3. Long-term Care Insurance

A. General

A long-term care insurance program within the scope of the National Insurance Law was approved by the Knesset in 1980 and came into effect in April 1988. The purpose of Long-term Care insurance is to help the elderly to continue leading relatively independent lives within the community for as long as possible, by providing personal care to those needing assistance with daily activities or supervision and thus, help families who are caring for them. The law applies to all insureds under Old-age and Survivors' insurance, to housewives (married women who do not work outside the home) and to new immigrants who are not insured under Old-age and Survivors' insurance. Every elderly person residing in Israel with impaired physical and/or cognitive functioning and who passes the means test and the test of dependence on others in performing activities of daily living is eligible for the benefit, provided that he is living in the community (in his home, in the home of a family member or in an "assisted living" residence). Anyone residing in a long-term-care (nursing) institution or in a nursing ward in a senior-citizens residence is not eligible for this benefit.

The ADL (Activities of Daily Living) dependence test evaluates the extent of a person's dependence on assistance from others to perform basic activities of daily living: bathing, dressing, mobility (moving about the home, or frequent falls), continence/incontinence and eating (including the ability to heat up food and beverages). The ADL dependence test also evaluates the need for supervision due to impaired cognitive capabilities, deteriorating mental health or a need for supervision due to a physical-medical condition.

Professional evaluators, including nurses, occupational therapists and physiotherapists who undergo appropriate training, perform the ADL dependence test. A person aged 90 or over may have the ADL evaluation done by a physician specializing in geriatrics in a hospital, clinic or public institution. On January 9, 2012, the Knesset passed a government bill under which the option of being evaluated by a geriatric physician would be given to those aged 80-89 in three geographic areas as a pilot project.[1] For the means test, whose rules were also set by this legislative amendment, only the income of the elderly person and his spouse are examined.[2]

1 According to the National Insurance Law (Amendment #132 – Temporary Order) 5772-2012, the test project was set to start on May 1, 2012.

2 The law differentiates between those who receive the benefit in cash as part of the experimental program and those who get the benefit in cash because there is no way to supply them with services in kind. For the former, the means test conducted is identical to the one conducted for those getting the benefit in kind (i.e. services). The latter, as a condition for receiving the benefit in case, the income of the family member caring for the elderly person and living with him is also taken into account.

In January 2007, three levels of long-term care benefits were defined, corresponding to three levels of dependency: a benefit at the rate of 91% of the full disability pension for an individual, which funds 9.75 hours of home caregiving per week; a benefit at the rate of 150% of the full disability pension for an individual, which funds 16 hours of home caregiving per week; and a benefit at the rate of 168% of the full disability pension for an individual, which funds 18 hours of home caregiving per week.

An individual is eligible for a full long-term care benefit according to the determined level of dependence if his or her income does not exceed the average wage (NIS 8,307 in 2011). If the individual's income is over the average wage and up to 1.5 times the average wage, then he or she is eligible for half of the benefit. If the individual's income exceeds 1.5 times the average wage, then he or she is not eligible for a benefit. In the instance of a couple, eligibility for a full benefit is contingent upon their combined income not exceeding 1.5 times the average wage; if their combined income does not exceed 2.25 times the average wage, they are eligible for half of the benefit. Anyone whose income exceeds 2.25 times the average wage is not eligible for a long-term care benefit.

In January 2011, the long-term care benefit was updated by 2.3% in accordance with the price rise in 2010, and in January 2012 – by 2.6%, according to the price rise in 2011

When both spouses are filing a claim for this benefit, their combined income is divided in half and the means test is performed for each of them separately as if they were single individuals. In January 2011, the long-term care benefit was updated at the rate of 2.3% in accordance with the rise in prices in 2010, and in January 2012 – at the rate of 2.6%, according to the rise in prices during 2011.

The long-term care benefit is not paid in cash, but rather in the form of services to those eligible, which are provided by organizations whose services are paid for by the NII. The basket of long-term care services covered by the benefit includes personal caregiving or supervision provided in the elderly person's home, transportation and personal caregiving at a seniors' day-care center, the provision of absorbent products, laundry services and funding for the use of medical-alert transmitters.

A benefit in cash is granted to eligible persons residing in any locality nationwide where services are not available or where services cannot be provided within the timeframes specified in the law, and to those eligible within the framework of a pilot program being operated at a number of NII local branches.[3]

In March 2008, the NII initiated a pilot program providing a benefit in cash in communities belonging to the NII's branches in Ashkelon, Bnei Brak, Nahariya and Ramat Gan. In May 2010, the program was expanded and also began operating in communities belonging to the NII's local branches in Ashdod, Tiberias and Jerusalem, and, in June 2011, also in communities belonging to the NII's local branches in Holon and Netanya. Under the program, elderly persons residing in these communities can opt

3 In December 2011, 217 persons eligible for the long-term care benefit received the benefit in cash who were not part of the pilot program, while 1,177 eligible persons received the benefit in cash as part of the pilot program.

for a long-term care benefit in cash provided that they are eligible for the benefit at the rate of 150% or 168% (or to half of the benefit, as a result of the means test) and provided that they are actually receiving long-term care services from a caregiver who is other than a family member for at least 12 hours a day, six days a week. Elderly persons may choose to switch to a benefit in cash or to return to a benefit in kind at any time.

The pilot program was the subject of a research study that examined the characteristics of those who opted for the benefit in cash compared with all those eligible, and audited the quality of the long-term care that recipients of the benefit in cash are receiving, compared with the long-term care that recipients of the benefit in kind are receiving in the same regions as well as in other regions.

A recipient of a long-term care benefit at the two highest benefit levels who employs an Israeli caregiver only and no foreign worker at all (whether as a caregiver in the scope of the long-term care benefit or outside the scope of the benefit, in another capacity), is eligible for additional weekly hours of care. Anyone meeting these criteria who is severely dependent on assistance from others – i.e., is eligible for a benefit at the rate of 150% of the full disability pension – is eligible for an additional three hours of care per week. Anyone who is totally dependent on assistance from others and, therefore, is eligible for a benefit at the rate of 168% of the full disability pension, is eligible for an additional four hours of care per week. Anyone who is eligible for half of the benefit as a result of the means test is eligible for half of the additional hours according to the level of dependence determined for him.[4]

The law prescribes that the Minister of Welfare and Social Services must appoint local professional committees, whose members include a social worker at the local authority, a nurse from a sick fund and a representative of the NII. These local committees are charged with formulating a plan for caring for those elderly persons who are eligible for the benefit: what services should be provided to each elderly person and who will be providing them. The committees must also ensure that these services are indeed being provided, or alternatively, to expressly determine that no services are available for a particular elderly person. The committees are authorized to refuse requests to receive the long-term care benefit in cash in the scope of the pilot program, if they believe that the elderly person and his family are not fit to use the benefit money for the purposes for which it is intended. The committees are also authorized to determine whether the personal caregiver is suitable and whether the long-term care services that the elderly person is receiving are adequate. The committees are also empowered to revoke the payment of a benefit in cash, and to obligate the recipient to receive the benefit in kind (through services).

