3. Long-Term Care Insurance

A. General

The Long-term Care Insurance (LTCI) program was approved by the Knesset in 1980 in the framework of the National Insurance Law, and it began operation in April 1988. Long-term care is intended to enable the elderly to continue living as part of the community for as long as possible, by providing personal care to those who are in need of assistance with daily functioning or supervision and thereby helping the families who care for them. The Law applies to anyone who is insured in Old-age and Survivors' Insurance, to housewives (married women who do not work outside their homes) and to new immigrants not insured in Old-age and Survivors' Insurance.

Any elderly resident of Israel who has limited physical or cognitive functioning and who passes the means test[1] under the regulations and the test of dependence on the assistance of others in performing activities of daily living is entitled to a long-term care benefit, provided that he lives in the community (in his home, in the home of a family member or in an "assisted living" residence). The means test examines the income of the elderly person and his/her spouse only. The Law differentiates between the recipients of cash benefits as part of the pilot program and the recipients of cash benefits since services cannot be provided to them (in-kind benefit). A means test is conducted for the former that is identical in rules to that conducted for recipients of in-kind benefits. For the latter, as a condition to receiving a cash benefit, the income of the family member who cares for the elderly person and lives with him is also tested. A person who resides in a long-term care facility or in a nursing ward of a retirement home is not entitled to a benefit.

The dependence test (ADL) evaluates the extent that the assistance of others is needed in the performance of the basic activities of daily living: bathing, dressing, mobility (ambulation in the home and falls), bowel / bladder control and eating (including the ability to heat food and beverage). The dependence test also evaluates the need for supervision due to impaired cognitive ability, deterioration of mental health or due to a physical medical condition. The dependence test is conducted by professional assessors: nurses, occupational therapists and physiotherapists who undergo appropriate training.

An elderly person who has reached age 90 may have the dependence test performed by a geriatric specialist in a hospital, in a clinic or, in certain communities, in a public institution. From May 2012 to April 2013, in three of the local NII branches, persons aged 80-89 could, in the framework of a pilot program, choose to be examined by a

1 The means test tests the income of the elderly person and their spouse only. The Law differentiates between the recipients of cash benefits as part of the pilot program and the recipients of cash benefits since services cannot be provided to them (benefit in kind). A means test is conducted for the former that is identical in rules to that conducted for recipients of benefits in kind. For the latter, as a condition to receiving a cash benefit, also the income of the family member who cares for the elderly person and lives with him is tested.

geriatric specialist. As of October 2013, the pilot program has been extended to persons aged 80 – 89 for three additional local NII branches and it is scheduled to be conducted until July 2014 (see Section B below).

In January 2007, **three levels of long-term care benefits** were established, and these correspond to three levels of dependence: a benefit at a rate of 91% of a full individual disability pension, which funds 9.75 weekly home care hours; a benefit at a rate of 150% of a full individual disability pension, which funds 16 weekly home care hours; and a benefit at a rate of 168% of a full individual disability pension, which funds 18 weekly home care hours. An individual is entitled to a full long-term care benefit according to the established level of dependence, if his income does not exceed the average wage (NIS 8,828 in 2013) and to half the benefit – if his income is higher than the average wage and up to 1.5 times the average wage. If his income is higher than 1.5 times the average wage – he is not entitled to a benefit. A couple is entitled to a full benefit when its combined income does not exceed 1.5 times the average wage and to half the benefit if its income is higher than 1.5 times the average wage and up to 2.25 times the average wage. A couple whose income is more than 2.25 times is not entitled to a long-term care benefit. When both spouses submit a benefit claim, their combined income is divided into two and the means test is performed for each one of them as though they were individuals. In January 2013, the long-term care benefit was updated at a rate of 1.4% and in January 2014 – by 1.9% (according to the price increase in 2012 and 2013).

Whoever receives a long-term care benefit under one of the two highest levels of the benefit and employs an Israeli worker only (not a foreign worker at all, neither within nor outside the framework of the long-term care benefit) is entitled to additional weekly care hours. Whoever is heavily dependent on the assistance of others, meaning that he is entitled to a benefit at a rate of 150% of a full disability pension, is entitled to three additional weekly care hours. Whoever is entirely dependent on the assistance of others and is therefore entitled to a benefit at a rate of 168% of a full disability pension is entitled to four additional weekly care hours. Whoever is entitled to half the benefit due to income is entitled to half the additional hours, depending on the level of dependence determined for him[2].

The long-term care benefit is not paid in cash, but rather is provided to entitled persons as services by organizations that are paid by the NII for these services (benefit in kind). The basket of long-term care services covered by the benefit includes personal care or supervision at home, transportation and personal care at elderly day care centers, supply of absorbent products, laundry services and funding use of distress alert transmitters. A

2 From March to September 2009, this addition was paid pursuant to an agreement with the Ministry of Finance and was financed thereby. As of October 2009, in accordance with the Economic Efficiency Law for 2009 – 2010, the addition is being paid pursuant to the National Insurance Law and is financed thereunder.

cash benefit is granted to entitled persons for whom there are no available services or services that can be provided within the timeframes stipulated in the law and to entitled persons within the framework of a pilot program being operated at some local NII branches.

In March 2008, the National Insurance Institute began operating a **pilot program providing cash benefits** in communities belonging to the Ashkelon, Bnei Brak, Nahariya and Ramat Gan local NII branches. In May 2010, the program was also extended to communities belonging to the Ashdod, Tiberius and Jerusalem local branches and in June 2011 – also to communities belonging to the Holon and Netanya local branches. The pilot program in this format terminated in April 2013. Under the program, elderly persons in these communities could opt for a cash benefit, provided that they had been entitled to a benefit at a rate of 150% or 168% of a full disability pension (or to half the benefit, due to the means test) and actually received long-term care services from a caregiver other than a family member for at least six days a week, 12 hours a day. The elderly person could opt to switch to a cash benefit or to revert to a benefit in kind at any time he so wished. The program was accompanied by studies which examined the characteristics of persons selecting a cash benefit compared to all entitled persons, and control of the quality of care of the recipients in these regions and in other regions was carried out. From March 2014 to the end of 2014, the pilot program was extended throughout the country (see Section B below).

