

Policy Paper

Long-Term Care in Israel: Funding and Organization Issues

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and Jochanan Stessman**

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Abstract

Israel's population is aging quickly; the share of seniors in the population, especially those aged 70 and over, is projected to double by 2035. Due to this, functional impairment – which is naturally higher among the elderly – is expected to rise 16 percent faster than growth in Israel's population. This will increase the need for in-home as well as institutional long-term care. The changing ratio between age-groups – more people aged 70 and over, in relation to those aged 15-69 – is expected to increase the long-term care challenge as well as the burden on households and on the economy as a whole.

This paper discusses the main challenges currently facing long-term care in Israel: (A) the lack of universal coverage; (B) the multiplicity of authorities charged with overseeing and managing the sector; and (C) the lack of preparation for the changing demographics of the future. This paper also looks at current Israeli government proposals for regulating the field, and points out the inconsistencies and weaknesses in those proposals.

International comparison indicates that the share of private funding out of total long-term care expenditure in Israel is particularly high, reaching nearly 50 percent – more than three times the average share of OECD countries. This extensive reliance on households leads to inequality between families at different income levels, and points to systemic inefficiency and a lack of sustainability in the long term. Based on international experience, the paper proposes reform based on universal entitlement to a basic long-term care basket of benefits, financed by taxes and other earmarked mandatory contributions, to be overseen by a single authority.

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Introduction

Issues related to long-term care often come up in public debate, as they pose many challenges to Israel's society and economy (Horev, Kaidar and Hershkovitz, 2011; Chernichovsky and Kore, 2009; Chernichovsky, Koreh, Soffer, and Avrami, 2010). Recently, there has been much discussion of the funding aspects of long-term care, spurred by two rather contradictory governmental initiatives. On the one hand, the Ministry of Finance proposes to make prevailing long-term care insurance — much of which consists of plans based community rated premiums that are sold through health funds (HMOs) and workplaces — into insurance that is based to a much greater degree on personally rated premiums. The Ministry of Health, on the other hand, seeks to make long-term care insurance more publicly-oriented: to institute universal insurance for institutional care by raising the health tax, and moving budget implementation to the health funds. This proposal is also meant to eliminate means testing for state-subsidized institutional care. Thus, the first proposal is meant to advance personally-tailored insurance, reducing the potential for cross-subsidies where stronger groups (young people and people with higher incomes) subsidize weaker groups (older citizens and low-income people). The second proposal would operate in the opposite direction by reducing family responsibility for funding long-term care, and cancelling the means test.

The impact of these conflicting proposals transcends funding issues. The plans leave some major questions almost entirely unanswered regarding insurance eligibility and service management and organization: Will long-term care be government-funded and encompass all of Israel's state supported long-term care services — those currently under the authority of the National Insurance Institute, government ministries, health funds, and other public entities? What should be the areas of responsibility of various institutions with regard to funding, management and care provision, and for what should households be responsible? Should long-term care be a medically based endeavor or one separate from the health care system?

This paper intends to examine the funding and implementation of long-term care within Israel, as well as in international comparison, and to offer new approaches and solutions beyond those already raised by the government. Sections 1 and 2 lay out the conceptual foundations for the topic; in particular, they clarify the functions included in the system and the sources of funding for long-term care. This is followed by an international comparison in Section 3, and a discussion of the main challenges that Israel is expected to face over the next 20 years, in Section 4. Against this background,

Section 5 will present methods by which a number of other countries have addressed similar challenges. The final section will offer possible guidelines for reform in the long-term care sphere.

1. Long-term care

Long-term care is defined as assistance to people of all ages suffering from long-term disability who need functional, mental or social assistance for activities of daily living. Such assistance includes support for healthy behavior and access to medical care, to prevent or delay, insofar as possible, additional deterioration in health and functioning.

Naturally, there is a very high correlation between old age and the need for long-term care. Aging, especially beyond age 75, brings with it increased disease and a worsening of pre-existing morbidity. At these old ages new diseases -- some of them chronic -- appear, particularly conditions that do not affect younger people and that feature cognitive decline and sensory impairment. Morbidity outcomes are reflected in declining functional status and in the loss of independent living, which in turn lead to greater need for long-term hospitalization in appropriate institutions or for round-the-clock care at home (Stessman, 2011).