4 Between March and September 2009, these additional hours were paid for under an agreement with the Treasury, which also financed them. From October 2009, in accordance with the Economic Efficiency Law for 2009-2010, these additions are covered under the National Insurance Law and funded by it.

B. Legislative changes

- Under the National Insurance Law (Amendment No. 126) 5771-2011, the pilot plan for choosing to receive the long-term care benefit as cash was extended for two more years, until the end of 2012. In addition, from June 2011, towns served by the NII branches in Holon and Netanya were added to those areas where the pilot program is in effect.
- Under the National Insurance Law (Amendment No. 129), 5771-2011, the income that Holocaust survivors receive as monthly pensions from other countries (pensions as defined in clauses (1) to (3) as "pensions due to Nazi persecution" in the Benefits to Holocaust Survivors' Law 5767-2007, and pensions paid under the stipulations of the law with regard to Pensions for Work in Ghettos, as stated in the amendment to Germany's Sixth Book of Social Legislation, passed on June 20, 2002) are not considered income for purposes of the means test to determine eligibility for the long-term care benefit. This law is effective for all long-term care benefit claims submitted from August 11, 2011.

Recipients who had been receiving only half the long-term care benefit because of such income and who would now be eligible for the full benefit due to these legislative amendments can receive the full benefit from the first day of the month after the month in which they present the NII with documentation from other countries affirming their receipt of the above-stated pensions.

C. Administrative changes

"Fast-track" functional assessments: As of April 2011, a "fast track" functional assessment to determine eligibility for the long-term care benefit was introduced for those who are in a very serious physiological or cognitive state. Under the fast track, the dependence assessment is based on documents, including detailed medical information, from which conclusions can be drawn.

In instances where the medical documentation points to severe physiological or cognitive limitations, which are likely to make the person eligible for the highest level of the long-term care benefit, an NII claims official can make a dependence assessment based on documents. In such cases no ADL dependence test will be administered by a home visit.

The number of claims for long-term care benefits in 2011 rose by 2.1% compared with 2010, and reached 79,500 claims. Thus, the uptrend in the number of annual claims is persisting, as it has during most of the last decade

D. Claims for a long-term care benefit

The number of claims for long-term care benefits in 2011 rose by 2.1% compared with 2010, and reached approximately 79,500 claims (Table 1). Thus, the uptrend in the number of annual claims is persisting, as it has during most of the last decade. The number of initial claims in 2011 declined by approximately 0.7% compared with 2010; but the number of repeat claims (second claim or higher) rose by approximately 3.9%.

Table 1
Claims, Percentages of Approved Claims and Repeat Claims, 2007-2011

Year	Claims	Annual growth rate	Percentage of repeat claims	Percentage of claims approved*
2007	75,375	4.3	58.2	47.3
2008	74,085	-1.7	59.1	47.4
2009	77,003	3.4	59.0	46.0
2010	77,926	1.2	59.7	44.1
2011	79,537	2.1	60.8	44.9

* Claims approved for initial eligibility. The calculation does not include claims submitted by people who subsequently died or whose eligibility was suspended.

The ratio of repeat claims to total claims in 2011 rose from 59.7% in 2010 to 60.8% in 2011.

In 2011, the percentage of claims approved for initial eligibility rose to 44.9%. The ratio of approved claims to all initial claims submitted rose to 52.3% in 2011 from 51.6% in 2010, and the ratio of approved repeat claims also rose from 39.1% from 40.3%. The percentage of "false claims" (claims for which a score of 0 to 1 was obtained in the ADL dependence test) rose from 41.5% in 2010 to 43.4%,[5] and the percentage of applicants who received 2.5 points – which is the threshold score conferring eligibility for a benefit – increased from 15.3% in 2010 to 15.6% in 2011.[6]

E. Persons eligible for a long-term care benefit

1. General

Table 2 shows that the number persons eligible for a long-term care benefit continued to rise in 2011 by approximately 2.9%, and reached a monthly average of 145,500 persons. The number of eligible persons has risen from 1991 to 2011 by 362%, despite the higher eligibility age. This is an extremely high percentage, significantly higher than the increase in the number of elderly persons during that period. One possible explanation is that more eligible people are claiming the benefit because awareness of it has risen over the years.

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During 2009, the eligibility age for women was raised to 62, and this will remain in effect until the end of 2016. The process of raising the eligibility age for men to age 67 was completed in 2009. In 2011, as in 2010, the eligibility age for men and women did

5 In analyzing the percentage of claims that were approved, the percentage of false claims and the rate of those who received the minimum score for eligibility includes claims for which a dependence test was never conducted and thus claims were not approved because of pre-conditions such as the claimant's age.

6 This statistic does not include those awarded 2.5 points because they need only partial supervision. The rate of all those who received a score of 2.5 points on the dependence test for initial eligibility in 2011 was 16.3%, while the rate for 2010 was 15.8%.

Table 2
Persons Eligible for a Long-Term Care Benefit, and the Elderly Population in Israel, 2007-2011

Year	Elderly persons eligible for a long-term care benefit*		Elderly persons in Israel**		Coverage ratio***
	Numbers (thousands)	Annual growth rate	Numbers (thousands)	Annual growth rate	
2007	125.5	4.3	836.5	2.8	15.1
2008	131.5	4.9	859.1	2.8	15.3
2009	136.6	3.9	788.4	4.7	17.3
2010	141.4	3.5	816.8	3.6	17.4
2011	145.5	2.9	837.1****	3.0	17.4****

* Monthly average.
** Until 2008 – average population of men at and above the age of 65 and women at and above the age of 60, according to data from the Central Bureau of Statistics. The data for 2009 – 2010 are for men at and above the age of 67 and women at and above the age of 62.
*** The number of those eligible for a benefit as a percentage of the number of elderly persons in the population. Since mid-2004, the retirement age has been raised gradually from 65 to 67 for men and from 60 to 62 for women. Therefore, up until 2008, the number of elderly persons according to the former retirement age was greater, while the coverage ratio was lower. Since 2009, the ratio relates to the same age brackets both relative to the number of elderly persons in the population and the number of those eligible for a benefit.
**** The figures for 2011 are estimates.

not change during the entire year. The ratio of elderly persons eligible for a long-term care benefit to total elderly persons in the population rose significantly: from approximately 6% during the initial years after implementation of the law to 17.4% in 2010 and 2011 (estimated). This ratio of eligible elderly persons was calculated using an estimate of the number of elderly persons who have reached the eligibility ages for a long-term care benefit (62 for women and 67 for men).