Under the law, the Minister of Welfare and Social Services must appoint local professional committees, comprised of a social worker of the local authority, a sick fund nurse and a representative of the National Insurance Institute. The committee is charged with determining the care plan for the elderly person entitled to benefit – which services should be provided thereto and who is to provide them. The committee must also ensure that the services are indeed provided, or alternatively, specifically determine that there are no available services for said elderly person. The committee may also deny an application to receive a long-term care benefit in cash within the framework of the pilot program, if it believes that the elderly person and his family are incapable of using the benefit monies for their intended purposes; furthermore, the committee may determine whether the personal caregiver is suitable and whether the long-term care services that the elderly person is receiving are adequate. The committee can deny payment of a cash benefit and require the recipient to receive the benefit in kind.

B. Legislative Changes and Administrative Changes

- **Payment of cash benefits**

  The pilot program providing cash benefits at nine of the 23 National Insurance Institute local branches terminated on April 30th, 2013. On July 31st, 2013, an amendment to the law was passed and thereby whoever is entitled to a long-term care bene-

fit and employs a personal caregiver other than a family member for at least six days a week, 12 hours a day, can receive a cash benefit. The rates of the cash benefit are 80% of the rates of the long-term care benefit in kind[3]. The amendment does not restrict the receipt of the cash benefit by benefit level, caregiver category (Israeli or foreign) or region in the country.

The amendment to the law provides that the law shall be instituted as a temporary order from publication of regulations for implementation of the provisions of the law and until December 31st, 2014. During this period the National Insurance Institute is obligated to conduct a follow-up study of the implementation and implications thereof. Box 1 presents the conclusions of the accompanying study carried out by the Brookdale Institute for the National Insurance Institute.

On February 6th, 2014, additional regulations were published, whereby whoever begins to employ a foreign caregiver or renews a suspended permit to employ a foreign caregiver shall be requested to choose, at the time of submission of the application, whether to receive the benefit in kind or in cash.

On March 1st, 2014, another amendment came into force, whereby the entitled persons may switch between the benefits – cash and in kind – at any time, and the changeover shall be made in the month subsequent to approval of the application. The entitled person can also receive additional long-term care services under the law and the value of the additional long-term care services shall be deducted from the value of his full benefit and from the difference – 20% shall be deducted (so that the value of the cash benefit shall be 80% of the value of the benefit in kind).

It was further prescribed that recipients of cash benefits who employ a foreign worker are entitled to request that the NII deduct from their benefit 12% of the minimum wage for a pension fund for the caregiver, and if they do so, they are deemed to have fulfilled their obligation to set aside monies for deposit under the Foreign Workers Law.

- **Dependency assessment for persons aged 80 – 89**

  On April 30th, 2013, the pilot program allowing persons aged 80 -89 in communities belonging to the local NII branches in Tiberius, Jerusalem and Petah Tikva to have the dependency test performed by a geriatric specialist ended (conclusions of the program are presented in Box 2)[4]. The program was extended to three additional local branches – Be'er Sheva, Nahariya and Ramat Gan – and it is scheduled to continue until the end of July 2014.

3 The discrepancy between the values of long-term care benefits in kind and in cash stems from the additional costs incumbent on the long-term care companies, which individuals are not required to bear: VAT payment and the costs of employing professionals, such as social workers.

4 Under Section 224(c)(2) of the National Insurance Law [Consolidated Version], 5755-1995, as of August 2008, persons aged 90 or older can elect to have a geriatric specialist perform the dependency assessment in lieu of an assessor on behalf of the National Insurance Institute.

The dependency assessment must be carried out in the claimant's home and not in the physician's clinic, by a physician in the framework of his practice at a publicly owned medical institution. The claimants are not required to pay for the assessment, apart from the deductible pursuant to the rules of the National Health Insurance Law. They can elect to have the dependency assessment performed by assessors on behalf of the NII, as was done in the past.

- The committee to examine the assessment test for long-term care and attendance allowance within the framework of the NII (Ben Yehuda Committee): In July 2012, a public committee headed by Prof. Arie Ben Yehuda, a geriatric specialist from Hadassah Ein Kerem Hospital, convened in order to examine the existing dependency assessment test for long-term care and attendance allowance (the latter under the General Disability branch). The committee, whose members included geriatric specialists, gerontology specialists, representatives from the NII and representatives from the Ministry of Health and the Ministry of Welfare and Social Services – submitted its conclusions to the Director General of the National Insurance Institute in April 2013[5].

  The committee was appointed in order to assess the existing dependency test in light of the professional and public criticism thereof and in light of the need for periodic examination in the wake of the developing knowledge in the fields of long-term care, medicine and gerontology and the need to compare Israel to other countries. The committee also addressed the matter of improving the existing test and strengthening the public legitimacy of NII activities in this field.

  The committee recommended leaving the existing test intact, but introducing improvements to it, among them an assessment of the need for supervision due to cognitive changes, limited mobility and bowel / bladder control, simplifying the use of the test and setting a clearer definition of the scoring system. The assessment tests used around the world were rejected, since they deal with medical, psychological and social aspects and not with the degree of need for home care. The committee recommended continuing to adhere to the Brill Committee[6] recommendations and minimizing the need for performing demonstrations, which feel like an invasion of privacy.

  The Long-Term Care Department of the Benefits Administration, in collaboration with the Research and Planning Administration, examined the proposed test and the existing test in order to ensure that the use of the new test indeed facilitates matters for the examinees and for the examiners and similarly scores the level of dependence. Assessments were made of how the use of the proposed test would affect the number

5 **The committee to examine the assessment tool for long-term care and special services within the framework of the NII, Final Report**, April 2013.

6 The committee to examine arrangements for performing dependence test to receive a benefit under the Long-term Care Law, headed by Dr. Shai Brill, Director of Beit Rivka Hospital, submitted its recommendations on July 5, 2005.

of entitled persons and their level of dependence. The recommendations of the committee were approved by the Minister of Welfare and Social Services, the Director General of the NII and the administration of the NII. To date, the preparations for using the new test have not been completed.

