Box 8.1

**The National Long-Term Care Program**

In January 2018, the government approved a reform of public long-term care (LTC) insurance for the elderly – the National Long-Term Care Program. The cost of the plan is about NIS 1.4 billion annually[[1]](#footnote-1) (Table 8-1) and when fully implemented—in 2021—it will increase public expenditure on LTC by about 20 percent relative to 2015. The reform includes several important elements and its implementation will improve service to the citizen and reduce the burden of expenditure on some of the households with an elderly LTC member. However, the program does not deal with all of the problems of long-term health care services in Israel nor does it include long-term planning. This box will briefly present the economic and institutional background to the reform and a survey of its components and their implications, as well as examining the issues that it neglects.

Table 1

Components of the National Long-Term Care Program, their implications and the budget allocated to them1

|  |  |
| --- | --- |
| Description | Addition to the budget |
| The size of the LTC benefit will be divided into 6 levels (as opposed to 3 today) and public funding will be increased, particularly for those with multiple needs. The new mechanism will streamline the provision of the benefit since it will create a better alignment between the value of the public service and the financing needs.  | NIS 500 million on full implementation in 2021.  |
| The basket of services included in the benefit will be broadened and additional services in the community will be developed.  | NIS 100 million on full implementation in 2021. |
| A workgroup will be established to reduce the bureaucracy that the elderly and their families have to deal with and a new function of care coordinator will be created who will assist in the full realization of rights.  | There is no budget source for this component. |
| The quality of home care will be improved by increasing the budgets for supervision of home care services and for the training of LTC workers in the community.  | NIS 335 million on full implementation in 2021. |
| Care in geriatric hospitals will be upgraded by improving the working conditions of the caregivers.  | NIS 45 million starting from 2019. |
| The mechanism that requires the patient's children to participate in the cost of hospital care for their parents will be cancelled. This measure will reduce the cost burden borne by the families and will increase the State's subsidization. | NIS 400 million on full implementation in 2021.  |
| Rehabilitation in the community, which is meant to prevent the decline in the patient's situation, will be broadened. | NIS 100 million on full implementation in 2020.  |

1 In addition, the reform allocates NIS 400 million annually to enlarge the basket of dental care treatments for the elderly. However, since this component does not relate only to LTC patients, we did not include it in the table.

Source: Government Decision 3379 of January 11th, 2016.

**Economic and institutional background to the LTC insurance reform[[2]](#footnote-2)**

The population in Israel is aging, as is the case in other developed countries. This process is expected to accelerate in the future and will increase the proportion of the very elderly in the population (Figure 8.1). The probability of requiring LTC increases rapidly with age. According to Bank of Israel estimates, in 2015 about one-third of the 65+ age group,[[3]](#footnote-3) 64 percent of the 80+ age group and 88 percent of the 90+ age group required LTC. Since the elderly population is expected to grow in the future and since is it is reasonable to assume that the proportion of LTC patients among them will not decline significantly, there is no reason to believe that the LTC population will not grow accordingly.

Figure 1

**The proportion of the 65+ and 80+ age groups in the population; 2015 and forecasted**

Source: Central Bureau of Statistics (2017), *Forecast of Israel's Population up to 2065*

The national expenditure (both private and public) on LTC services in 2015 stood at NIS 14.5 billion, or about 1.2 percent of GDP, which includes only an estimate of the expenditure on care provided for payment (formal services).[[4]](#footnote-4) The public expenditure stood at about one-half of the national expenditure. Relative to the OECD, this is a low level of expenditure, even if one takes account of the fact that the population in Israel is younger. However, in view of the large variation between countries and the level of GDP in Israel, the level of expenditure in Israel is not especially low.

The elderly in long-term care in Israel generally receive care in the community (in their homes or in sheltered housing). A minority of about 15 percent are hospitalized in LTC institutions (Figure 8.2). The main public services in the community are under the responsibility of the National Insurance Institute and the main public services in geriatric institutions are under the responsibility of the Ministry of Health.[[5]](#footnote-5) These bodies determine the policy for the supply of services under their responsibility and oversee their provision. The significant decline in the tendency to hospitalize the elderly who are in need of LTC is the result of two factors: First, the public and the professional community feel that care in the community is more beneficial for the elderly since it is provided in the home and close to their families and social environment. Second, the cost of hospitalization is high for those who are not eligible for state support.