Basic concepts: funding, provision, organization and management

The long-term care system (like all social service systems, especially in the healthcare sphere) comprises several basic functions. Chernichovsky (1995; 2002) has proposed a clear distinction between three health system functions:

1. Funding: out-of-pocket, insurance, or public funding
2. Service provision: provision of care
3. Organization and management of service use: fund-holding

Of the three functions, the third merits elaboration since it is relevant to the discussion and often goes unrecognized. The fund-holder is an institution or organization that receives a publicly-funded budget or that collects funds on the state's behalf, organizes service arrangements and

networks, and contracts with providers — all in order to ensure that public entitlement to medical care is met in an orderly and efficient manner. Healthcare budget holders can be health funds/HMOs, as in Germany and Israel, or governmental bodies other than the ministries, such as the British National Health Service. The model in which health funds are the budget holders is known as “managed competition,” while the other is called the “non-competitive model.”

Budget holding can be integrated with funding functions (supplemental insurance, for example). However, the budget holder need not also be the service provider.¹ In most countries — including Germany and the UK, which have two distinct fund-holding systems — service provision is not the budget holders’ responsibility; rather, it is its responsibility to oversee and coordinate the service provision by independent providers it contracts. Several countries have actually prohibited organizational integration of fund-holding and provision, to ensure that the budget holder sees to the interests of clients or patients and not of service providers.

Projected increase in the need for long-term care in Israel

Israel’s population forecasts through 2035 point to continued and intensified aging (Figure 1). According to the forecasts, the 70 and over population will increase by 103 percent, versus a 31 percent increase for the rest of the population. That is, the 70 and over age group is expected to double over the course of two decades, from about 610,000 today to about 1.24 million in 2035.

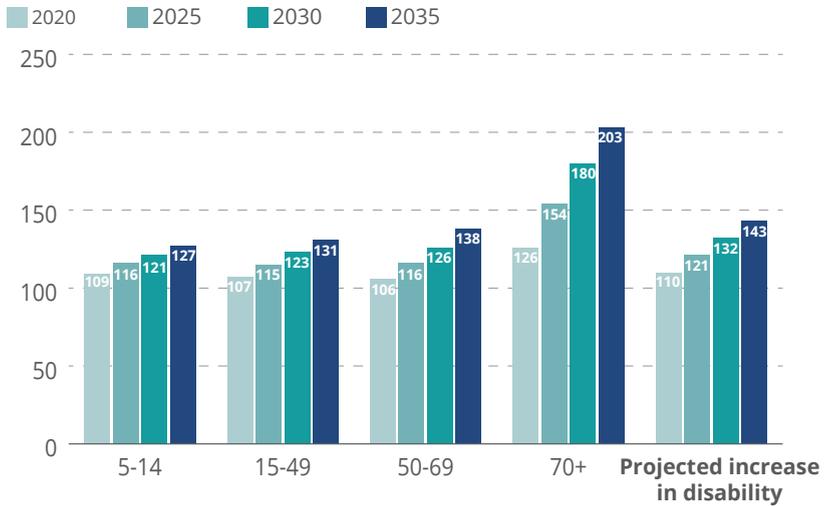
On the assumption that there will be no substantial improvement in the functional status of those aged 70 and over,² the demographic process will be accompanied by a 43 percent rise in of the functional impairment index, part of the morbidity burden. Based on the data presented in Figure 2, the senior population’s contribution to total functional impairment will rise from 16 percent in 2015 to 23 percent in 2035.

Thus, an anticipated population growth of 1.5 percent per year, and a 1.8 percent annual rise in the functional impairment index, will be basic features of Israeli society and its economy over the next 20 years. In other words, the growth rate of functional impairment — and, therefore, of long-term care and healthcare needs — will be 16 percent higher per year than the rate of population growth. Although this is a welcome change that reflects improved longevity, it nevertheless emphasizes the need for further preparation on the part of the long-term care and healthcare systems.