2. Characteristics of eligible persons

Seven out of every 10 eligible persons are women, and the ratio of eligible women to all eligible persons rose slightly compared to 2010. More than one-third of all eligible persons are at or above age 85, and nearly two-thirds (65.3%) are at or above age 80

An examination of the demographic characteristics of eligible persons in 2011 shows that seven out of every 10 eligible persons are women, and the ratio of eligible women to all eligible persons rose slightly compared to 2010. In terms of the distribution by age, more than one-third of all eligible persons are at or above the age of 85, and nearly two-thirds (65.3%) are at or above the age of 80. As in 2010, in 2011, the increase in the number of eligible persons was mainly among those at or above the age of 85, which rose from 36.9% of all recipients to 38.6%, while the ratio of those eligible who are at or below the age of 84 is steadily decreasing.

The aging of the recipients of the long-term care benefit has been a steady trend: thus, for example, in 2001, elderly persons at and above the age of 85 constituted less than one third (32.1%) of those eligible, and elderly persons at and above the age of 80 constituted less than three-fifths (55.2%) of all eligible persons. The aging of the eligible derives, in part, from the raising of the retirement age: the number of women in the age bracket of 60-64 who are eligible for a benefit is decreasing, and so is the number of both men and women in the 65-69 age bracket, due to the raising of the retirement age for men.

Table 3
Persons Eligible for a Long-term Care Benefit, by Demographic Characteristics and Benefit Level (monthly average), 2011

	Absolute numbers	Percentages
Total	**145,461**	**100.0**
Gender		
Men	42,232	29.0
Women	103,229	71.0
Age bracket		
Up to 64*	1,165	0.8
65-69	5,521	3.8
70-74	15,860	10.9
75-79	27,864	19.2
80-84	38,847	26.7
85+	56,204	38.6
Family composition		
Living alone	67,382	46.3
Living with a spouse	57,942	39.8
Living with children or with others	20,137	13.9
Residence in Israel		
Veteran residents	109,259	75.1
Immigrants** – total	36,202	24.9
Thereof: immigrated after 1999	4,475	3.1
Benefit level		
Very dependent (91%)	79,932	55.0
Severely dependent (150%)	36,435	25.0
Totally dependent (168%)	29,094	20.0
Eligible for an additional 3 hours	19,890	54.6***
Eligible for an additional 4 hours	11,981	41.2***

* This age bracket includes women only.
** Elderly who immigrated to Israel after 1989.
*** Eligible for additional hours as a percentage of all those eligible at that level of benefit.

When we examine family composition[7], the data between 2010 and 2011 have remained stable: nearly half of those eligible are living alone, two out of every five are living with a spouse, and one out of seven is living with someone else, usually a son or daughter. When we examine the statistics relative to number of years since immigration to Israel, the data between the two years have also remained stable: one out of every four eligible persons immigrated to Israel after 1989, while one out of every eight eligible persons immigrated after 1999.

When we examine family composition, the data between 2010 and 2011 have remained stable: nearly half of those eligible are living alone

Table 3 illustrates the aging of the population of eligible persons, and indicates a trend of a change in the composition of those eligible by benefit levels in 2011 compared

7 In the data for 2011 there was a change in definition "living with a spouse" and "living with their children or others. The definition of living with a spouse now includes those living with a spouse and other people. The similarity between 2010 and 2011, however, remained even after adjusting the 2010 data to match the new definitions: 46.6% lived alone; 40.1% live with their spouse and 13.3% live with their children or with others.

with 2010: the ratio of recipients of a benefit at the rate of 91% of a full disability pension for a single person (the lowest level of dependency) decreased from 55.6% in 2010 to 55.0% in 2011; the ratio of recipients at the rate of 150% (severely dependent) rose from 24.9% in 2010 to 25.0% in 2011; and the ratio of recipients at the rate of 168% (totally dependent) rose from 19.5% in 2010 to 20.0% in 2011.

The share of those eligible for a benefit at the highest level has been steadily increasing – from 13.7% in 2007 to 20.0% in 2011

The share of those eligible for a benefit at the highest level has been steadily increasing – from 13.7% in 2007 to 20.0% in 2011 – and this group has the highest growth rate. Compared with 2010, the number of benefit recipients at the lowest level in 2011 increased by 1.7%, at the high level (severely dependent) by 3.8%, while at the highest level (completely dependent) the number of benefit recipients has increased by 5.8% compared with 2010.

In March 2009, hours of care were added to whoever employs an Israeli caregiver only. The absolute numbers of recipients of additional hours for the employment of Israeli caregivers at both benefit levels increased in 2011 compared to 2010 – approximately 1,500 persons were eligible for additional hours at the severely dependent benefit level and 1,100 persons were eligible for additional hours at the totally dependent level.[8]

The rate of long-term care benefit is determined by the level of the recipient's dependence on others to perform basic daily tasks or their need to be supervised to prevent any risk to themselves or to others. Box 1 presents the way the level of dependence is determined and examines the most common problems at the various levels of dependence, as characterized by the dependence test. Box 2 focuses on the link between the level of dependence and the level of benefit, on the challenges that arise from the structure of the current benefit levels and on suggestions for changing the levels of benefit that were debated by the NII during 2011 but are not yet developed enough to apply.

Box 1
Common Profiles of Long-Term Care Benefit Recipients

The population of those elderly eligible for long-term care benefits is a heterogeneous group with regard to the physical and cognitive/mental limitations from which they suffer. At different levels of dependence, from which the levels of long-term care benefits are derived, one can identify a wide variety of common profiles (characteristic features) or features that are more common than others at a given level of dependence.[1]

1 See a presentation of the common profiles at each dependence level in Ramsees Gharrah, Recipients of the Long-Term Care Benefit, 2003, Jerusalem, the National Insurance Institute, Periodic Surveys, No. 193, July 2004, pp. 19-20.

8 A discussion of the additional hours of care-giving and of its possible influence on a shift from the employment of foreign caregivers to the employment of Israeli caregivers was covered in the annual survey for 2010, and the explanation there applies to this survey as well.

Table 1
Score Rankings for the Dependence Tests

Component/criterion in the dependence evaluation	Possible points/scores
ADL	0-8.5* in increments of 0.5
Mobility (ambulation at home)	0; 0.5; 1
Falls (ambulation at home)	0; 0.5; 1
Dressing	0; 0.5; 1
Bathing	0; 0.5; 1; 1.5
Eating	0; 0.5; 1; 1.5
Bowel/bladder control	0; 0.5; 1; 2; 2.5; 3
Supervision	0; 2.5 (partial supervision)** 9 (constant supervision
Living alone	0: 0.5 (for those getting 0-4 points); 1 (for blind people 85 and older living alone); 2 (for those getting 4.5-9 points)
Total	**0-11 in increments of 0.5; minimum score for a benefit: 2.5**

* Under the guidelines of the Long-Term Care Branch, claimants are not (other than in exceptional circumstances) to get a maximum score of 1 point for movement and also for falling.
** From January 2012 the score for partial supervision was raised from 2.5 to 4 points.

At the different levels of dependence one can find a wide range of profiles, some of which are common to many eligible persons. In this box we focus on a different way of presenting the frequency of the different handicaps by presenting the average scores on every section of the dependence test at the different dependence levels.