The expansion during the last decade in LTC services in the community is manifested in the rapid growth in the number of those eligible for LTC benefits from the National Insurance Institute (without there having been any easing of eligibility conditions) and the growth in the number of homecare givers, both Israeli and foreign. During some of the period, the number of homecare givers grew more rapidly than the number of elderly (75+), although during the last four years the rates of growth have been similar. In this context, it should be mentioned that in addition to the aging of the population, other factors have contributed to this growth, some of which are social, such as: (1) the drop in the proportion of family members caring for an elderly individual in the home due to the increased labor force participation rate among women, particularly older women; and (2) the increase in household income, some of which was directed to the purchase of services.

According to the National Insurance Institute, about one-quarter of the elderly LTC patients in the community in 2015 were completely dependent on assistance from a caregiver and were in need of supervision and assistance around the clock.[[6]](#footnote-6) The rest were more independent though they were also in need of assistance in carrying out day-to-day activities, at least during part of the day. The elderly in need of LTC in the community (both those who are eligible according to the LTC Law and those that are not) were cared for in that year by about 80 thousand Israeli caregivers and about 50 thousand foreign ones. The foreign caregivers are employed in households on a fulltime basis and usually care for only one elderly patient. The Israeli caregivers are employed part-time and usually take care of several elderly patients and rotate between their homes.

Figure 2

**LTC patients among the 65+ age group: Breakdown by place of care (in the community or in an institution) and according to eligibility for public assistance in the financing of LTC, 2015**

Source: The National Insurance Institute, the Ministry of Health and Bank of Israel calculations.

The eligibility for public financing of LTC in the community is based on the level of the patient's functioning and the amount of the benefit is also dependent on a means test. Elderly individuals whose income is higher than the lower threshold are eligible for only one-half of the benefit and those whose income is higher than the upper threshold are not eligible at all. About 24 percent of the elderly in need of LTC in 2015 did not receive any financial assistance from the National Insurance Institute because their income exceeded the upper threshold. About 82 percent of the elderly in need of LTC that lived in the community (71 percent of all the elderly in need of LTC) were eligible for some financial assistance to pay for their care. Most of the assistance is provided as services (in kind) rather than as a financial benefit, according to one of three levels of payment. The lowest level finances 9.75 weekly hours of care and about one-half of the eligible individuals were in this category. The highest level finances 18 weekly hours of care,[[7]](#footnote-7) and the elderly individuals eligible for it are dependent on financial assistance or they need round-the-clock supervision.

Among the elderly hospitalized in geriatric institutions, only 46 percent receive any financial support from the State to pay for the hospitalization (according to a Ministry of Health key)[[8]](#footnote-8) and the monthly costs they bear range from NIS 750 to about NIS 12.9 thousand (the latter figure is equal to the amount paid by the Ministry of Health for hospitalization). The size of the out-of-pocket payment is also affected by the income level of the LTC patient and of his children. Since public insurance provides low-income LTC patients with more generous coverage in geriatric institutions, they have an incentive to prefer hospitalization in an institution over care in the community, even when that is not their care preference.

Table 2

**An estimate of the number of holders of private LTC insurance in the form of supplementary insurance from the healthcare funds and other private frameworks, according to income tertiles, 20151**

**1** The data relates to the entire adult population surveyed in the Social Survey.

Source: The Social Survey for 2010 carried out by the Central Bureau of Statistics and data of the Capital Market Authority regarding the holding of group and individual insurance in 2015.

The ability of households to finance LTC services is dependent on several factors: the cost of the LTC services; the scope of LTC care and its duration; the elderly individual's income and assets; the eligibility for public insurance; and the possession of private LTC insurance. In order to determine the ability of elderly individuals to finance LTC services in the community, given that the public services exist, we compared the costs of LTC service to the net income of households according to net income deciles, on the assumption that the expenditure on personal LTC in the community totals about NIS 8000 per month.[[9]](#footnote-9) The simulations that we carried out related to full dependence (elderly patients who are in need of assistance or supervision around the clock),[[10]](#footnote-10) and are based on data from the Survey of Household Expenditure.