1 The Israeli example of this kind of arrangement is Maccabi Healthcare Services, which provides most of its services through agreements with independent providers who work at facilities not owned by the fund but by the providers themselves.

2 Should there be functional improvement due, for instance, to technological advances in medicine, the rise in functional impairment would then be delayed to an older age.

Figure 1. Projected rates of increase, different age groups and total functional impairment-adjusted life years relative to 2015



The calculations are based on projections for the “middle option.”

Source: Dov Chernichovsky, Taub Center. Data: Central Bureau of Statistics, Projections of Israel’s Population until 2035, Table 10.

Compared with the developed world, Israel is relatively young (despite its faster rate of population aging), and the current share of those aged 65 and over in the country’s population is expected to reach that of the OECD countries only in 2040. This being the case, Israel can learn from the experience of these countries with regard to the funding and organization of long-term care.

Types of state-assisted long-term care in Israel

From an institutional-organizational perspective, Israel’s long-term care system can be divided into four basic types of care:

1. **Home or community-based medical care.** This encompasses the care provided in public frameworks, at clinics of the health funds. This assistance is not specific to the elderly although they need it to a greater degree, due to the chronic conditions that arise with old age.

- 2. Functional assistance in the community or home-based long-term care.** The purpose of home-based long-term care is to help the elderly with impaired function to carry out activities of daily living in their homes. The assistance is provided by long-term caregivers, and does not include the aforementioned medical services provided by the health funds, at times provided in the home. Funding for home-based long-term care is currently granted by the National Insurance Institute on the basis of dependency assessments, and the service is provided by long-term care companies (and, in part, by foreign caregivers). Such assistance is provided to 20 percent of the over-65 population, in the form of 10-20 weekly hours of care per recipient.
- 3. Functional assistance in institutional settings – assisted living³.** A housing or inpatient care. Arrangements for patients confined to a bed or wheelchair due to illness or accident, and who usually also suffer from impairments in one or more activities of daily living (washing, incontinence, dressing, independent eating) and other fine-motor activities. This type of care also encompasses hospitalization of the “mentally frail:” patients suffering from Alzheimer’s disease or dementia. This care is subsidized differentially from the Ministry of Health budget, on the basis of a means test for the patient and his/her children as well as the use of any private long-term care insurance held by the patient.⁴ This functional category also includes institutional care of individuals categorized as “frail,” under the auspices of the Senior Citizen's Service in the Ministry of Labor and Social Affairs. This category includes older individuals who have trouble with two or more activities of daily living in their homes, and who also suffer from social problems. Those who fall into this category are hospitalized in institutional frameworks that mainly provide assistance in activities of daily living, with a limited degree of medical and nursing care. The funding for these institutions comes from the Ministry of Welfare and Social Services budget and from local authorities.
- 4. Inpatient complex nursing care.** This form of hospitalization is for patients classified as seriously ill who, in addition to their long-term care status, also suffer from complex medical problems, such as end-stage kidney disease, the need for partial or full ventilation, patients with stage 3-4 pressure sores, or terminal disease. The responsibility

³ The term “assisted living” is exceedingly broad and encompasses an array of housing types, from the institutional arrangements described here to housing for seniors who function independently but have chosen to live in settings with physical and social infrastructures that aid them in everyday life. The arrangements described here are referred to as “non-complex inpatient care.”

⁴ The process of determining eligibility is known as the “coding system.”

for, and funding of, complex inpatient nursing care lies with the health funds, with a 10 percent copayment by patients or their families according to ability to pay. Such patients are hospitalized only in special departments licensed for complex nursing care.

It is often a thin and undefined line that separates medical and functional assistance. Generally speaking, the tendency is to leave patients in their homes (community care), with the primary task of long-term care defined as practical, mental and social assistance in functioning, with limited medical intervention. In other words, the tendency is to minimize, to the extent possible, the medical aspect of long-term care, while expanding the social aspect. Thus, the healthcare and long-term care systems are commonly viewed as separate branches of social insurance. Among the developed nations, only Belgium has a degree of funding and operational linkage between long-term and medical care (Francesca, Ana, Jérôme, and Fritz, 2011).