Box 1
Providing A Long-Term Care Benefit In Cash – Accompanying Study[1]

Introduction and Objectives

The pilot program for providing a long-term care (LTC) benefit in cash was in operation from March 2008 to April 2013 at the Ashkelon, Bnei Brak, Nahariya and Ramat Gan local NII branches. In May 2010 the program was extended to the Ashdod, Tiberius and Jerusalem local branches and in May 2011 also to Holon and Netanya. Participants were persons entitled to a long-term care benefit at the 150% or 168% levels (or to half these benefits, due to the means test), who reside in communities belonging to these local branches and who employ a personal caregiver other than a family member at least six days a week, 12 hours a day. They could choose between a benefit in kind or in cash and also switch between the two methods of benefit provision at any time, with no limitation as to the number of changeovers.

At the request of the NII, the Brookdale Institute conducted a follow up study of the program. The study had four objectives: (a) to examine the volume of cash benefit selection and the characteristics of those making the selection; (b) to examine the considerations for selecting and not selecting a cash benefit; (c) to examine the implications of the cash benefit for the quality of care, responsiveness to needs and employment of the long-term caregiver; (d) to examine the perceived value, difficulties and satisfaction with the arrangement. This box presents a summary of the study and the main findings arising therefrom.

Volume of the Selection

The first section of the study was based on an analysis of administrative data of the National Insurance Institute on all the persons entitled to the 150% and 168% benefit levels in July 2012, in order to canvass the volume of the selection and the characteristics of those making the selection and those not making the selection. From the beginning

1 The complete study: Brodsky J., Resnick S. and Cohen Y. (2013). **Pilot Program for Providing Cash Benefits under the Long-term Care Insurance Law, Studies for Discussion 112**. Jerusalem: National Insurance Institute / Research and Planning Administration and Myers – JDC – Brookdale Institute / Center for Research on Aging. This box presents the highlights of the abstract appearing in this publication.

of the pilot program, until July 2012, 1,953 entitled persons received a cash benefit for a certain period. 83% of the applications for this benefit were approved by the local professional committees. The primary reasons for denying applications were absence of a valid permit for employing a foreign caregiver and absence of an employment contract therewith.

In July 2012, at all the nine local NII branches, 1,224 entitled persons received a cash LTC benefit – nearly all of them employed foreign caregivers – and they constituted approximately 4.5% of all the potentially entitled persons. 9.8% of the foreign caregiver permit holders opted for a cash benefit – from 5.9% at the Nahariya branch to 18.7% at the Ashkelon branch. Nonetheless, the differences between the local branches were not thoroughly explored in this study.

The more disabled entitled persons, whose principal supporters have vaster resources, had a higher likelihood of receiving a cash benefit. A multivariate analysis, which included the characteristics of the entitled person and the characteristics of the principal supporter, found that those relatively likely to receive a cash benefit were entitled persons who have not surpassed their nineties, who have a benefit level of 168%, whose principal supporter has not surpassed his nineties, has a fairly high level of education and his economic status is assessed by him as fairly good. No difference was found in the likelihood of receiving a cash benefit between those who were or were not entitled to an income supplement and also not between those who had been entitled to a long-term care benefit prior to the beginning of the pilot program and those who began receiving it subsequently.

The Research Method

Additional research data was also gathered through interviews with the principal supporters of the entitled persons – 1,176 family members – 307 among recipients of cash benefits within the program regions, 307 among recipients of benefits in kind within the control regions, 281 among recipients of benefits in kind within the program regions, 281 among recipients of benefits in kind within the control regions. The interviews were conducted by telephone using special questionnaires by specifically trained interviewers, and they sought to examine the differences between the recipients of the two benefits. Therefore, in order to ensure that the groups would be similar, the entitled persons in the control group were selected by matching according to nine characteristics, which may influence the condition and the care of the entitled person: age, gender, living alone or with others, whether or not the entitled person immigrated to Israel from the 1990s onward, whether he requires constant supervision according to the dependence test, whether he has a permit to employ a foreign caregiver, the benefit level, whether he receives an

income supplement. In addition, the residential region was taken into account in the sampling and in the matching with the control groups[2].

Under the study, 190 observations and interviews were conducted in the homes of the entitled persons: 95 observations of recipients of cash benefits within the program regions (Ramat Gan and Ashkelon), 95 observations of recipients of benefits in kind within the other regions (Be'er Sheva and Herzliya) and 132 interviews with entitled persons. Also in the observations the entitled persons were sampled and matched as in the method used for sampling the family members so as to ensure that the groups would be as similar as possible. Some of the information was gathered through interviews with the entitled persons, when this was possible, primarily through observations in their homes of their condition and their living environment. The home visits were carried out by health professionals hired directly by the research team of the Brookdale Institute.

Considerations for Selecting and not Selecting a Cash Benefit

The supporters' main source of information on the long-term care benefit in cash was the National Insurance Institute. Nonetheless, in half the cases, the sources of information were friends or the media. The supporters who selected a cash benefit had clear information, but many of them were interested in further information with regard to the benefit and the employment of the caregiver. 44% of the foreign worker permit holders within the program regions reported that they did not know that they could switch to a cash benefit. Only 26% of the entitled persons (and their family members) within the program regions could have actually selected a cash benefit, i.e., they employed a personal caregiver and knew about the benefit.

Tables 1 and 2 present the primary considerations for selecting a cash benefit (Table 1) and for selecting a benefit in kind (Table 2).

Table 1
Primary Considerations for Selecting a Cash Benefit

Consideration	Rate of respondents who indicated the consideration
Financial savings	82%
Desire to manage the care independently	69%
Greater control over the work of the caregiver	39%
Dissatisfaction with the nursing company	32%

2 For complete information on the research method, see Note 1 in this box.

Table 2
Primary Considerations for not Switching to a Cash Benefit

Consideration	Rate of respondents who indicated the consideration
Satisfaction with the nursing company	79%
Did not think that this could save them money	58%
Apprehension of the difficulties in dealing with employing a caregiver without assistance from the nursing company	58%
Did not thoroughly consider switching to a cash benefit	45%
Thought that the process of changing over to a cash benefit is complicated	33%
The letter from the National Insurance Institute regarding the cash benefit was not sufficiently clear	29%
The nursing company worked to dissuade them from switching to a cash benefit	22%
Apprehension that the changeover to a cash benefit would compromise long-term care services in addition to the personal home care within the framework of a long-term care benefit	20%

Findings: Quality of the Long-term Care

The study examined the various aspects of the care, the degree of responsiveness to the needs of the patient and the employment conditions of the caregivers, and made a comparison between the recipients of the two benefits. The findings showed that the recipients of the two benefits were satisfied with the care. Under most of the parameters no differences were found between the groups and under others only a small difference was found (although statistically significant) in favor of the cash benefit recipients. Under no parameter was it found that persons entitled to a benefit in kind receive better care than do persons entitled to a cash benefit or that the employment conditions of the caregiver are better.