Indentifying the profiles of those eligible for a long-term care benefit is necessary to identify the most common problems at the different dependence levels. The distribution of the profiles within the different dependence levels and between these levels shows the process of the primarily physical deterioration of those eligible for a long-term care benefit. The move from one level of dependence to another stems in many cases from further deterioration caused by an existing condition in a specific category or from the addition of an additional limitation at a milder level in another category.

A long-term care benefit is given in accordance with the level of dependence that is diagnosed during a dependence test performed on the claimants. The score on the dependence test is made up of three elements: (1) the extent of the claimant's dependence on others for mobility within the home, dressing, bathing, eating, and handling bowel/bladder activity;[2] (2) the extent to which the elderly person needs supervision;[3] (3) whether or not the claimant lives alone. The score

2 The National Insurance Institute, Long-Term Care Branch, Long-Term Care Insurance – A Guide to Conducting an Evaluation of Functioning, January 2012, P. 3
3 Ibid, Ibid.

Table 2
Level of Disability Among Those Eligible for a Long-Term Care Benefit, December 2011*

Category	Level of disability	Number of incidents	Percentage out of disability category
Bathing	1.5	36,586	25.0
	1.0	69,163	47.3
	0.5	40,023	27.3
	0.0	529	0.4
Dressing	1.0	132,054	90.2
	0.5	12,824	8.8
	0.0	1,423	1.0
Mobility	1.0	17,628	12.0
	0.5	48,698	33.3
	0.0	79,975	54.7
Falls	1.0	5,732	3.9
	0.5	23,727	17.6
	0.0	114,842	78.5
Bowel/bladder control	3.0	14,118	9.7
	2.5	16,764	11.5
	2.0	21,064	14.4
	1.5**	3	0.0
	1.0	24,054	16.4
	0.5	26,949	18.4
	0.0	43,349	29.6
Eating	1.5	5,427	3.7
	1.0	11,724	8.0
	0.5	120,894	82.6
	0.0	8,256	5.7
Supervision	9.0 (constant)	24,933	17.1
	2.5 (partial)***	3,709	2.5
	0.0 (no supervision needed)	117,659	80.4
Living alone	2.0	39,762	27.1
	1.0****	67	0.1
	0.5	42,802	29.3
	0.0	63,670	43.5

* Not included are eligible persons who stopped receiving the long-term care benefit in the course of the month (died or moved to a nursing home or for a lengthy hospitalization) nor eligible persons whose benefit was determined in the "fast track" arrangement (see sub-chapter C).

** In the past, it was possible to get 1.5 points for bowel/bladder control. This was for very few incidences in which dependence tests weren't done in recent years.

*** Because the data in this Annual Survey refer to 2011, partial supervision in this box confers 2.5 points in the dependence assessment.

**** In 2011 it was decided to increase the additional points for the "living alone" category for blind people 85 or older living alone from 0.5 points to 1 point.

on the dependence test is the higher of the two:[4] The score on the claimant's level of dependence on other for daily activities[5] (ADL) and the level of supervision needed – constant/partial (because of cognitive deficiencies, mental illness or certain physiological illnesses)[6]. To the higher of these two scores, additional points are given for living alone.

Among most of those receiving a long-term care benefit the activities of daily living (ADL) that are affected as their physical condition worsens are in this order: bathing, dressing, mobility, bowel/bladder control and eating. Therefore it is possible to expect that in the most common profiles and in the weight of each category of activity there will be an expression of this in the various levels of dependence, and between them.

Table 2 presents the frequency of physical limitations and their intensity in the population of eligible persons. The distribution in the areas of bathing, dressing, mobility (and falls) bowel/bladder control and eating correspond well with the sequence of activities that are affected as the eligible person's physical condition deteriorates. Therefore, very few eligible persons had no points in the bathing and dressing categories – 0.4% and 1.0% respectively – while the overwhelming majority accumulated 1 or 1.5 points (for bathing) in these categories, 72.3% for bathing and 90.2% for dressing.

We see the opposite with regard to mobility (ambulation and falls) and eating; most of those eligible did not score points or scored low (0.5) on these: 88.0% for mobility, 96.1% for falls and 88.3% for eating.[7] The bowel/bladder control category is an exception in the sense that a relatively high percentage of those eligible attained a high score (2 or above) for this – 35.6%.

Characterizing the profiles at each dependence level can be a tool to diagnose exceptions and problems in conducting the dependence tests (or in recording their results). In the most common process of physical deterioration, basic activities such as dressing and bathing are affected before eating, bowel/bladder control and mobility. As a result, indentifying elderly persons characterized by profiles that are medically or statistically less frequent can help determine whether there were faults in the way that some of the dependence tests were conducted.

At a number of dependence levels it was found that most of those eligible are characterized by one common, dominant profile. For example, 1,591 of 2,209 (72%) of those who scored 5 points on the dependence test were characterized by getting 1

4 Ibid, 65.
5 Ibid, 31.
6 Ibid, 65, 70.
7 The Long-Term Care branch guidelines call for giving 0.5 points in the eating category for needing help with heating and serving food and/or for taking medication. The ability to heat and serve food is affected at an earlier stage than is the ability to eat and drink independently.

point each in the bathing and dressing categories, 0.5 points each in the mobility and eating categories and 2 points in the bowel/bladder control category.

At other dependence levels, if was found that the most common profiles were not really all that common, but did occur more often than other profiles. Thus, among those receiving 11 points on the dependence test, 783 out of 12,436 (6.3%) received 9 points because they needed constant supervision, 2 points for living alone, 3 points in the bowel/bladder category, 1.5 points each in the bathing and eating categories and 1 point each for dressing and mobility. It should be noted that anyone who receives 11 points on the dependence test is designated as "alone" and is eligible for constant supervision, irrespective of the physical limitations they suffer from.

At most levels of dependence, one can find a number of common profiles, meaning more than a thousand incidences, but no profile constituted more than half the profiles. As an example, among those getting 3 points on the dependence test, one can find three common profiles: One profile characterizes 7,254 of 21,962 people (33.0%), whereby the score is made up of 1 point each in the bathing and dressing categories and 0.5 points each in the eating and living alone categories; in the second profile, covering 3,753 of 21,962 people (17.1%), the score was made up of 1 point each for the bathing and dressing categories and 0.5 points each for the eating and bowel/bladder categories; and the third profile, found among 3,046 of the 21,962 people (13.9%), the score was made up of 1 point in the dressing category, and 0.5 in each of the bathing, eating, bowel/bladder and living alone categories.

Table 3 shows the average score on each of the components of the dependence test at each of the dependence levels. The initial rates (dependence level of 2.5) and rate of their growth at the later dependence levels show the pattern of deterioration in the ability to perform the activities of daily life (as the physical limitations increase): Dressing and bathing are the first to be affected, and they are the primary components of the dependence score at the lower levels.