Table 1 provides detailed information on the types of long-term care noted above, broken down by the aforementioned functions. This comparison highlights the division in responsibility between various government and public agencies, a topic about which much has already been written (Chernichovsky and Kore, 2009).

The aforementioned fund-holding/coordinating function is of particular importance for long-term care since a multitude of state agencies are involved in the care system and older people often “shuttle” from one to another, depending on changes in their conditions. In such situations, the lack of appropriate and comprehensive professional management may compromise the quality of care, cause the patient’s status to deteriorate, and, of course, increase the suffering of the patient and the patient’s family. This being the case, responsibility for the organization and management of long-term care is a topic of major importance to the present discussion (Table 1].

Table 1. Types of public long-term care**By the authority responsible for financing, fund-holding and service provision**

Type of care	Financing	Fund-holding	Main service provider
Community-based medical care	State (through the National Insurance Institute)	Health funds	Health funds and independent service providers (primarily in the smaller funds)
Home-based nursing care	National Insurance Institute (through Long-Term Care Law)	Individual/household	Private companies - local and foreign workers
Assisted living	State (through the Ministry of Health and the Ministry of Labor and Social Affairs)	Primarily households and inpatient institutions, and to a lesser extent, the Ministry of Health and the Ministry of Labor and Social Affairs	Private companies
Inpatient complex nursing case	State (through the National Insurance Institute)	Health funds	Health funds and independent service providers (primarily in the smaller funds)

Notes: The table details public agencies only, although households participate in one way or another in the financing of all types of care. The table details public agencies only, although households participate in one way or another in the financing of all types of care.

Source: Chernichovsky, Kaplan, Regev, and Stessman, Taub Center

2. Funding of long-term care

As noted, funding for long-term care in Israel comes from several different sources. Table 2 gives provides a financing picture for the various types of care, alongside estimates of the cost of care and distribution among the different types. The basic division is between public and private funding.

Public funding is used for three main types of care: individual home-care, assisted living and inpatient complex nursing care.⁵ The National Insurance Institute is the primary public funder of home-based long-term care services. It subsidizes the care of 160,000 seniors at a cost of NIS 5.31 billion, amounting to 64 percent of the total public funding for long-term care, with the remainder funded by households.⁶ The Ministry of Health (through the “codes”) and the Ministry of Welfare and Social Services are the public funders of assisted living for 14,000 seniors, at a cost of NIS 2.1 billion (26 percent of total public funding). The state (the National Insurance Institute), through the health funds, finances complex nursing care for 1,597 seniors at a cost of NIS 891 million, constituting 10 percent of total public funding. Total public funding in 2014 is estimated at NIS 8.3 billion — 55 percent of the total national expenditure on long-term care.

Private funding is used for three main types of care: individual home-based care (supplementing public funding), assisted living and net private insurance premiums (i.e., after reductions of insurance company payments for care and hospitalization). Israeli households spend NIS 2.6 billion per year on foreign caregivers who provide individual care to 44,000 older individuals. The share of this expenditure amounted to 39 percent of the total private expenditure on long-term care. Moreover, Israeli households spend NIS 2.52 billion per year (37 percent of total private spending) on assisted living.

5 The cost of home-based medical care is not included in the table since it is not specific to seniors.

6 At the time of writing this report 1 NIS = 0.27 US\$.

Table 2. Estimates for the financing of long-term care, 2014
By the type of care and the financing authority

