Israel's Long-Term Care Insurance Scheme

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1. *The Emergence of Israel's Long-Term Care Insurance (LTCI) Law*

Israel began to implement the LTCI law fully in April 1988. However, the Knesset (Israel's parliament) passed an initial framework law in April 1980. Concerns about the implications of population aging in general and the rapid aging of the aged population in particular for the burden of long-term care – that is, for the size of the elderly population with functional disabilities – were the main factors that ultimately contributed to the passage of the 1980 framework legislation.

These concerns were accentuated by two facture. The first was the inadequacy of the home-care services in existence in Israel at the close of the 1970s (Brodsky & Naon, 1993). Thus, prior to the implementation of the LTCI law, there was an enormous gap between needs and available services, especially with regard to assistance in activities of daily living (Cnaan, Olsson, & Wetle, 1990). The second factor was the growing recognition among professionals working in care for elderly people as well as among policy makers that this situation would have implications for the burden of care borne by family caregivers.

Concern about the implications of Israel's age structure has persisted. This is because the population has aged rather rapidly, even though Israel today is relatively young demographically. In 1948, when the state of Israel was established, elderly persons comprised 3% of the total population (Guttman & Lowenstein, 1994); and by the end of 1996, the population aged 65 and over represented a little over 9.5% of Israel's total population. By 2008, the population of elderly persons reached 715,500, or slightly over 10% of the population (Israel Central Bureau of Statistics, 2009).

In addition, the elderly population itself is quite old, and has aged even more rapidly than the population as a whole. The rapid growth in the number of elderly

persons aged 75 years and over is largely due to prior waves of immigration (most notably from the Former Soviet Union), which comprised relatively high proportions of older people (Litwin & Lightman, 1996). Thus, the number persons aged 75 years and older increased by a factor of about 8.5 between 1955 and 1996, and grew further by about 50% by 2008 (Brodsky & Habib, 1997; The Brookdale Institute, 1997; The Brookdale Institute & Eshel, 1998; Israel Central Bureau of Statistics, 2009).

2. *The Goals of the LTCI Law*

Israel's LTCI law essentially sought to provide long-term care benefits as a matter of right or entitlement under clearly defined eligibility criteria. The primary purpose of the LTCI Law was to benefit the chronically severely disabled elderly persons living in the community through the provision of personal care and homemaking services.

Additionally, the LTCI law sought to complement rather than replace the existing limited system of service provision, in an attempt to bring about a real increase in the overall scope of services. It also took into account the burden of care borne by family members of elderly persons. Thus, the LTCI law sought to support not only the elderly persons with severe disabilities, but also the caregiving family within the framework of home- and community-based services. In that way, the aim was to reduce the demand for institutional placement.

3. *Eligibility*

The LTCI law covers women aged 60 years and men aged 65 and over with who have disabilities and are permanent residents of the State of Israel. It also includes new immigrants who arrived in Israel after reaching the age of 65.

Eligibility is also subject to an income test – a feature that is obviously at odds with the principle of contributory social insurance. However, the income test limits are so generous (three times the average wage) that only 1% of the applicants were excluded from benefit entitlement by the income test in 1996 (Zipkin & Morginstin, 1998). Of course, the income test may have discouraged an unknown number of elderly people from applying in the first place.

4. *Benefit Type*

Israel's LTCI law provides neither cash benefits nor an option for cash benefits (except in highly limited circumstances). Rather, it provides a basket of specified in-kind services. These services include personal care, help with household management (e.g., light preparation of food and light cleaning), supervision, transportation to and care at day centers, laundry services, disposable absorbent undergarments for the incontinent, and personal alarm units. Local professional committees funded by the National Insurance Institute (NII) make decisions regarding the precise service mix and service providers. Since March 2008, an experimental program has been implemented in three regions of Israel. In that program, which is scheduled to continue for a period of two years, frail elderly residents of those regions who have reached a certain level of dependency based on an ADL test and other requirements can choose to receive cash benefits rather than in-kind benefits.

Determination of eligibility and benefit levels. First, the processing of claims for benefits under the LTCI law involves, establishing initial eligibility (income test, age, residency, etc.) by the NII. Second, it involves an assessment of dependency by a Ministry of Health public health nurse based on an ADL assessment instrument. Depending solely on the score yielded by the assessment, the claimant will be deemed either ineligible for benefits or eligible for the following levels of benefits: 91% of the

disability insurance program, 150% of that program, or 168% of that program. These levels are intended to provide approximately 10 and 17 hours of home care per week, respectively. Payment for the services is made directly by the NII to the service providers.