In several similar questions asked of the family members and the entitled persons – although not involving cases where the entitled person and his family member were asked, inasmuch as the samplings were independent – a high degree of correlation was found between the distributions of the answers in both groups.

From the interviews with the family members, no significant differences were found between the two groups in the following parameters: the areas in which the caregiver assists the entitled person; the communication between the caregiver and the entitled person; the entitled person's need for further assistance with personal care; the percentage of entitled persons who visit an elderly day care center or the percentage of entitled persons in a supportive community; in the family member's perception of the caregiver's training; the family member's feeling that he can rely on the caregiver; the satisfaction with a variety of aspects of the caregiver's work; the assistance that the family members provide to the entitled person; the degree of turnover and the difficulties in recruiting the caregiver; various aspects related to the

employment conditions of the caregiver; difficulty of finding a substitute caregiver when the regular caregiver is on vacation; the likelihood that the entitled person would move into an institution.

From the interviews with the family members, significant differences were found in favor of persons entitled to a cash benefit in the following parameters: less need for further assistance of the entitled person in managing the household, in escorting outside the home for treatments and arrangements and in leaving the house for a walk; less strain on the family member who constitutes a principal supporter; a higher rate of cash benefit recipients signed an employment agreement and are prepared to pay compensation; more cash benefit recipients believe that the caregiver helps the entitled person remain in the community rather than moving into an institution.

From the interviews with the entitled persons no significant differences were found among the two groups in the following parameters: the caregiver assists them with personal care and in managing the household; there are no communication problems with the caregiver due to the language differences; most of them feel that the caregiver does not lack training; most of them rely on the caregiver; most of them are satisfied with the work of the caregivers in various dimensions of the care.

From the interviews with the entitled persons, significant differences were found in favor of persons entitled to a cash benefit in the following parameters: they receive more assistance from the caregiver in escorting outside the home for medical purposes and for arrangements; they receive more assistance from the caregiver in cleaning the house; a higher percentage reported that they do not feel uncomfortable asking the caregiver to do things differently or commenting to her about the quality of the work; a higher percentage reported that they have felt comfortable since the caregiver entered the home and that the latter keeps them company and helps ease the loneliness.

From the observations in the homes of the entitled persons, no significant differences were found in the following parameters: the mood of the entitled persons; their personal state (personal cleanliness, etc.), which in both groups was overwhelmingly good; the state of the housing environment, which was overwhelmingly good; the nutritional state and the content of the food products in their homes, which were adequate in the overwhelming majority of the cases; and in the working conditions of the caregiver.

From the observations in the homes of the entitled persons, significant differences were found in favor of persons entitled to a cash benefit in the following parameters: calmer emotional state in the homes where there is cooked food.

Findings: Satisfaction

Approximately 85% of entitled persons who received a cash benefit had previously received service from a nursing company and 77% of their family members claimed

that the changeover to this benefit saved them money. The most common amount of savings was NIS 400 – 600, but a considerable portion of them could not specify an exact amount. 46% of the principal supporters reported that they feel greater control over the care that the entitled person is receiving. 14% of the supporters reported that dealing with the employment of the caregiver is less burdensome for them and 14% that it is more burdensome, 65% reported that they feel no change and the rest could not say. 77% of the supporters reported that there was no change in the wage of the caregiver following the changeover, 22% said that they raised the wage and a few supporters reported that they lowered the wages.

Of all the supporters of the cash benefit recipients that were asked, 98% reported that they are very satisfied or satisfied with the arrangement and 97% recommended to implement it throughout the country. The predominant advantage that was reported is the sense of greater control over the care and that this arrangement is convenient and easier for them in terms of the bureaucratic arrangements of payment to the caregiver. A few supporters noted that they miss the assistance of the nursing company in finding a substitute for the caregiver when necessary. Approximately one fifth noted that they would like further information on the rights of the caregiver.

The findings of the study, which as stated was conducted by the Brookdale Institute, are similar to the findings of a previous study of the National Insurance Institute, according to which great satisfaction with the cash benefit arrangement is evident[3]. Also in this study the supporters noted financial savings and a sense of control over the care of the entitled person following the changeover to this benefit. The study found no evidence of difficulties among those who opted for a cash benefit in the direct employment of a caregiver in terms of the payment arrangements and finding a substitute caregiver when necessary.

3 See Gharrah R. (2010). **Long-term Care Benefit in Cash – Study Accompanying Pilot, Studies 103**. Jerusalem: National Insurance Institute, Research and Planning Administration, December).

Box 2

Pilot Program for Choosing a Geriatric Specialist to Perform Dependency Assessments for Persons Aged 80-89[1]

Guidelines of the Law

On January 9, 2012, the Knesset adopted an amendment to the Law, whereby a pilot program would be implemented that allows persons aged 80-89 to be examined for a dependence test by a geriatric specialist within the framework of his practice at a

1 The complete study is published on the NII website under this name.

medical institution. The program commenced on May 1, 2012 and terminated on April 30, 2013 and the NII was required by law to have it accompanied by a study[2].

The Law prescribed that the dependency assessment is not to be conditioned on payment from whoever is requesting to be examined, apart from the deductible under the National Health Insurance Law. It was agreed between the National Insurance Institute and the Ministry of Finance on the one side and the health care system and the geriatric physicians on the other side that the NII would pay the public medical institutions for the dependency assessments that would be carried out by their physicians within the framework of their public – not private – practice: NIS 1,000 for an examination of persons aged 80 – 89, which, under the Law, must be carried out in the home of the claimant and NIS 500 for an examination of persons aged 90 or older, which can be carried out either in the clinic of the physician or at the home of the claimant. The difference between the rates stems from consideration of the time and travel cost of the physician performing a home examination.