We found that care in the community places a heavy financial burden on the elderly patient's household and for a significant proportion of the population the costs involved exceed net income. Many of the elderly in need of LTC will find it difficult to finance care on their own in the absence of savings or other sources of income, such as income from capital or from property, transfers from other households or designated insurance.[[11]](#footnote-11) The financial burden can be met, whether wholly or partially, by means of private LTC insurance of the type marketed by the healthcare funds as supplementary insurance, when the beneficiary meets the functionality criterion for activating the insurance. This conclusion also applies to the elderly in the lowest income decile. However, households in the lower income tertile possess very little of this type of insurance relative to households in the upper tertile (Table 8.2).

**The National Long-Term Care Program: the planned reform of the LTC sector in 2018-21**

The government approved the National Long-Term Care Program in January 2018 and its implementation and final details are subject to the approval of the Knesset. The program is based on a deepening of the existing array of services and their financing by the public system, as opposed to the alternative that includes development of a private insurance system that includes the option of partial public funding.[[12]](#footnote-12) The components of the reform are described in Table 8.1 and they involve a not insignificant increase in the budget for public LTC insurance and they introduce some welcome changes into the system. However, the reform neglects some of the lacunae in the LTC insurance system and in other cases deals with them only partially. For some of its components, it is unclear what action is planned and whether the budget increases are in line with the targets – transparency should be increased in these cases.

In what follows, we present the main issues that do not receive attention in the components of the reform that were approved:

1. **A long-term view of the trend in the demand for LTC services for the elderly and its internalization in the planning of the system of public and private services:** The reform relates to the current problems in the system but does not discuss the steps needed in order to deal with the growth in public expenditure that will be required in view of demographic and economic trends. It is important that the government estimate the public cost and determine the policy measures needed to maintain a reasonable level of services in the future, based on the demographic and economic forecasts.[[13]](#footnote-13) Furthermore, there is currently no single government unit that is taking a leading role in planning in this sector for the short or the long term, which includes the supply of public and private services, their quality and their financing; the formulation of policy regarding manpower in the sector; and the assimilation of technological developments and innovation in general.
2. **The LTC burden on households:** The National Long-Term Care Program significantly reduces the burden of expenditure on LTC services for households with a highly dependent elderly member. Thus, their LTC benefit (in terms of service units) will grow by 36 to 44 percent[[14]](#footnote-14) and the value of the increase will be calculated according to the level of the benefit that they are eligible for after the reform. This significant increase will improve the ability of the aforementioned households to finance LTC services. The reform is not expected to improve the ability of elderly patients at low to intermediate levels of dependence to finance LTC.[[15]](#footnote-15) Figure 8.3 presents a simulation of disposable income after the deduction of expenses for LTC currently and after the full implementation of the reform. It focuses on LTC patients at the highest level of dependence and divides them according to income deciles. The graph shows that although the implementation of the reform will ameliorate the problem of financing LTC, in the lower part of the income distribution the problem will remain severe. The problem of financing LTC expenditure is even more serious among the elderly that live on their own and among those that do not own a home or do not have capital income. The need to implement further measures that will ensure the ability of households to finance LTC, such as, for example, measures that encourage them to purchase private LTC insurance or to open a designated savings plan.

Figure 3

**The breakdown of the 75+ age group according to net income deciles1 (2015) and disposable income net of LTC expenditure, currently and after the reform2**

1 The income deciles are determined according to standardized income per capita in the general population.

2The simulation focuses on the elderly who are eligible for the highest level of assistance. It assumes that the elderly at the two highest levels of dependence after the reform (levels 5-6) and the highest level of dependence prior to the reform (total dependence) are in need of assistance or supervision around the clock and therefore they spend NIS 8000 on long-term care.

Source: Bank of Israel processing of data from the Survey of Expenditure carried out by the Central Bureau of Statistics.