5. *Service Delivery*

Because the government wished to be neither the service provider nor the employer of large numbers of home care workers (Naon, 1996), the LTCI law explicitly provided for the establishment of "internal" or "quasi" markets – the contracting out of service delivery to authorized voluntary nonprofit and proprietary for-profit organizations. The nonprofit providers comprise about 30% of the market, whereas the for-profits comprise 70%. In December 2008, the for-profit organizations provided 4.8 million hours, whereas the nonprofits provided 2 million hours. Two decades ago, the ratio was totally the opposite, as the market was controlled by nonprofits. This change reflects the accelerated process of privatization of services in the country. Notably, between 1988 and 2009, Israel spent NIS 21 billion (approximately $5.25 billion). In contrast to other social services, the share of the government budget for home care services has increased.

The local professional committees, which include an NII worker, a social worker, and a public health nurse, decide which agencies will engage in provision of health care for specific clients. In contrast to many other countries where nurses provide home care, in Israel personal care is delivered by paraprofessionals, who also perform basic homemaking tasks (most of them are foreign workers).

6. *Number of Beneficiaries, Service Received, and Coverage*

The current scope of the LTCI scheme is indicated by the fact that in March 2009 there were 135,336 LTCI beneficiaries (70% women, and 30% men) – a number more than six times the size of the beneficiary population during the early stages of the program in 1989 (The National Insurance Institute, 1999). Since personal benefits first began to be paid in 1988, there has been a rapid expansion in the number of elderly persons with disabilities who receive LTCI benefits. Not only has the number of beneficiaries outstripped the early projections of the future number of functionally disabled elderly persons who would require care services, but the rate of increase in the number of beneficiaries is also far greater than the rate of increase in the size of both the elderly population in general and the old-old population in particular.

The distribution of beneficiaries is as follows:

- Op to 64 years – 1%
- 65-69 years – 4.8%
- 70-74 years – 10.4%
- 75-79 years – 21%
- 80-84 years – 28%
- 85+ - 32.7%

The family composition is:

- Living alone – 47%
- Living with a partner – 39.8%
- Living with family members (daughter/son) – 13.2%

Veteran Israelis vs. new immigrants

- Veteran Israelis – 75.7%
- New immigrants – 24.3%

Level of benefits

- Low (91%) – 57.4%
- High (150%) – 25%
- Very High (16.8%) – 17.6%

Given the correlation between age (and gender) and functional disability in ADL, the continued high rate of increase in the proportion of old-old among the elderly population will ensure a continuation of the upward trend in the coverage rate.

With regard to the nature of services actually received, almost all (98%) of the LTCI beneficiaries receive personal care services. These are often supplemented by other services. Thus, 12% of the beneficiaries also receive personal alarm units; 7% attend day care centers; 8% receive disposable undergarments; and 0.5% receive laundry services (Zipkin & Morginstin, 1998).

7. *The Burden of Family Caregiving*

There are two aspects of the "burden of care" notion. The first aspect is the financial burden involved in privately purchasing services, and/or in foregoing earnings due to reduction of or total withdrawal from participation in the labor force in order to provide care for an elderly person. The second aspect is the burden borne by primary informal caregivers who provide direct care to an elderly person. The LTCI law has had an interesting effect on the burden of care.

There has been a significant reduction in private purchase of home-care services by elderly persons. Clearly, the LTCI law has reduced the financial burden of

eligible elderly persons with disabilities and their caregivers who, in the absence of the law, may have had no option other than to privately purchase the sorts of home-care services covered by the law or otherwise go without those services. Yet, there has been no decrease in the number of hours of care provided by informal caregivers. That suggests that, in this regard, the law has not been all that helpful. Indeed, a follow-up study of 400 elderly people with disabilities carried out one year after implementation of the law found that primary caregivers provided an average of 23 hours of care per week, compared with 21 hours prior to implementation of the law. Nevertheless, 43% of the primary caregivers reported that their sense of burden had been reduced, "… allowing them to feel that they are not the only ones responsible for the care of their elderly relative, and allowing them to relinquish responsibility for unpleasant (caring) tasks" (Brodsky & Naon, 1993, p. 387).