Availability of Geriatric Specialists

The Law implemented the pilot program in three local NII branches: Tiberius, Jerusalem and Petah Tikva. The considerations for selecting the population belonging to these branches were its ethno-national, urban/rural and socio-demographic diversity: This population is comprised of Jews and Arabs, urban and rural people, different socio-economic levels, secular, religious and ultra-Orthodox people as well as new immigrants and long-standing residents. Within these regions, there are also differences in the degree of availability of the public medical institutions and the specialists and different rates of dependency assessments carried out by physicians for persons aged 90 or older.

The main difficulty encountered by the program was the unavailability of geriatric specialists in several of the regions and particularly in the outlying areas. At the Jerusalem and Petah Tikva local branches nearly all the assessments were carried out by physicians in large communities and at the Tiberius branch, where there are few specialists in this field, few assessments were carried out. By contrast, the assessors on behalf of the NII were available to perform dependency assessments within a short period of time in each community.

Findings: Volume of Referrals to Physicians for Performing the Dependency Assessments

During the period between May 2012 and April 2013, 7,489 dependency assessments were carried out at the three branches, 374 of them (5.0%) by physicians (Table 1).

2 As of August 2008, persons aged 90 or older throughout the country can choose to have a geriatric specialist perform a dependency assessment as a condition to entitlement to a long-term care benefit.

The actual demand for the dependency assessments is approximately one third to half higher, inasmuch as there is no information on assessments by physicians performed contrary to the rules (in most cases since they were carried out in a clinic or within the framework of the private practice of physicians) and disqualified. Although the number of dependency assessments by physicians is still small, a gradual increase was recorded in the months of May – December 2012, so that in December 2012, 8.5% of the dependency assessments for persons aged 80-89 in the three regions were carried out by physicians – 57 overall. In January 2013, a decrease was recorded in the rate of assessments by physicians – a monthly average of 6.7% (7.0% - 7.3% in the months of January – March 2013 and 5.0% in April 2013).

Table 1
Dependency Assessments Performed by Geriatric Specialists, Select Local NII Branches

Branch	Number of dependency assessments by physicians	Total dependency assessments performed	Rate of dependency assessments by physicians out of all dependency assessments
Total	374	7,489	5.0
Tiberius	15	1,315	1.1
Jerusalem	221	3,836	5.8
Petah Tikva	138	2,334	5.9

Findings: a Comparison between the Groups by the Type of Examiner

An analysis of the dependency assessment and examinee data reveals the following findings[3]:

- Distributions of the dependency score and the benefit levels recommended by the physicians lean heavily toward the higher benefit level (1.1% of the assessments did not award a benefit, 23.4% awarded a benefit at a level of 91%, 25.3% - at a level of 150% and 50.2% awarded a benefit level of 168%). The assessors' situation is reversed: 17.3% of the assessments did not award a benefit, 48.4% awarded a benefit at a level of 91%, 21.2% - a level of 150% and 13.0% awarded a benefit level of 168%. It is impossible to pinpoint the cause of this disparity, inasmuch as the pilot program does allow for experimentation (a random allocation of assessees between types of assessors) or comparison (transferring assessments by physicians and assessors to the same people at the same point in time).
- Physicians are far more likely to give a recommendation for constant or partial supervision in each one of the situations compared to assessors – 10.7% and 4.8%,

3 The words "physicians" and "assessors" are used according to the majority principle in each group. It should be clarified that each group includes men and women.

respectively. The reason is not only possible differences between the two groups (for instance, the more severe cases come to the physicians), but also the different perception between physicians and assessors with regard to the need for supervision from a long-term care perspective (the National Insurance Institute only instructs the assessors).

- The rate of income supplement recipients was lower among persons examined by physicians than among assessors – 28.4% compared to 32.1%, respectively, and the rate of women and new immigrants was higher: 68.7% women and 30% new immigrants among physicians, compared to 65.5% women and 23.9% new immigrants among assessors. When distributed by age – the men and women examined by physicians were older (48.8% of the women examinees and 43.5% of the men examinees were aged 80-84, compared to 60.6% of the women and 59.6% of the men that were examined by assessors). The rate of members of Clalit Health Services, in which most of the long-term care benefit claimants are members, among persons examined by assessors was higher than their rate among persons examined by physicians (70.3% compared to 60.1%).
- Differences were found between women and men by household composition in both groups of examinees – by physicians and by assessors (Table 2).

Table 2
Long-term Care Benefit Claimants by Gender and Household Composition (percentages)

Gender	Living alone	Living with a spouse	Others	Total
		Examined by physicians		
Total	37.2	38.6	24.2	100.0
Women	41.9	27.4	30.6	100.0
Men	27.0	62.6	10.4	100.0
		Examined by assessors		
Total	38.1	40.3	21.6	100.0
Women	47.0	25.4	27.6	100.0
Men	21.6	68.0	10.4	100.0

Findings: Interviews with Entitled Persons and with Principal Supporters

During the interviews, long-term care benefit claimants or their supporters who were present at the dependency assessments were interviewed regarding various subjects. Of 411 interviews, 167 were carried out with the claimants themselves (20 who were examined by physicians and 147 who were examined by assessors) and 244 with family members (71 who were examined by physicians and 173 by assessors). The findings are as follows:

- 53.8% of persons examined by a physician learned from the family physician of the possibility of an exam by a physician. An overwhelming majority of persons examined by assessors did not know that they could be examined by a physician (92.1%).
- Testimonies emerged from the interviews of difficulty in locating physicians to perform the assessment in their homes: 31.0% said they had difficulty finding a specialist, while 64.0% said that they did not have difficulty. Nonetheless, the testimonies of difficulty are less as of the initial assessment.
- Both physicians and assessors asked the claimants to demonstrate some of the basic activities of daily living – 56.6% - 86.4% of the persons examined by the physicians and 43.1% - 90.2% of the persons examined by assessors[4]. The act of rising from a chair / bed was the activity that the highest rates of examinees in both groups were asked to demonstrate, and food preparation – the lowest rates. In a smaller proportion of the cases physicians and assessors sufficed with questions regarding the ability of the claimants to perform these activities.
- The overall satisfaction with the manner of examination of the assessors is considerably lower than the overall satisfaction from the manner of examination of physicians (82.0% compared to 100%, respectively), but in other aspects of satisfaction with the examination, the disparities are narrower: treated with respect – 93.4% compared to 100%, respectively – and treated with patience – 92% and 96.7%, respectively.