For example, at a dependence level of 3.5, the average score on the dressing and bathing components is 0.97 and 0.84, respectively, compared to average scores of 0.94 and 0.81 among those at a dependence level of 3 points. Another example is the gradual increase in the average score given to bowel/bladder control between dependence levels of 2.5 points to 6 points, going from 0.15 to 2.34. One can identify, by following the changes in scores, the broadening range of disabilities as one moves between levels of dependence. Thus, for example, the scores for mobility and bowel/bladder control are insignificant at the lower dependence levels while at the higher dependence levels these average scores rise and constitute a significant part of the dependence score. One can also see the degree to which the dependence level at scores of 6.5-7.5 are influenced by the living alone category, given that the level of physical dependence of those receiving scores of 5.5-6 are similar, or even higher.

Table 3
Scores for the Components of the Dependence Test According to Dependence Level – Average Weight of Each Category in the Final Score

Dependence level	Instances	Living alone	Supervision	Bowel/Bladder	Eating	Bathing	Dressing	Falls	Mobility
2.5	34,478	0.25	0.06	0.15	0.42	0.70	0.91	0.06	0.01
3	21,962	0.33	0.15	0.29	0.47	0.81	0.94	0.07	0.03
3.5	10,088	0.28	0.07	0.65	0.50	0.84	0.97	0.12	0.13
4	6,469	0.23	0.07	0.92	0.51	0.93	0.98	0.12	0.31
4.5	4,259	0.31	0.06	1.13	0.52	0.98	0.98	0.17	0.40
5	2,209	0.00	0.06	1.91	0.52	0.99	0.99	0.08	0.50
5.5	1,098	0.07	0.07	2.14	0.54	1.15	0.99	0.14	0.55
6	5,267	0.00	0.06	2.34	0.56	1.31	1.00	0.18	0.62
6.5	10,065	1.16	0.06	1.78	0.58	1.20	0.99	0.26	0.52
7	8,852	1.46	0.05	2.12	0.58	1.13	0.99	0.14	0.57
7.5	5,482	1.66	0.06	2.24	0.62	1.20	1.00	0.19	0.59
8	4,239	1.74	0.07	2.43	0.67	1.31	1.00	0.22	0.64
8.5	2,399	1.96	0.05	2.56	0.63	1.39	1.00	0.23	0.72
9	15,282	0.36	7.38	1.84	0.73	1.24	0.92	0.15	0.48
9.5	1,056	2.00	0.08	2.80	1.03	1.49	1.00	0.28	0.89
10	600	2.00	0.09	2.95	1.37	1.50	1.00	0.22	0.96
10.5	60	2.00	0.13	2.93	1.39	1.49	1.00	0.76	0.93
11	12,436	2.00	8.99	1.42	0.68	1.13	0.87	0.15	0.33

In the final analysis, although the diversity of characteristics of physical dependence on others to perform basic daily tasks among those with dependence scores of 9 and 11 in the dependence evaluation is very broad, the primary component among these elderly people (most of those who score 9 and almost all who score 11) is the need for supervision.

Box 2
Levels of Dependence and Long-Term Care Benefits

One of the criteria for determining a person's eligibility for a long-term care benefit is his dependence on others for the performance of basic activities of daily living (ADL) such as movement, dressing, bathing, eating, drinking and bowl/bladder control, or the need for supervision because of cognitive, mental or physical deterioration. Each of these areas is given a point score, and persons living alone are eligible for additional points. The points assigned to the different areas are shown in Table 1 of Box 1.

The level of a person's dependence on others is determined by a dependence assessment. The final dependence score is the higher of the ADL score, and the need for supervision score with points added for those who live alone.[1] To be eligible for a long-term care benefit, the claimant must receive a score of at least 2.5 points. The level of benefit is determined first and foremost by the level of the person's dependence, as shown in Table 1.

Table 1
Long-term Care Benefit and Level of Dependence

Score on the dependence evaluation	Level of benefit	The number of home long-term care hours for those receiving the full benefit*	The number of home long-term care hours for those receiving half the benefit**
2-0	No eligibility	-	-
5.5-2.5	91%	9.75	5
8.5-6	150%	16	8
11-9	168%	18	9

* Those entitled to benefit at one of the two higher levels and who do not have a valid permit for employing a foreign caregiver are entitled to an additional 3-4 hours. Those receiving half the benefit at the two higher levels are entitled to half of the additional hours.

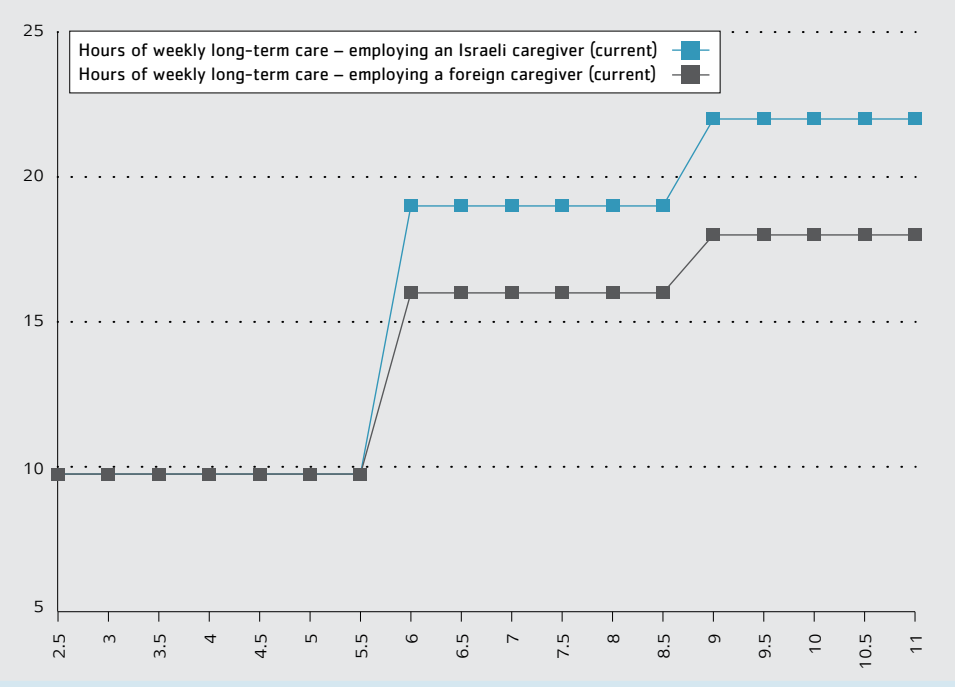
** The benefit rate is dependent on a means test as well.

1 In the letters sent to those entitled, affirming the approval of their claims, the cumulative score is for the three components of the dependence assessment, except for those eligible for constant supervision (for whom the calculation of the dependence score is as described above), which means that the score can reach as high as 20. Under the law, the rate of benefit is derived from the level of dependence on others to perform daily tasks or from the need for supervision. In reality, however, there is no significance to the cumulative score of the three components, since a score higher than 9 currently confers eligibility for the highest possible level of benefit.

