitled to a pension, as said in section 9;

(4) An Israel resident who came to Israel under the Law of Return 5710-1950 and is not insured under old age insurance and survivors' insurance;

"deficiency" — a physical, mental or emotional deficiency due to disease, accident or birth defect.

"daily activities" — dressing, eating, control of urine and bowel movements, washing, mobility in the home.

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* From a translation by A.G. Publications, Ltd., P.O. Box 7422, Haifa, Israel.

"attendance" — attendance on and supervision over the insured person, to prevent damage or danger to himself and to others;

"long term care benefit" — a monthly benefit paid under the provisions of this chapter as participation in the cost of long term care services;

"long term care services" — services to assist in the performance of daily activities, or of attendance, or of housekeeping;

"nursing home" — a nursing home or a long term care department, in which people in need of long term care, mentally incompetent and infirm people are cared for;

"single person's full pension" -- as defined in section 127 KK;

"local professional committee" — a local professional committee for long term care, under section 127 MMMM.

Article Two: Benefits

Long term care benefit

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

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

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

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

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

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

Payment of long term care benefit

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

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

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

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

Qualifying period

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

Restriction of entitlement

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

Prevention of double payment

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

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

Beginning of entitlement

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

Reexamination

127 LLLL. The institute may examine —

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

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

Local professional committee

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

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

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

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

Functions of local professional committee

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

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

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

Appeals committee

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

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

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

Expansion of categories of entitled persons and of benefits

127 PPPP. The Minister may, by regulations with the agreement of the Minister of Finance and the approval of the Knesset labor and Social Welfare Committee —

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

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

Article Three: National Committee

National committee on long term care

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

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

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

(2) two representatives of the Ministry of Health;

(3) a representative of the Ministry of Finance;

(4) a representative of the Ministry of Interior;

(5) two representatives of the Local Government Center;

(6) two representatives of the National Insurance Institute;

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

(8) a representative of all these sick funds:

(1) Kupat Holim Maccabi

(2) National Workers' Sick Fund;

(3) Kupat Holim Meuhedet;

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

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

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

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

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

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

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

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

Functions of national committee

127 RRRR. The national committee shall advise the Institute on the financing of activities, as said in section 127 SSSS (hereinafter: development activities); for this purpose it shall —

(1) examine plans for development activities submitted to it by public bodies, and it shall express its opinion on them;

(2) recommend national priorities for development activities;

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

Article Four: Funding

Development and current maintenance of services

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

(b) If, in any fiscal year, the Ministry of Labor and Social Welfare or the Ministry of Health increased the number of persons cared for in nursing homes, the Institute shall finance the current maintenance of the number of

persons added in that fiscal year in the said homes, provided that the total allocation in any fiscal year for each of those Ministries not exceed 15% of the annual estimate of the collection of long term care insurance contributions for that year; such financing shall be provided in amounts, at times and in ways agreed between the Institute and the Ministries, but from fiscal year 1987 on amounts for any years shall be paid after the receipt of a report on the utilization of funds allocated under this subsection in the preceding year.

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

Expansion of scope of entitlement

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

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

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

Amendment of section 143

2. In section 143 of the main law —

(1) insert after subsection (a):

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

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

" (4) a long term care benefit."

Amendment of section 159

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

Amendment of section 169

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

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

Amendment of section 181

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

Amendment of section 217

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

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

Effect

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

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

Publication

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