Challenges in Implementing the Law

Conversations with officers at the National Insurance Institute and with physicians who performed dependency assessments revealed several problems with regard to the implementation of the program:

- Unavailability of geriatric specialists. There are a limited number of geriatric specialists in Israel and some of them do not work full time in the public sector, so that the number of physicians available for tests is actually even smaller.
- Inequality between the examinees. Currently, the dependency assessments performed by assessors and physicians are not identical in terms of the professional background, the training and the manner of examination. Assessors test functioning or the need for supervision according to performance capabilities, while physicians test according to the medical condition in the present and the future prognosis. This situation creates inequality between the examinees.

4 Rising from a chair / bed, ambulation in the home, washing face / hands, preparing food, wearing layered clothing.

- Inequality between regions of the country. The accessibility to geriatric specialists is not uniform in all regions of the country and sometimes even within the regions themselves disparities may be created between different communities and even within large communities.
- Lack of control over the physician assessments. Currently, there is no control system for the physician assessments. When physicians' decisions are translated into public expenditure on benefits, a control system similar to the existing system for the assessors' work is necessary.
- Concern over private payment for the dependency assessments. There is concern that long-term care benefit claimants who wish to be examined by a physician are in some cases paying or are required to pay in order to bring an appointment forward and particularly in order to receive a dependency assessment that meets their expectations.
- Difficulties in cooperation between the National Insurance Institute, medical institutions and geriatric specialists. The dispersion of dependency assessments performed by physicians among numerous entities requires much coordination.
- The bureaucratic processes are cumbersome. The information among the public and among the physicians was fairly limited and not sufficiently clear and therefore the provisions of the Law were not observed in many cases; physicians performed examinations within the framework of their private practice or at clinics of the sick funds or in hospitals; the claimants were forced to repeat the assessments or "to choose" an assessment by assessors on behalf of the National Insurance Institute. The processing of these claims imposed a heavy burden on NII employees and discontent and criticism of the NII were aroused on the part of the claimants and their family members.

C. Claims for Long-term Care Benefits

The number of claims for long-term care benefits rose in 2013 by 2.8% compared to 2012 and reached 83.1 thousand[7]. 40.8% of the claims were initial claims (compared to 40.5% in 2012) and 59.8% - repeat claims (compared to 59.5% in 2012). The number of initial and repeat claims rose by 2.8% compared to 2012 (Table 1). 53.5% of the initial claims in 2013 were approved (compared to 55.1% in 2012) and 46.5% were denied (compared to 44.9% in 2012). By contrast, 38.2% of the repeat claims in 2013 were approved (compared to 41.4% in 2012) and 61.8% were denied (compared to 58.6% in 2012). Overall, 44.1% of the long-term care benefit claims were approved in 2013 and

7 Including claims the processing of which has not been completed.

55.9% were denied (compared to 146.9% and 53.1% in 2012, respectively). The rate of approved claims fell by 46.9% in 2012 to 44.1% in 2013. There was a similar decrease also in the rate of repeat claims that were approved.

The rate of false claims (claims that received a score of 0 or 0.5 for some of the ADL in the dependence test[8] and that established no entitlement in respect of the need for supervision) out of all claims rose from 35.3% in 2012 to 36.8% in 2013. The rate of persons receiving 2.5 points in the dependency assessment – the threshold score for benefit entitlement – out of all claims fell from 16.8% to 15.7% between the two years[9].

Table 1
Claims, Approved Claims, Initial Claims and Repeat* Claims (absolute numbers and percentages), 2009-2013

Year	Total claims (numbers)	Annual growth	Percentage of claims approved	Percentage of initial claims approved	Percentage of repeat claims	Percentage of repeat claims approved
2009	77,003	3.9	46.0	52.7	59.4	41.3
2010	77,926	1.2	44.1	51.6	59.9	39.1
2011	79,542	2.1	45.0	52.1	61.0	40.4
2012	80,885	1.7	46.9	55.1	59.5	41.4
2013	83,130	2.8	44.1	53.5	59.2	38.2

* (1) The calculation does not include claims of persons who submitted claims and died and persons whose entitlement has been suspended. (2) Presents claim results following an initial entitlement decision. (3) Claims include claims whose processing has not been completed in 2013. The percentage of claims approved, the percentage of initial claims approved, the percentage of repeat claims and the percentage of repeat claims approved only includes claims whose processing has been completed in 2013.

The rate of false claims among initial claims rose from 33.6% to 34.8% and among repeat claims – from 36.4% to 38.1%. The rate of persons receiving 2.5 points in the dependency assessment among initial claims fell from 17.2% to 16.7%; among repeat claims – fell from 16.5% to 15.1%.

D. Persons Entitled to a Long-term Care Benefit

1. General

The number of persons entitled to a long-term care benefit increased in 2013, reaching a monthly average of 156.6 thousand – an increase of 2.9% (Table 2). The number of entitled persons rose from 1991 to 2013 fivefold despite the raising of the entitlement age. This is an extremely high rate of increase and it is considerably higher than the increase in the number of elderly persons during said period. A possible explanation may

8 See Annual Survey for 2011, pg. 125.

9 The threshold for admission to the long-term care system is 2.5 points under the dependency assessment for someone other than an individual ("single") or 2 points under the dependency assessment with the addition of 0.5 points for an individual.

be the increased take up rate of benefit entitlement in light of the increased awareness thereof over the years. In the course of 2009, the entitlement age for women reached 62, which shall remain in effect until the end of 2016. In 2009, the entitlement age for men reached the end of a process of increasing the entitlement age and is currently 67. In 2013, as in 2012, the entitlement age for women and men did not change from the beginning of the year until the end. The percentage of persons entitled to benefits among the population's elderly rose markedly, from approximately 6% in the initial years of implementation of the law to 17.7% in 2013 (estimated). This rate of entitled persons is calculated from the estimated number of elderly persons who have reached age of entitlement to benefit (62 for women and 67 for men).