1. **Home care – supervision, training, professional support and regulation of labor relations:** Long-term care is labor-intensive and it is reasonable to assume that its efficiency will improve only slowly unless there is major technological improvement. Many of the caregivers in the household LTC sector do not receive any training or professional instruction, since the State demands this of only one-third of them. The caregivers are caring for patients with serious health problems; their work is physically and mentally strenuous and requires a high level of responsibility, reliability and compassion. Furthermore, they do not belong to an organized social-professional network. The foreign caregivers sometimes do not enjoy work and living conditions that provide them with privacy and the gaps in culture and language are liable to be a problem both for the caregiver and the patient. In these situations, an uncomfortable relationship often develops between the caregiver and the patient and his family. Without appropriate training and professional guidance, the accumulation of problems is liable to harm the functioning of the caregivers and increase the chances of them developing compassion fatigue and becoming physically, emotionally and mentally exhausted. This is liable to affect the quality of their work and the quality of their lives and as a result the quality of life of the patients.[[16]](#footnote-16)

The State Comptroller has pointed to the deficiencies in the mechanism for supervising the care provided by home caregivers in the community.[[17]](#footnote-17) The State Comptroller devoted a major portion of his criticism to phenomena such as care hours that are not actually provided, deficient labor norms and insufficient supervision. Mechanisms are needed that will ensure the provision of LTC hours and will regulate the work relations between the caregiver and the patient, as well as enforcing the basic standards for reasonable care of elderly LTC patients and for the training of caregivers and professional guidance provided to them in their work. It may even be necessary to create salary scales that vary according to the caregiver's level of training and the complexity of his work. Although the National Long-Term Care Program relates to some of these issues, it is unclear what it will include, how the budget will be allocated and what will be the oversight mechanism to ensure that targets are met.