8. *Impact on Institutionalization*

One of the goals of the LTCI law was to reduce the demand for institutional placement of elderly persons with disabilities who live in the community. To assess whether the introduction of the law achieved this end, Naon and Strosberg (1996) undertook a comparison of patterns of institutionalization before the implementation of the law (in 1987) and afterwards (in 1992).

The study revealed a significant change in these patterns. Thus, the numbers of elderly persons residing in institutions or awaiting admission were 25% less than what would have been expected had the institutionalization pattern prior to implementation of the law remained unchanged. With regard to applicants for institutional placement, those applying for admission after implementation of the law had more severe disabilities, were older, and were more likely to be widowed than those who sought

admission prior to its implementation. Furthermore, after implementation of the law a higher proportion of these applicants either postponed or completely waived their applications within six months of applying. Overall, the services provided under the LTCI scheme permitted those who did not have the most severe disabilities (i.e., frail elderly persons in contrast to those who required nursing care or had mental impairments) to remain in the community and avoid institutionalization.

9. *Organizational and Structural Dilemmas*

9.1 *Service and Structural Dilemmas*

The introduction of quasi-markets in the delivery of human services – contracting out of service to a mixed economy of voluntary nonprofit and proprietary agencies – has typically been driven by considerations of greater economic efficiency, improved quality, enhanced consumer sovereignty, and the desire to reduce the role of the state in the welfare domain. What does Israel's experience of a quasi-market in home-care services for elderly persons with disabilities suggest about the desirability of this approach to service delivery?

The rapid expansion in the number of voluntary and proprietary agencies engaged in supplying home-care services to LTCI beneficiaries indicates that where the existing capacity for service delivery is insufficient, these types of organizations are able to respond quickly to the rapid growth in the demand for personal care services following the introduction of a community long-terms care insurance scheme. This should come as no surprise, since the incentive can be very strong. Thus, the in-kind services funded by the LTCI law created a guaranteed market for the services offered by the voluntary and proprietary agencies (Ajzenstadt & Rosenhek, 2000). Had the direct supply of LTCI services rested in the hands of the public sector, it is highly doubtful that its agencies could have responded so quickly to

the service requirements of the large number of LTCI beneficiaries (Morginstin, 1998). By other criteria of efficiency, however, there is room for some concern. Thus, for example, the profit margin allowed the proprietary agencies necessarily diminishes the overall number of hours of care that the LTCI scheme can deliver.

With regard to the quality of services, the case mix of the voluntary and proprietary providers is fairly similar. As noted, surveys of home-care service providers, elderly clients, and their home-care workers revealed little difference between the types of providers in service quality, although the voluntary NPOs appear to enjoy a small advance. Nevertheless, there may be room for both providers to improve the quality of their services. Quasi-markets, in contrast to services delivered by public agencies, are also justified on the grounds that they are thought to be more responsive to consumer preferences. However, under the provisions of the LTCI law, the entire delivery system, the type and mix of services to be made available to beneficiaries from the service package as well as the service provider are all highly regulated and controlled, and seem to leave little room for the expression of consumer preferences.

9.2 *Easing the Burden of Care*

Israel's LTCI law has substantially reduced the financial burden of caring for elderly members with disabilities. It has not, however, resulted in a reduction of the hours of care provided by informal primary caregivers. At least on the face of it, this is rather surprising. Although there was no expectation that formal services would displace any caregivers exception for those there were most marginal, it was expected that the availability of formal services would decrease the load borne by informal caregivers. This is especially the case in Israel, where women – who provide much of

the informal care received by their disabled elderly husbands and parents living in the community – "enjoy" comparatively high levels of labor force participation.

It has been suggested that the "ethic of care" in Israel – the strong tradition of duty and caring felt by children towards their parents – together with low geographic mobility because of Israel's small size, which facilitates adult children's accessibility to their elderly parents (Cnaan, Olsson, & Wetle, 1990) – may partly account for the persistence of high levels of informal care despite the availability of formal services. However, what may appear to be a shortcoming of the LTCI scheme, raises a more fundamental, broader question regarding the relevance of seeking to ease the temporal aspect of the caregiving burden for schemes that provide home- and community-based care for elderly persons with disabilities.