Table 2
Persons Entitled to a Long-term Care Benefit, Elderly Persons in Israel and Rate of Coverage, 2009-2013

	Entitled to long-term care*		Elderly persons in Israel**		
Year	Numbers (thousands)	Annual growth rate	Numbers (thousands)	Annual growth rate	Rate of coverage***
2009	136.4	4.0	788.4	4.7	17.3
2010	141.1	3.4	812.7	3.1	17.4
2011	144.8	2.7	840.3	3.4	17.2
2012	152.1	5.0	861.9	2.6	17.6
2013	156.6	2.9	884.3****	2.6	17.7

* Monthly average.
** The data for 2009 – 2013 is for men aged 67 or older and for women aged 62 or older, according to data of the Central Bureau of Statistics.
*** The number of persons entitled to a benefit as a percentage of the number of elderly persons.
**** The figure for 2013 is an estimate.

2. Characteristics of entitled persons

An examination of the demographic characteristics of entitled persons in 2013 shows that 7 of every 10 entitled persons are women and that their proportionate rate of all entitled persons has fallen slightly in comparison with 2012. When distributed by age, approximately 2/5 are aged 85 or older and approximately 2/3 are aged 80 or older. As in 2012, in 2013 the main increase n the number of entitled persons was among persons aged 85 or older, whose proportion of total recipients rose from 39.4% to 40.5%, while their proportion of persons aged 84 or younger has been falling steadily.

The trend of the aging benefit recipients is continuing: thus, for instance, in 2001 persons aged 85 or older constituted less than one third (32.1%) of the entitled persons and persons aged 80 or older constituted less than 3/5 (55.2%). This trend reflects aging trends in Israeli society and particularly the increase in the proportion of the older ages, and it stems in part from the raising of the retirement age: the group of women up to 64 years of age who are entitled to a benefit is reduced and so also the group of entitled men and women aged 65 – 69, due to the raising of the retirement age for men.

Table 3
Persons Entitled to Long-term Care Benefit by Demographic Characteristics and Benefit Level (monthly average), 2013

Characteristics	Absolute numbers	Percentages
Total	**156,621**	**100.0**
Gender		
Men	45,784	29.2
Women	110,837	70.8
Age		
Up to 64*	1,117	0.7
65-69	6,333	4.0
70-74	14,947	9.5
75-79	29,526	18.9
80-84	41,276	26.4
85+	63,422	40.5
Family composition		
Living alone	74,086	47.3
Living with a spouse	62,486	39.9
Living with their children or with others	20,049	12.8
Length of residency in Israel		
Long-standing residents	117,167	74.8
New immigrants** - total	39,454	25.2
Of which: immigrated subsequent to 1999	5,420	3.5
Source of funding of the benefit		
NII	125,366	80.0
State Treasury	31,255	20.0
Benefit level		
Low benefit (91%)	83,645	53.4
High benefit (150%)	39,444	25.2
Very high benefit (168%)	33,532	21.4
Entitled to 3 additional hours	23,984	60.8***
Entitled to 4 additional hours	15,157	45.2***

* The age group includes women only.
** Whoever immigrated to Israel from 1990 onward.
*** Entitled to additional hours as a percentage of all entitled persons within the benefit level.

Within the domain of family composition[10] stability has been maintained in 2013 compared with 2012: nearly half of the entitled persons live alone, two of every five live with a spouse and one of every eight lives with someone else – usually a son or daughter.

There is also stability between the two years with regard to the length of residency in Israel: one of every four entitled persons immigrated to Israel subsequent to 1989, and

10 There has been a change in the 2011 data regarding the definitions of living with a spouse and living with their children or with others: the definition of living with a spouse now also includes persons living with a spouse and with additional people.

one of every eight new immigrants immigrated subsequent to 1999. The proportion of entitled persons who immigrated to Israel subsequent to 1989 of all entitled persons rose from 25.1% in 2012 to 25.2% in 2013, and the proportion of entitled persons who immigrated subsequent to 1999 rose from 3.3% to 3.5% between the two years. Among the entitled persons, a monthly average of 589 immigrated to Israel subsequent to 2009. The Ministry of Finance funds the cost of a long-term care benefit for whoever immigrated to Israel at age 62 or older. In 2013, the benefits of approximately 20% (on monthly average) were funded by the State Treasury, compared to 20.7% in 2012. In recent years, the relative proportion of entitled persons whose benefits are funded by the State Treasury of all entitled persons diminished, and their average monthly number fell in 2013 by approximately 200 compared to 2012.

With the aging of the entitled population, a trend of change in the composition of entitled persons by benefit level has been created, which is also reflected between 2012 and 2013: the share of recipients of the low level benefit (91% of a full individual disability pension) fell, from 54.0% to 53.4%; of recipients of the high level (150%) – rose – from 25.1% to 25.2%; and the share of recipients of the highest level (168%) also rose– from 20.9% to 21.4% between the two years (Table 3).

The proportion of persons entitled to the highest benefit level has been rising steadily: from 17.6% in 2008 to 21.4% in 2013. The growth rate of this group is the highest. In comparison with 2012, the number of recipients of the low-level benefit increased in 2013 by 1.7%, of the high level – by 3.3% – and of the very high level – by 5.8% compared to 2012.

In March 2009, care hours were added for persons employing an Israeli worker only. The number of those employing Israeli caregivers within both high benefit levels increased in 2013 compared to 2012: by approximately 1,600 in the high level and by approximately 1,000 in the very high level. The primary cause of this is the relative scarcity of foreign caregivers in long-term care; since June 2010 the government has imposed quotas on the Long-term Care branch[11]. The additional hours apparently have the effect of encouraging the employment of Israeli caregivers, but it is more limited[12].

E. Organizations providing Long-term Care Services and Services Provided

The services provided in the framework of LTCI are provided through official organizations recognized by the Ministry of Welfare and Social Services as authorized

11 If 1% or more of the foreign long-term care workers who are present in Israel under permit are not employed during the course of the year, approval is not granted for bringing additional foreign caregivers. Private agencies who received a permit to bring long-term caregivers to Israel, are authorized to increase the number of foreign workers by 10% each year, if their placement rates are not lower than the threshold prescribed under procedures of the Immigration and Population Authority of the Ministry of the Interior (97%).