Type of care	Principal funder	Estimate of the number of those in care or in patient beds	Cost estimate (NIS billions)	Percent out of total expenditure	Notes
Public services					
Individual home-based care	National Insurance Institute	157,846 receiving care	5.31	35%	Estimates of those entitled includes only those receiving care without additional home-based services provided by the Ministry of Labor and Social Welfare (such as day care centers for the elderly) or the health funds (such as outpatient care)
Assisted living	Ministry of Health, Ministry of Labor and Social Welfare	About 14,000 beds	2.10	14%	Calculated on the basis of the budget of the Ministry of Health for nursing care (services for care, actual expenditure) + expenditures of the Ministry of Labor and Social Welfare for nursing care
Inpatient complex care	State	About 1,597 beds	0.89	6%	Calculated on the basis of the number of beds 365 days at a cost of NIS 1,550 per hospitalization day in a unit for complex nursing care in a general hospital
Total public financing			8.30	55%	

Type of care	Principal funder	Estimate of the number of those in care or in patient beds	Cost estimate (NIS billions)	Percent out of total expenditure	Notes
Private services					
Individual community based care	Households	43,468 in care (on the assumption that each authorized caregiver is caring for only one person)	2.61	17%	Calculated on the basis of the number of work permits in nursing care (as of 2014), at a cost of NIS 5,000 per month per household
Assisted living	Households	About 15,000 beds	2.52	17%	Calculated by the average cost of assisted living; NIS 14,000 per month
Individual net insurance premiums, after payments for hospitalization	Households	About 5.31 million people with nursing care insurance	1.60	11%	Calculated on the basis of the total premiums for private nursing care (NIS 2.97 billion) reduced by the total private claims (NIS 1.37 billion)
Total private financing			7.31	45%	
Total private +public			15.64	100%	

Notes: Due to the lengthy nature of hospitalization (more than a year), the number of beds represents the number of annual patients. Estimates are given for the division between public and private financing.

Source: Chernichovsky, Kaplan, Regev, and Stessman, Taub Center.

Data: National Insurance Institute, Research and Planning Administration, Annual Report (2014); Ministry of Health, Information Division, Hospitalization Institutions and Day Hospitalization Units in Israel (2014); Ministry of Health Price List; Population and Immigration Authority, Policy Planning Division (2014); Ministry of Finance, Capital Markets Division, Annual Report 2014.

Private long-term care insurance

As shown in Table 2, the total cost of private funding is NIS 7 billion, slightly less than half of the total national expenditure on long-term care. The total cost of net private insurance premiums (after deductions of insurance company payments for non-complex inpatient nursing care) is estimated at NIS 1.6 billion – 22 percent of total private spending on long-term care. Private long-term care insurance in Israel breaks down into several categories.

1. **Individual commercial insurance.** These policies are purchased by individuals at their discretion. The insured can choose the extent and duration of coverage, and the premium is determined in accordance with the nature of the coverage and the level of personal risk. This risk of course increases with age, meaning that the premium for those joining at older ages is relatively high. Policies can be valid for the insured's entire life, unless otherwise desired.
2. **Group commercial insurance.** Policies are purchased by organizations, such as worker unions. The organization representatives are the policy owners, and the insurance coverage and premiums are usually community rated. The premiums are determined by an actuarial calculation of the group's average risk – i.e., there are cross-subsidies among individuals (those with lower risk fund those with higher risk). The policies are limited in duration, and when an insured member leaves the group, the insurance is cancelled. As suggested above, the Ministry of Finance is seeking to end the sale of these insurance policies since it deems them unsustainable in the long term.
3. **Health fund insurance.** These are policies that insurance companies sell through the health funds. The fund is the policy owner and is responsible for choosing the commercial insurance agency and for managing negotiations over the policy terms. The policy is uniform and the premium can depend on age group; that is, this kind of policy also entails cross-subsidies. These policies are also time-limited: newly insured individuals through the health funds have to undergo medical underwriting.⁷ Switching health funds means termination of the insurance at the former fund and joining the insurance of the new fund. These policies are similar in many ways to the group policies, and are subject to the same policy objectives of the Ministry of Finance.

⁷ Medical underwriting is the process by which an insurance company decides whether to accept a candidate for coverage and on what terms, based on a health declaration and medical tests.

Supervision and regulation of the various kinds of commercial long-term care insurance is under the authority of the Commissioner of Insurance in the Ministry of Finance Capital Market, Insurance and Savings Department.