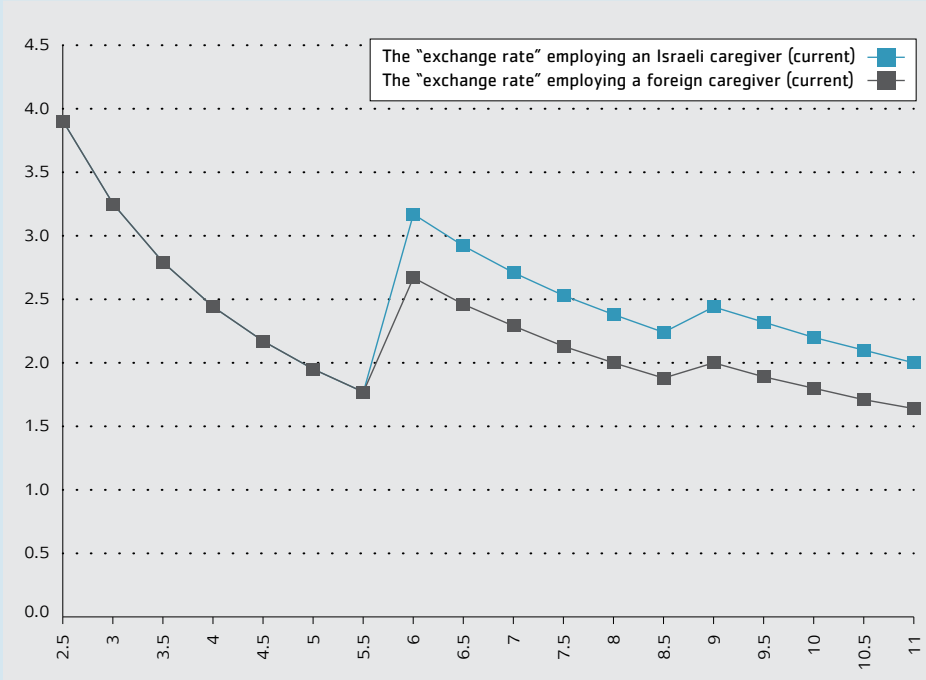
The current structure of long-term care benefits is based on a rather weak connection between the person's level of dependence and the level of benefit to which he is entitled (Graph 1). This structure has three problems that are linked to one another: (1) The level of coverage is low compared to need at the higher dependence levels, resulting in a number of weekly long-term care hours that is lower than what is actually needed. The gap between the two higher benefit levels, for example, results in an addition of only two hours of care a week, while between the first and second levels, the addition ranges from 6.25 to 9.25 weekly hours of care; (2) The regression level is too high; in most cases, a person who is highly dependent on others receives too few hours to meet his needs, compared to someone who is less dependent (Graph 2). Thus, for example, someone who has a dependence score of 5.5 points receives the benefit at the same level as someone has a dependence score of only 2.5 points. (3) There's a non-linear progression as expressed in the too-large jump in the value of the benefit when moving from a score of 5.5 dependence points to a score of 6 dependence points.

The structure of this benefit evolved in two basic stages. At the end of the 1980's, when the long-term care program was enacted as part of the National Insurance Law, two levels of benefit were adopted. In 2007, the higher level of benefit was split into two

Graph 1
Connection between Hours of Weekly Long-term Care and Score on the Dependence Evaluation



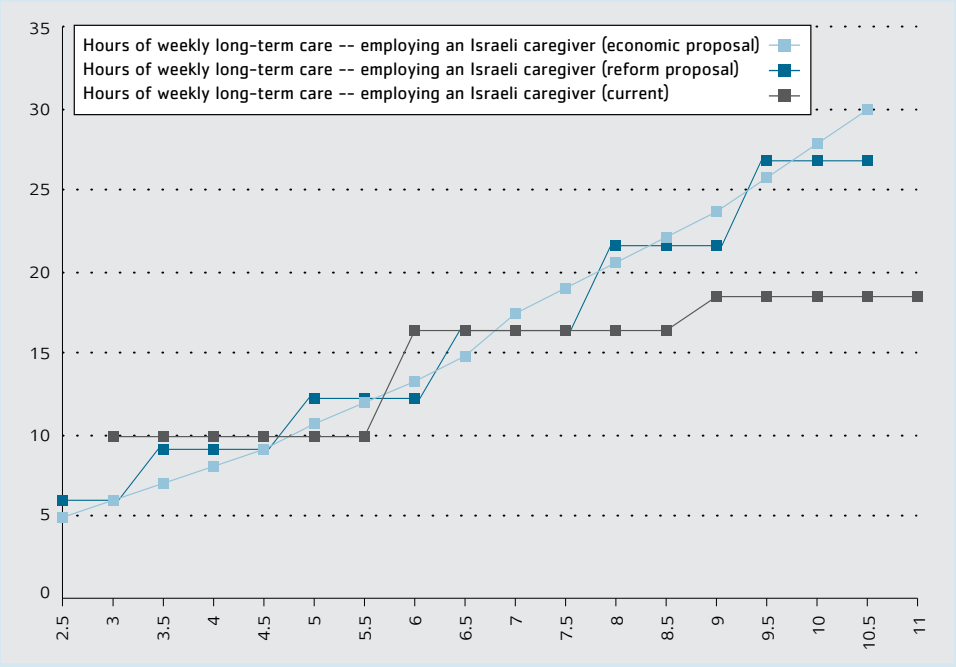
Graph 2
The "Exchange Rate" – the Number of Weekly Long-term Care Hours for Each Dependence Point



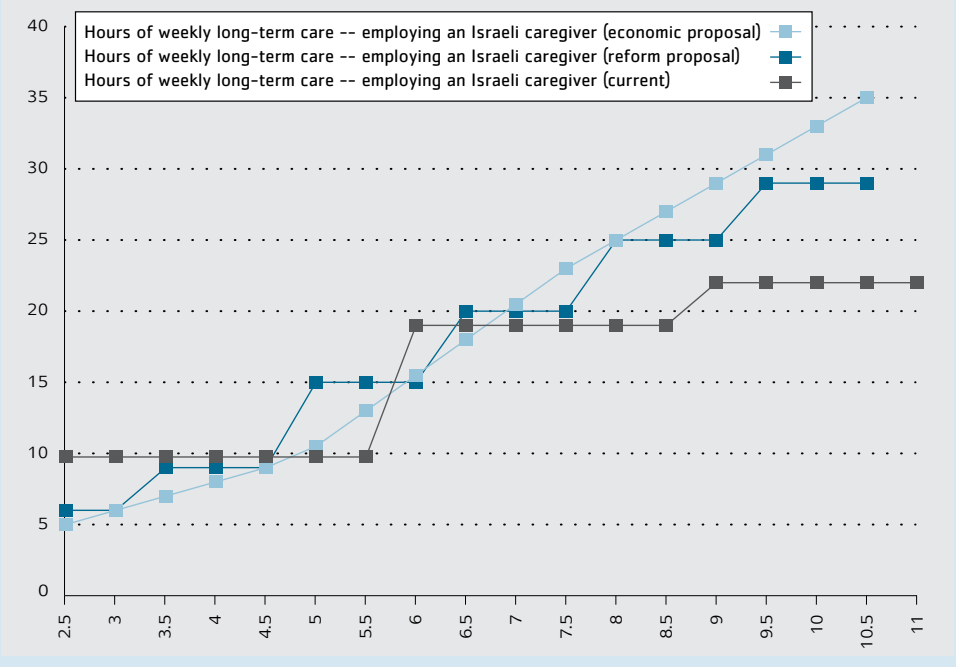
levels. Defining the limits of the benefits in terms of dependence points and the rate of the benefits according to the scope of services that they can supply was influenced over the years by three factors: recognition of the eligible population's changing needs; budgetary limitations and past decisions (such as a reluctance to reduce the number of weekly long-term care hours to those who have fewer points on the dependence evaluation).