12 With regard to the effect of the additional hours on encouraging the employment of Israeli caregivers, see the Long-term Care Insurance section in the Annual Survey for 2010.

service providers under a contract executed between them and the National Insurance Institute. At the end of 2009, the results of the last tender were published, including the names of the companies entitled to provide long-term care services.

A long-term care service provider can be a public non-profit organization, such as Matav (home caregivers, day care center for the elderly or a private organization operating as a business. At the end of 2013, 117 long-term care service providers were in operation: 49 NPOs (42% of all the companies) and 68 private companies (58% of all the companies). Overall, service providers provided a monthly average of approximately 8,011 million personal care hours in the homes of persons entitled to a long-term care benefit: approximately 5,840 million hours (72.9%) were provided by private organizations and 2.171 million hours (27.9%) by non-profit organizations (NPOs) (Table 4).

Table 4
Number of Personal Care Hours Provided, by Category of Service Provider (monthly average), 2013

Category of service provider	Numbers (thousands)	Percentages
Total	**8,011**	**100.0**
Private organization	5,840	72.9
NPO	2,171	27.1

The monthly average number of total care hours increased from 2012 to 2013 by 3.1% – from 7.767 million to 8,011 million. The number of hours provided by private companies increased by 3.8% – from 5,628 million in 2012 to 5,840 million in 2013 and by NPOs increased by 1.5% – from 2.139 million to 2.171 million. The share of the private companies of all the hours increased from 72.5% to 72.9% between the two years.

Table 5
Recipients of Long-term Care Services, by Category of Service, December 2013

Category of service	Number of recipients	Percentage of recipients	
		Of total benefit recipients	As a sole item, out of recipients of this service
Total*	**222,791**	-	-
Personal home care	155,738	98.6	68.3
Personal care in elderly day care center	11,777	7.5	6.1
Absorbent products	35,866	22.7	0.3
Distress alert transmitter	13,938	11.6	0.4
Laundry services	472	0.3	1.1

* A person entitled to a benefit can receive more than one category of service, therefore the total recipients of long-term care services in the Table is greater than the number of benefit recipients (excluding those refusing to receive services) in December 2013 – 157,964.

The overwhelming majority (98.6%) of recipients of long-term care services[13] in December 2013 received personal home care by a local caregiver or a foreign caregiver, 7.5% received personal care in an elderly day care center, 22.7% received absorbent products and 11.6% received distress alert transmitters (Table 5)[14]. 68.3% of the recipients of personal home care received it as a sole item from the basket of services. Only 6.1% of the recipients of personal care in an elderly day care center received it as a sole item and the rest combined it with other services. It should be recalled that a person entitled to a benefit can receive more than one category of service and therefore the total recipients of long-term care services is greater than the number of persons entitled to a benefit.

D. Volume of Payments

Concurrently with the direct benefit payments, the National Insurance Law mandates payment for additional items associated with long-term care insurance. 15% of the annual receipts are allocated to the Ministry of Health and to the Ministry of Welfare and Social Services to fund the growing number of persons hospitalized in institutions. In practice, the Ministry of Health generally utilizes the entire allocation while the Ministry of Welfare only utilizes a very small portion thereof. Funds are also allocated to the Fund for the Development of Community and Institutional Services for the Elderly.

In 2013, the total payments transferred to fund LTCI reached approximately NIS 5.0 billion (in 2013 prices): NIS 4.8 billion for the provision of services to entitled persons and the balance for the development of services of institutions and services in the community and for conducting dependence tests (Table 6). An amount of approximately

Table 6
Total Payments within the Framework of Long-Term Care Insurance, by Category of Payment (NIS million, 2013 prices), 2009-2013

Year	Total	Long-term care benefits	Transfer to outside entities*	Development of services	Admitted to long-term care facilities	Pursuant to agreements with the Ministry of Finance
2009	4,036.0	3,746.1	88.9	24.0	86.5	90.5
2010	4,269.0	4,035.9	90.7	46.8	91.8	3.6
2011	4,350.3	4,126.2	93.0	31.4	97.2	2.5
2012	4,750.3	4,528.0	99.2	26.2	94.0	2.9
2013	5,048.9	4,806.0	101.8	30.9	107.0	3.3

* Transfers to the Ministry of Welfare and Social Services and to Clalit Health Services for introducing care plans for entitled persons and transfers for conducting dependence tests.

13 Of all entitled persons excluding those refusing to receive services – entitled elderly persons who were offered a basket of services, but refused to receive the service or to receive a service from a certain provider. Approximately 97.9% of all entitled persons (including those refusing service), 159,110 in number, received personal care in the home within the framework of their entitlement to a long-term care benefit.

14 Of all entitled persons excluding those refusing to receive services. Of all entitled persons (including those refusing service) the rates are 7.2%, 12% and 21.7%, respectively.

NIS 107 million was transferred to the Ministries of Health and Welfare and Social Services for increasing the number of persons hospitalized in long-term care institutions. Furthermore, an amount of about NIS 101.8 million was transferred to the Ministry of Welfare and Social Services, to the sick funds and to the assessors, for preparing care plans for entitled persons and for conducting dependence tests.

In 2013, the payments under LTCI increased by 6.3% in fixed prices (2013 prices). The benefit payments increased by 6.1% as a result of the increase in the number of persons entitled to a benefit, particularly persons entitled to the highest benefit. The average benefit level[15], in fixed prices, rose in 2013 by 0.3% in real terms.

15 Average benefit - had the long-term care benefits been paid to all entitled persons for all the hours in a given month of entitlement. Long-term care benefit payments are lower by a few percentages since some of the entitled persons do not receive long-term care benefits for part of the month for the following reasons: the entitled person died, moved into a long-term care facility or was admitted to a hospital for more than 14 days; the nursing company did not provide all the long-term care hours required from it since the caregiver could not come and a substitute caregiver was not found; different rates and different dates of update for the benefit and for the different payment rates, such as care hours. The nursing companies receive payment for the care hours or other services that they actually provided. The figure in Table 7 regarding the expenditure on long-term care benefits is the actual expenditure.