It is not entirely clear how many people have long-term care insurance coverage in Israel. According to an estimate by the Commissioner of Insurance, as of 2014, there were 5.31 million people with long-term care insurance in the country. Of these, 4.70 million people were covered by group long-term care insurance arrangements, mainly policies marketed via the health funds, with another 610,000 covered by individual private long-term care insurance (Ministry of Finance, 2014, see Table 2).

However, a Central Bureau of Statistics family expenditure survey points to a much lower coverage rate: 20.2 percent of all households, i.e., 479,000 people, report long-term care insurance expenditures. Even if we assume that only the adults in each household are covered, a difference of 80-90 percent remains between the two estimates. It is reasonable to suppose that some of this disparity is due to underreporting in the expenditure survey, due to lack of awareness of the insurance provided by the health funds and by workplaces.

One way or another, one can assume that insurance coverage is not universal, and there are income related disparities in coverage, as shown in Table 3. The substantial differences among income quintiles should be qualified by noting the greater likelihood of underreporting in the lower income quintiles. That is, the insurance coverage rate in these quintiles is most likely higher than reported, and the distribution of insurance coverage rates is more equitable than the data in the table suggest. However, these data still point to the burden that the state may be expected to bear when the need for long-term care increases for groups that cannot afford it: a rise in the need for subsidies for long-term care insurance.

Table 3. Share of those with nursing care insurance and average expenditure, 2014

By income quintiles

Income quintile	Percent reporting expenditure (out of all households in quintile)	Average reported expenditure in NIS	Average expenditure of all households in NIS
1 Lowest quintile	9	4.6	0.4
2	7	9.3	0.6
3	8	18.1	1.5
4	12	29.9	35
5 Highest quintile	20	60.3	12.2
Average	11	24.4	3.6
Standard deviation	5	22.2	4.9
Difference between the highest and lowest quintiles	2	13.1	28.0

Source: Chernichovsky, Kaplan, Regev, and Stessman, Taub Center
Data: Central Bureau of Statistics, Expenditure Survey (2014)

3. The international perspective

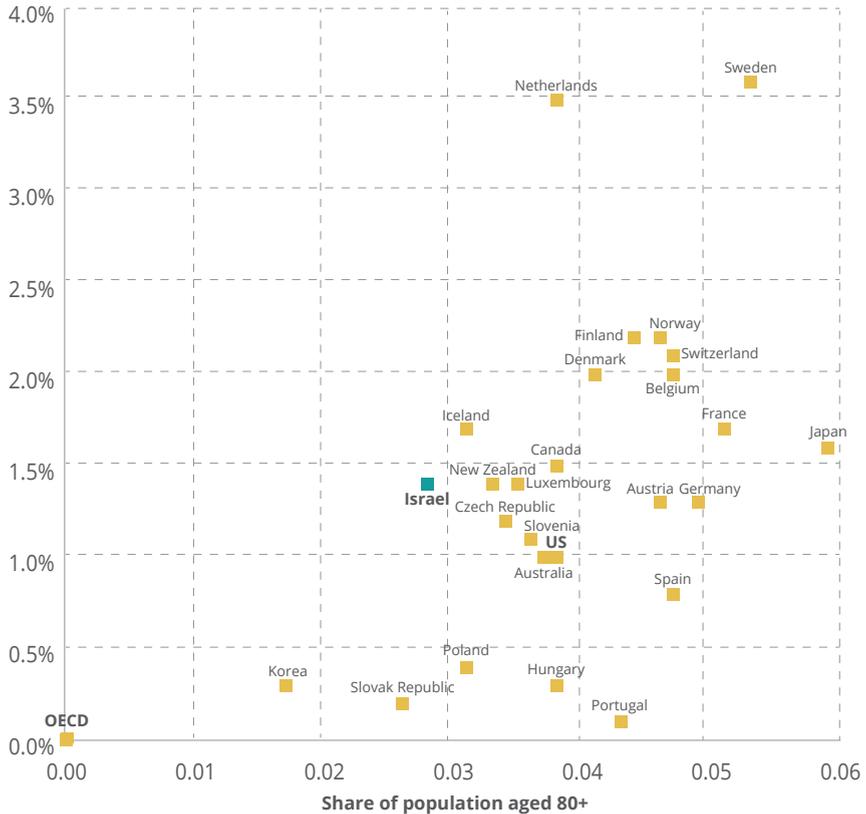
Israel spends 1.4 percent of its GDP on long-term care (Figure 2).⁸ This percentage is similar to the OECD average, if one does not take the population's age distribution into account. When this distribution is considered, the picture changes. Israel's relative place in the comparison is close to that of the group that includes most of the Scandinavian countries. Most of these countries have instituted mandatory state long-term care insurance with universal coverage – which does not exist in Israel. On the other hand, Israel's expenditure level is higher than that of countries such as Austria, Australia, Germany, Japan, and France, which are more like Israel in terms of their approach to social services. What these data mean is that Israel's relative situation is an issue from two perspectives: Israel does not provide universal coverage as do other countries at the same expenditure level, meaning that equity is compromised; at the same time, its relative expenditure level is similar to that of nations that do have universal coverage – i.e., Israel's efficiency level is low.