In recent years the NII has become increasingly aware that at the higher levels of dependence there is an acute need to raise the quota of weekly long-term care hours, and that those entitled to benefit at the lowest levels of dependence have a surplus of hours compared to their needs. Thus, so as not to increase the budget outlay by very much and to preserve the financial strength of the long-term care insurance branch, the number of weekly long-term care hours must be reduced for those with a very low score on the dependence evaluation. Graphs 3 and 4 illustrate two alternatives for changing the level of the long-term care benefit; Graph 3 illustrates the alternatives for those employing Israeli caregivers while Graph 4 shows the alternatives for those employing foreign caregivers.

Graph 3
Alternatives for Benefit Levels for Those Employing Lsraeli Caregivers



Graph 4
Alternatives for Benefit Levels for Those Employing Foreign Caregivers



The "economic" proposal maintains that to arrive at a the fairest possible distribution of the long-term care benefit, there must be a different benefit level for every dependence level, and a relative increase in the number of hours granted as the state of dependence or the need for supervision grows. The "reform" proposal has been debated in recent months by the NII and the Finance Ministry in an effort to advance critical changes to the long-term care insurance program. Both alternatives preserve the current budget framework for the long-term care benefit and both preserve the incentive to employ Israeli caregivers at the highest dependence levels, as is true today.

The two alternatives present five changes to the current long-term care benefit structure: (1) Increasing benefit levels with the aim of dealing with the primary problems of the current long-term benefit system. (2) transferring some of the benefit money from the lower dependence levels to the higher levels. (3) Changing the way points are awarded to those living alone by awarding a uniform 1.5 additional points (except for the 0.5 points given to those who score 2 points on the ADL test, as is done today, to enable them to be eligible for a benefit). (4) The scoring sequence on the dependence tests would run from 0 to 10.5 (the minimum eligibility threshold would not change). (5) In both alternatives the incentive for employing Israeli caregivers begins at a lower level of dependence than today (at 5.5 points for the "economic" proposal and at 5 points for the "reform" proposal).

From Graphs 3 and 4 it emerges that both proposals (the red line and the green line), particularly the "economic" one, respond to the three problems faced by the long-term care benefit system today. The main principle of the "economic" proposal is that it preserves a progressive exchange rate, through all the dependence levels; between the dependence level and the number of long-term care hours: The number of weekly long-term care hours for each dependence point rises gradually from 2, at 2.5 points, to 3.33 at 10.5 points in Graph 3 and rises gradually from 2, at 2.5 points, to 2.76 at 10.5 points in Graph 4. In the long-term care benefit system today, the exchange ratio is regressive, dropping from 3.9 long-term care hours for a dependence score of 2.5 points, to 2 and 1.64 weekly long-term care hours for a dependence score of 11 points, for employing an Israeli caregiver and a foreign caregiver, respectively (after 6 dependence points, the long-term care system provides additional hours only for employing an Israeli caregiver). The "economic" proposal is also likely to somewhat moderate the current pressures at the threshold point for entering the benefit system and at the moves between benefit levels, which puts many entitled persons above the thresholds compared to a minority of those entitled under the thresholds.

The "economic" proposal, however, may present a problem that the "reform" proposal is meant to overcome. It is known that in evaluating dependence, in addition to the objective measures and the detailed instructions the evaluators must follow, there is an element of judgment at work. The current structure of the long-term care

benefit allows freer exercise of judgment because in any case over a range of scores the benefit remains the same. Under the "economic" proposal, there is likely to be pressure brought to bear on the evaluators that could push scores upward or downward. The "reform" proposal increases the number of benefit levels from 3 to 6 (broadly splitting each of today's benefit levels into two levels), and every level is made up of three adjacent scores (except for the lowest level, which covers two scores). This, therefore, constitutes a compromise between the advantages and goals that the "economic" proposal tried to promote and the limitations involved in providing Long-term Care insurance under the National Insurance Law.

3. Benefit in cash: The pilot program

At the end of 2011, eligible persons affiliated with nine local branches of the NII were being given the option of receiving the benefit in cash, rather than in services. In December 2011, 1,177 eligible persons received a long-term care benefit in cash under this arrangements, while in December 2020, 908 eligible persons received it. The growth stems from the addition of two regions to the program (an increase of 135 recipients) and an increase in the number of recipients in the other regions (of 134). Table 4 shows the changes in the number of those receiving the cash benefit in 2011.

In all the local branches that were participating in the pilot at the end of 2010, except for the Ashkelon branch, the number of those choosing to receive their benefit in cash grew between the end of 2010 and the end of 2011. The rates of increase were greater in those local branches that had joined the program in May 2010 than among those who started in March 2008. The lower rate of growth in those branches that are in the program longer indicates that one could expect the ratio of those choosing the benefit in cash from among the potential eligible persons in those regions to stabilize over time.

There are differences in the cash benefit utilization rates among the different local branches under the pilot program that is tied to the dates the branches joined. In the four local NII branches that have been taking part in the pilot since March 2008 (Ashkelon, Bnei Brak, Nahariya and Ramat Gan), the rate of those choosing this benefit was 8.0% of potential eligible persons compared to 8.1% at the end of 2010. In the three local NII branches that have been taking part in the pilot since May 2010 (Ashdod, Tiberias and Jerusalem), the ratio of those choosing the benefit in cash in December 2011 reached 3.5%, compared to 2.5% in December 2010, and their number grew by 108. In the two local branches that joined the program in June 2011, 1.8% of those eligible, 135 men and women, chose this benefit over the subsequent seven months.

It should be stressed that because the different local branches joined the program at different starting points and because of the differing lengths of time between them, the total utilization rate – meaning the portion of those choosing the cash benefit at a given time from among the total of those potentially eligible -- is insignificant.