This is so, because Israel's experience with the LTCI scheme in relation to easing the hours of informal caregiving is by no means unique. There is a growing body of research literature on home- and community-care programs, including the prominent U.S. National Long-Term Care (Channeling) Demonstration during the 1980s), which reports that the amount of formal care does not significantly reduce the informal care received by elderly people with disabilities. A number of explanations have been offered for this phenomenon, including: (1) Despite formal care, many elderly persons have unmet needs that the availability of formal care now permits the informal caregivers to attend to; (2) Although formal services may provide care with some of the same activities of daily living as those that the informal caregiver provides, the informal is enhanced by the formal services (e.g., by sharing some of the physical tasks, by allowing more flexibility in the informal caregiver's time, by sustaining affective bonds between family members through alleviating the stress associated with caregiving and thereby facilitating the ongoing commitment to care,

etc.); and (3) The caring task is so large that modest amounts of informal care do not change the perceived scope of the burden of care.

These explanations suggest that it may not be pertinent to emphasize easing the temporal burden of care borne by all informal caregivers as a goal of community long-term care insurance schemes. Rather, it would seem that the focus should be on formal and informal caregivers to work cooperatively to reduce the unmet needs of elderly persons with disabilities who living in the community.

9.3 *The Fit between Worker and Client*

Although the service itself – that is, the performance of household chores – is quite simple, its success depends on a trusting interpersonal relationship between the workers and the recipient of services, a relationship that occurs outside organizational boundaries. It involves an intrusion into some of the most personal and intimate domains of the client's life.

Moreover, the provision of care is made more difficult by the high degree of variability in the needs of the frail elderly persons and their families. Not surprisingly, home-care workers frequently indicate that one of the most difficult aspects of their work is the unpredictable physical and behavioral problems they encounter. Frequently, the home-care worker intrudes on a complex family relationship, especially between the frail elderly persons and their spouses. This imbues home chores with complex and latent psychosocial ripple effects far beyond the chores themselves.

Unlike institutional care, home care occurs outside organizational boundaries, severely hampering the organization's ability to exercise effective control over it. A home-care organization must ensure that an appropriate and trusting relationship develops between workers and client when the relationship is not readily visible to the

organization. This task is further complicated by the fact that clients are highly dependent on their workers and therefore cannot readily exercise their rights as consumers or effectively monitor their home-care workers. Typically, organizations offering comparable service technologies attempt to control them through professionalization. This is clearly not possible for home-care organizations. Hence, effective management of services hinges on the fit between the home-care worker and the client. One strategy for assuring this fit is for the agency to assume an active matchmaker role; the agency tries to find home-care workers who are compatible with clients in term of work expectations, cultural background, and temperament, and who are sensitive to the emotional needs and physical disabilities of the elderly person. To do so, the agency must invest resources in assessing the capabilities and needs of both the client and the home-care worker. Matchmaking depends on a stable pool of home-care workers, which can best be attained if the workers are full-time employees of the agency. Such a strategy is obviously costly and may not be feasible in the current economy of home care. It does, however, increase the probability of an appropriate, trusting, and effective relationship between worker and client.

An alternative strategy is to shift the responsibility to clients and their families, despite the limitations imposed by communication barriers and inability to give clear expression to thoughts and feelings. Even though clients and their families may lack the capacity to make an informed decision, they are often left to determine which home-care worker is best suited to their needs and how to manage the relationship.

9.4 *The Dilemma of Control of Monitoring*

Because home care requires a carer to function under conditions not readily visible to the organization, providers encounter acute difficulties in controlling and

monitoring their workers. The organization cannot rely solely on its consumers to supplant or complement its own monitoring function. Frail elderly clients become highly dependent on home-care workers and, as such, experience a considerable power disadvantage, which precludes effective control over the behavior and activities of the workers. Clients cannot readily exercise the option to terminate the relationship or to complain about the quality of the service they receive. As noted, some workers may also be reluctant to exercise these options for fear of loss of income. In addition, one of the unique aspects of home-care work is the workers' isolation from coworkers. Thus, they are unable to rely on peers for guidance and support.