⁸ The Bank of Israel (2012) estimated national expenditure on the order of 1.2 percent of GDP in 2010, not including net insurance expenditures. The estimates in this paper, which are based on the scope of expenditure as calculated herein (see Table 2) relative to GDP, are on a similar order of magnitude. Nevertheless, one can reasonably assume that this is an underestimation, as it does not include foreign workers without official permits; moreover, it lacks full information on the extent of assisted living. Thus, it is reasonable to suppose that the expenditure in 2014 ranged from 1.3 to 1.5 percent of GDP.

Figure 2. Percentage of those aged 80 and over in the total population, and spending on long-term care as a percentage of total GDP, 2012

OECD countries

Expenditure on long-term care, as a % of GDP

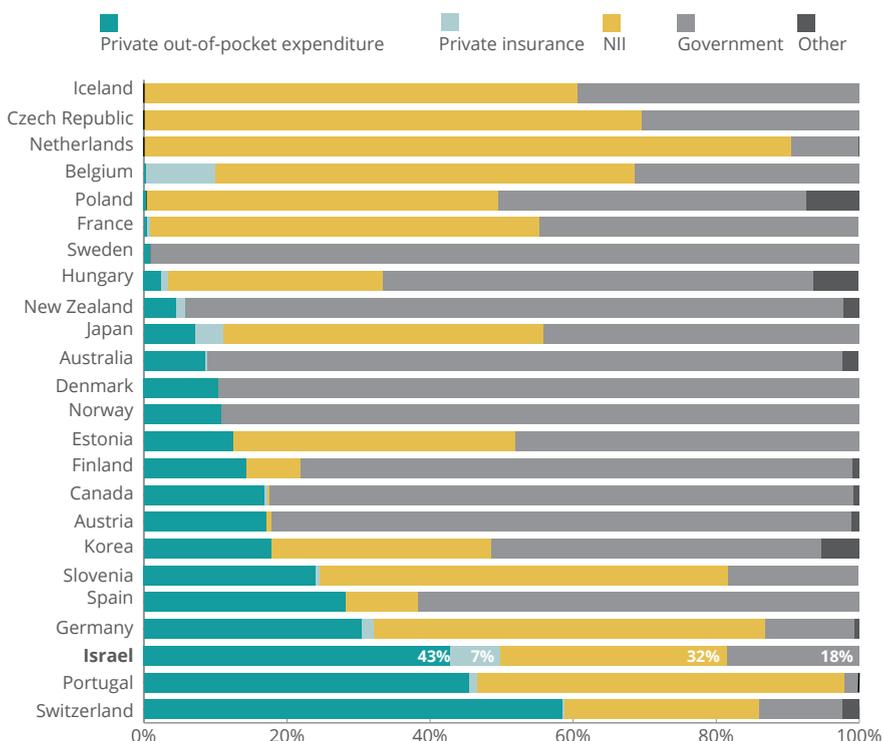


Source: OECD: Dataset: Health Expenditure and Financing; OECD Dataset: Population.