Table 4
Recipients of Long-term Care Benefit in Cash, December 2011 Compared to December 2010

Local branch	Joined the pilot program	Potential eligible persons in December 2011	Potential eligible persons in December 2010	Change (%)	Number of cash benefit recipients, December 2011	Percentage of potential eligible persons	Number of cash benefit recipients, December 2010	Percentage of potential eligible persons	Change in the number of cash benefit recipients in 2011 (%)
Ashdod	May 2010	2,296	2,174	5.6	79	3.4	57	2.6	38.6
Ashkelon	March 2008	1,854	1,802	2.9	145	7.8	149	8.3	2.7-
Bnei Brak	March 2008	1,005	943	6.6	51	5.1	45	4.8	13.3
Holon	June 2011	3,693	-	-	81	2.2	-	-	-
Tiberias	May 2010	1,491	1,514	1.5-	38	2.5	33	2.2	15.2
Jerusalem	May 2010	6,006	5,596	7.3	225	3.7	144	2.6	56.3
Nahariya	March 2008	1,514	1,319	14.8	34	2.2	30	2.3	13.3
Netanya	June 2011	3,801	-	-	54	1.4	-	-	-
Ramat Gan	March 2008	4,390	4,222	4.0	470	10.7	450	10.7	4.4

Nevertheless, among those branches that joined the program at the same time, one can discern differences among the rates of those choosing the cash benefit. Possible reasons for these differences include the availability of foreign caregivers (since almost all those who receive the cash benefit employ non-Israeli caregivers), particularly between the center of the country and the peripheral areas, as well as cultural and socio-economic differences between the regions and between the cities within these regions regarding the willingness to employ foreign caregivers or the financial ability to employ them.

F. Organizations providing long-term care services, and the services provided

The services provided under long-term care insurance are provided through official organizations that have been recognized by the Welfare and Social Services Ministry as authorized service providers under a contract drawn up between them and the NII. The NII published a number of tenders in recent years to establish a pool of long-term care service-providers for eligible persons; however, agencies and nonprofit organizations filed petitions against each of the published tenders, which were not pursued for various reasons, among them the intense pressure applied by service-providers, who preferred working under a format of contractual engagements. At the end of 2009, the results of a new tender were published, along with the names of the agencies eligible to provide long-term care services.

A long-term care service-provider can be a public nonprofit organization, such as "Matav" (an association of home caregivers) or seniors' daycare centers; or it can be a private organization operating as a business. In August 2011, 112 long-term care service-providers were operating: 46 nonprofit organizations and 66 private agencies. Table 5 below presents the distribution of the number of hours of personal home caregiving provided in August 2011 by type of service-provider. In August 2011, service-providers provided approximately 7.75 million hours of personal caregiving in the homes of those eligible for the long-term care benefit. Approximately 5.6 million hours were provided by private organizations (72.2%), approximately 2.15 million hours were provided by caregiver organizations (27.8%).

Table 6 presents the distribution of recipients of long-term care services in December 2011 by the type of service provided to them. It should be recalled that a person who is

Table 5
Number of Hours of Personal Caregiving Provided, by Type of Service-Provider, August 2011

Type of service-provider	Numbers (thousand)	Percentages
Total	**7,747**	**100.0**
Private organization	5,591	72.2
Nonprofit organization	2,156	27.8

Table 6
Recipients of Long-Term Care Services, by Type of Service, December 2011

Type of service	Number of recipients	Percentage receiving the service	
		Out of all those eligible for a benefit	As the sole item, out of all recipients of this service
Total*	207,068	–	–
Personal caregiving in the home	145,744	97.8	68.5
Personal caregiving at a seniors' daycare center	10,710	7.2	6.2
Absorbent products	31,647	21.2	0.3
Medical-alert transmitter	18,431	12.4	0.4
Laundry services	545	0.4	1.5

* A person eligible for a benefit can receive more than one type of service. Therefore, the total number of recipients of long-term care services in this table is larger than the number of persons eligible for a benefit; in December 2011 – 149,072 persons.

eligible for a benefit can receive more than one type of service and, it is for this reason that the total number of recipients of long-term care services is greater than the number of persons eligible for a benefit.

The vast majority (97.8%) of recipients of long-term care services in December 2011 received personal care at home from an Israeli or foreign caregiver; 7.2% received personal care at a seniors' daycare center, 21.2% received absorbent products and 12.4% received a medical-alert transmitter. 68.5% of the recipients of personal care in the home received this service as the sole item from the basket of services. Only 6.2% of the recipients of personal care at a seniors' daycare center received the service as the sole item, while the rest combined this service with other services.

The vast majority (97.8%) of recipients of long-term care services in December 2011 received personal care at home from an Israeli or foreign caregiver; 68.5% received this service as the sole item from the basket of services

G. Volume of payments

Concurrent with the direct payments of benefits, the National Insurance Law mandates that payments be made for additional items associated with long-term care insurance. Fifteen percent of the annual receipts are allocated to the Health Ministry and to the Welfare and Social Services Ministry to fund the growing number of persons hospitalized in institutions. In fact, the Health Ministry usually utilizes its entire allocation, while the Ministry of Welfare and Social Services utilizes only a portion thereof. Funds are also allocated to the Fund for the Development of Community and Institutional Services for the Elderly.

In 2011, the total volume of payments transferred to fund long-term care insurance under the National Insurance Law reached approximately NIS 4.2 billion (at 2011 prices): approximately NIS 4 billion for the provision of services to those eligible, while the balance was for developing services in institutions and services in the community, and

Table 7
Total Payments of Long-Term Care Insurance, by Type of Payment (NIS million, 2011 prices), 2007-2011

Year	Total	Long-term care benefit	Transfer to entities outside the NII*	Development of services	Hospitalization in long-term-care institutions	Pursuant to agreements with the Treasury
2007	3,409.3	3,196.1	78.4	39.6	92.5	2.5
2008	3,501.3	3,310.4	83.8	21.9	82.6	2.3
2009	3,778.0	3,506.7	83.1	22.4	81.0	82.5
2010	3,996.4	3,778.1	85.2	43.8	85.9	3.4
2011	4,212.9	3,996.0	90.1	30.4	94.1	2.4

* Transfers to the Ministry of Welfare and Social Services and to Clalit Health Services to fund the preparation of treatment plans for eligible persons, and transfers to fund the conducting of ADL dependence tests.

for conducting ADL dependence tests. The sum of NIS 85.9 million was transferred to the Ministry of Health and to the Ministry of Social Affairs and Social Services to help cover the growing number of those hospitalized in long-term-care institutions (Table 7). Additionally, the sum of NIS 90.1 million was transferred to the Ministry of Welfare and Social Services, to the sick funds and for conducting ADL dependence tests.

In 2011, the volume of payments under Long-term Care insurance increased by approximately 1.9% at constant prices (2011 prices). The payments of benefits increased by approximately 2.2% as a result of an increase in the number of persons eligible for the benefit, particularly those eligible for the highest level of benefit. The average level of benefit at constant prices decreased in 2011 at the rate of 0.6%.

In 2011, the volume of payments under Long-term Care insurance increased by 1.9% at constant prices. The average level of benefit at constant prices decreased in 2011 by 0.6%