1. **Manpower and supervision in the geriatric institutions:** The reform in the LTC sector needs to determine the allocation of manpower to the LTC institutions, the mechanisms for supervision of their workers and the care they provide and the character of their instruction and training. In addition, it would be worthwhile defining transparent measures to determine whether targets are being met.
2. **Issues related to private LTC insurance:** The National Long-Term Care Program does not relate to issues connected to private LTC insurance. The private insurance policies do not ensure sufficient coverage when the need arises, since they are characterized by under-insurance. This is due to two factors: First the insurance companies link premiums on policies purchased for a future period to the CPI, but the cost of LTC services increases at a higher rate since they are based on the cost of manpower (salaries). This is liable to erode the value of the insurance, particularly for the young who purchase insurance for their old age. Second, most of the LTC policies pay out for a period of at most five years, even though an individual can be in an LTC situation for a longer period. Finally, some of the population does not purchase private insurance, such as those suffering from chronic health problems.
3. **Ensuring the full realization of rights in the system and in particular after the reform since it encourages the elderly to shift from in-kind services (the situation today) to services in money.** The shift to a benefit in money is liable to increase the bureaucratic burden involved in the acquisition of nursing services, particularly among elderly LTC patients at low levels of dependence, and the full realization of rights in the system should be ensured following the reform.
1. Government Decision 3379 of January 22th, 2018. In addition, the government decided that as part of the reform NIS 400 million per year would be added to the dental care basket for the elderly, whether or not they are LTC patients. [↑](#footnote-ref-1)
2. We present only a summary of the institutional and economic background to the reform. Further details can be found in Kahan-Kovech, C., M. Haran-Rozen and T. Ramot-Niska (awaiting publication), "LTC insurance in Israel", Bank of Israel. Most of the data relate to 2015, the year to which the aforementioned policy paper relates and for which we obtained the most data. Additional background to the reform can be found in Ministry of Health (2011), "Public long-term care insurance: a plan for reform". [↑](#footnote-ref-2)
3. An individual is considered to be in need of LTC when his day-to-day activities are dependent to a large extent on other people and the dependence is a result of a chronic illness or permanent disability. We include in the definition also the mentally frail, i.e. elderly individuals who are able to walk on their own but their functioning suffers from loss of memory, inability to navigate or lack of judgement and as a result they are in need of supervision and assistance in day-to-day activities. The dependence level of the elderly is determined by means of a test that quantifies the extent to which they are able to carry out day-to-day activities (ADL – Activities of Daily Living). [↑](#footnote-ref-3)
4. We did not take into account the economic price of care that is provided by family members (including the loss of income and output) and the households' expenditure on LTC insurance. [↑](#footnote-ref-4)
5. In addition, there are government bodies with secondary functions, such as the healthcare funds, the municipalities, the Ministry of Welfare and the Ministry of the Interior (the Population Authority). The latter is responsible for providing permits to employ foreign workers and they are also considered to be public support. [↑](#footnote-ref-5)
6. We do not have data on the level of dependence among the elderly in general. Therefore, we assume that the proportion of those in need of round-the-clock assistance in this population is identical to their proportion of those eligible for the LTC benefit. [↑](#footnote-ref-6)
7. The patients receive all, half or none of the hours, according to their household income. If individuals at intermediate and high levels of dependence choose to employ an Israeli worker rather than a foreign one, their benefit is increased by about 20 percent. [↑](#footnote-ref-7)
8. The Ministry of Health issues a tender for LTC hospitalization services, but its maximal price is lower than the market price of LTC hospitalization. The number of hospital beds in the closed tender is the number of beds that will be offered to the elderly LTC patients who are found to be eligible for hospitalization based on their level of functionality. If the elderly patients and their families request this service, they must pass a means test and based on its results they will pay an amount that ranges from a minimal out-of-pocket amount (NIS 750 monthly) to the amount (determined by the key) which the Ministry of Health pays to the geriatric hospital institutions as part of the tender (NIS 12,900 monthly). [↑](#footnote-ref-8)
9. This amount includes the cost of employing a caregiver on the assumption that the family members fill in for him on his days off and also the cost of equipment and services required for the elderly patient to function (such as transportation, mobility devices, drugs and diapers). The amount does not include normal living expenses. It is possible that this amount is an underestimate. [↑](#footnote-ref-9)
10. Research recently carried out by the OECD took a similar approach in order to determine the accessibility of LTC services in 14 of its members and/or members of the EU. See OECD, "Measuring Social Protection for Long Term Care", (2017), Muir, T., Health Working Paper, no. 93. [↑](#footnote-ref-10)
11. On the basis of the Survey of Expenditure carried out by the Central Bureau of Statistics, we estimate that 16 percent of the 45+ age group do not own a home and do not have private LTC insurance and that below the median income this figure rises to 28 percent. [↑](#footnote-ref-11)
12. A comparison of public and private insurance schemes and an analysis of the justification of state intervention in LTC insurance can be found in Kahan-Kovech, G., M. Haran-Rozen and T. Ramot-Niska (awaiting publication), "LTC insurance in Israel", Bank of Israel. [Hebrew] [↑](#footnote-ref-12)
13. The Bank of Israel prepared a forecast of LTC expenditure in Israel for the long term. The growth in the elderly population and in the cost of LTC services is expected to raise expenditure in any reasonable scenario. However, there is uncertainty with regard to a number of central parameters: (1) the extent of the expected drop in the proportion of those in need of LTC in each age group as life expectancy increases; (2) the price elasticity of demand for LTC services; and (3) the elasticity of the supply of informal care with respect to the price of LTC services. Therefore, the range of the forecast is relatively wide. In the more moderate scenario, expenditure will increase from 1.2 percent of GDP in 2015 to 1.3 percent in 2030 and 1.4 percent in 2045. In the more extreme scenario, expenditure will grow to 2.1 percent of GDP in 2030 and 3.2 percent of GDP in 2045 (further details appear in Kahan-Kovech et al. [awaiting publication]). [↑](#footnote-ref-13)
14. Currently, they are eligible for 18 (22) units of service if they employ a foreign (Israeli) worker and the reform will increase their eligibility to 26 and 30 units respectively. [↑](#footnote-ref-14)
15. The reform will not harm the eligibility of elderly patients who are already in the system. [↑](#footnote-ref-15)
16. See, for example, Pardes, A. and Y. Ben Nun (2014), "Compassion fatigue: manifestations, risk factors, prevention and treatment," *Gerontology and Geriatrics*, Vol. 41, no. 1. [Hebrew] [↑](#footnote-ref-16)
17. State Comptroller (2017), "State care of elderly LTC patients at home: special report". [Hebrew] [↑](#footnote-ref-17)