Although home-care organizations may promulgate rules and procedures and develop requirements for supervision and reporting, they face the same dilemma experienced by "street-level bureaucracies". That is, the workers are quite removed from the control center of the organization, and the organization is highly dependent on them for the information needed for monitoring. The workers, despite rules and procedures, can exercise considerable discretion in their interaction with clients. Hence, the capacity of the organization to detect deviations from organizational rues is greatly diminished, especially when the client or the worker choose to ignore them. The absence of institutionalized standards and measures of effectiveness or quality reduce the monitoring to such observable behaviors as attendance, reported hours of work, and client complaints.

The inability to measure effectiveness or quality can also be exploited by agencies to the detriment of either the client or the home-care worker. For some organizations, this vacuum serves as a stimulus to reduce the quality and quantity of the services that are due to the client by law. Workers, sometimes with the tacit

understanding of their agencies, may take advantage of their clients' dependence and fail to provide the required number of service hours. Failure to honor the commitment to provide a specified number of service hours, accompanied by fallacious reports on services rendered, enables some providers to reap undeserved profits and some workers to supplement the minimal wages and benefits they receive. The absence of an effective control apparatus in an industry operating at a low margin of profit invites unscrupulous practices.

An effective control system should be coupled with frequent on-site inspections, close supervision, and frequent communication with elderly people and their families. The most common practice is to use clients and their families as monitoring agents to substitute for or to complement the monitoring activities of the provider organization. Indeed, workers are often evaluated by the number and type of complaints received. Such a strategy has the obvious advantage of reducing administrative costs. In opting for this method, however, an agency relies on a reactive monitoring system that, again, shifts to clients at least some of the responsibility for system failures.

9.5 *Unstable Work Force*

Home-care organizations rely almost exclusively on an unskilled, non-nursing, female labor force, which profoundly affects their service delivery systems (60,000 workers). Studies indicate that home-care workers are predominantly women with a low level of education who earn a minimum wage. Most of the women work less than full time, and their earned annual income falls appreciably below the poverty level. There is little job security, few fringe benefits, limits training, and no opportunities for advancement.

Moreover, as most of the home-care workers are women and minorities or foreign workers, they are employed in a "tainted" market in which employers devalue their work and depress their wages because their jobs are female and ethnically stereotyped. The low wages and benefits and the lack of any job security or future career development trap them into a status of economic marginality from which few can escape, unless they leave such jobs.

9.6 *Services in Kind Versus Services in Cash*

There is still a debate regarding this issue, and there is no clear evidence to support the preference of one system over the other.

Conclusion

Like all efforts to improve the human condition, the LTCI scheme suffers from a number of limitations. For example, the scheme is underfunded; it serves only the most highly dependent populations, while those with less severe disabilities must rely on different and far less generous sources for funding of services; and LTCI services are limited both in their nature and scope. However, there is little doubt that after a decade of implementation, Israel's LTCI law represents a huge advance over what was in place prior to its introduction. Large numbers of elderly persons with functional disabilities who live in the community are receiving benefits; the scheme is broadly target efficient; the financial burden of the private purchase of home-care services has been substantially eased; there has been a significant change in the pattern of institutionalization; and the legislation has spawned a veritable explosion in the number of service provider agencies. The LTCI law has been central in creating a "caring community" for the growing population of disabled elderly persons in Israel. Yet, there is a need to stabilize the home-care industry. Toward that end, the

government has taken some measures – including an act that forced the nongovernmental agencies to improve the working conditions of the home care workers (paying fringe benefits such as health insurance, paid vacations, sick leave, etc.). The government also adopted some measures, including minimal requirements for training workers, professional credentials of supervisors, and frequency that the agency monitors workers.

There is a need to integrate home care with other services for the elderly. Home care services benefit from links with other services, and they become elevated in importance. Concomitantly, there is a need to increase the level of professionalization (e.g., social work, gerontology, and nursing) among the executives and middle managers of home care agencies. Instilling professional norms and ideologies throughout the organization is an important mechanism to ensure protection of the clients' well-being.

There also needs to be a considerable improvement in training of home car workers, and in the development of opportunities for advancement such as entry into monitoring and supervisory roles. This further highlights the importance of integrating home care with other services. Finally, to the extent possible, elderly persons and their families must become active participants in the decisions and monitoring of the home care services. Home care agencies should be given incentives to orient elderly persons and their families to the services they are entitled to, and to engage them in the service delivery system.