The most outstanding characteristic of Israeli long-term care funding, compared with the OECD countries, is its share of private funding (Figure 3). Of all the OECD countries, only Switzerland and Portugal have higher rates of private funding. The OECD average is just 16 percent, versus 45 percent for Israel – that is, Israel’s rate of private long-term care funding is nearly three times the OECD rate. Also notable is Israel’s private insurance expenditure rate, second only to Belgium’s.

Figure 3. Expenditure on long-term care by funding source, 2010-2011

OECD countries



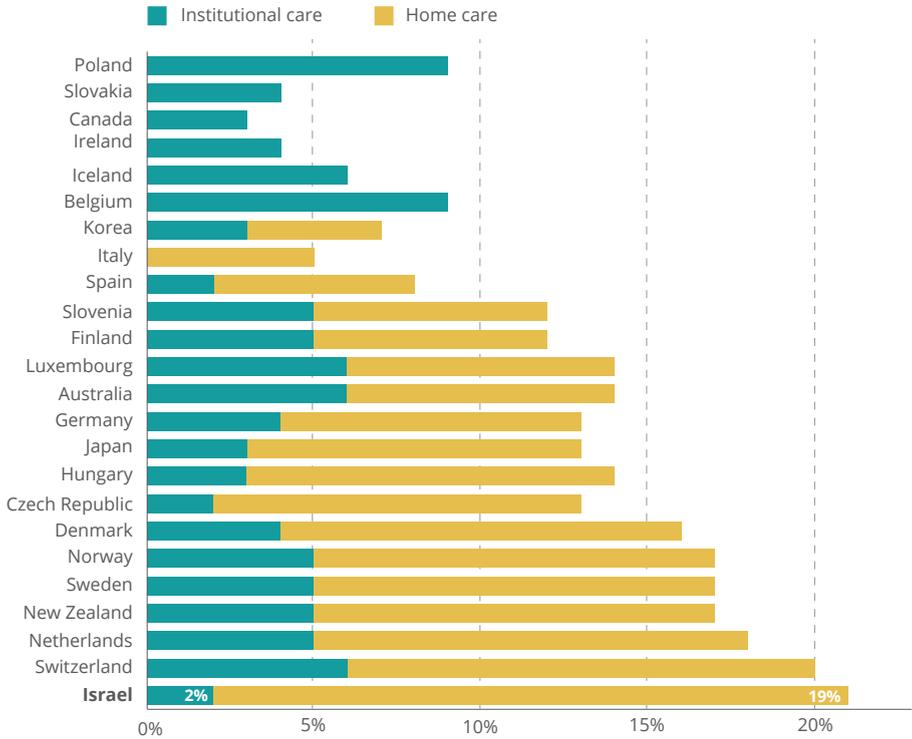
Source: Chernichovsky, Kaptlan, Regev, and Stessman, Taub Center

Data: OECD; Bank of Israel

The data also reflect the unique structure of Israeli long-term care relative to that of the OECD countries. When comparing type of care, Israel leads in its percentage of seniors cared for in the community (Figure 4). In this context it should be noted that the percentage of those aged 80 and over within Israel's entire older population (65 and over) is as high as that of the OECD countries (26.6 percent versus 26.3 percent, respectively) — i.e., the higher rate of institutional care in those countries cannot be attributed to the age distribution.

Figure 4. Long-term care service consumers as a percentage of the 65 and over population, 2014

OECD countries



Note: Countries for which comparable data are available. The data for Ireland are from 2015; for Slovenia — from 2013; for Canada and Denmark — from 2012; for the Czech Republic — from 2009; for Iceland — from 2010; for Japan — from 2006. The data for Japan underestimate the percentage of long-term care consumers who are cared for in institutions, as seniors in that country receive long-term care in hospitals. According to Campbell et al. (2009), Japan provides public benefits to 13.5 percent of those aged 65 and over. The data for Austria represent the percentage of financial allowances for the purchase of long-term care.

Source: OECD (2016).

4. Major challenges in long-term care in Israel

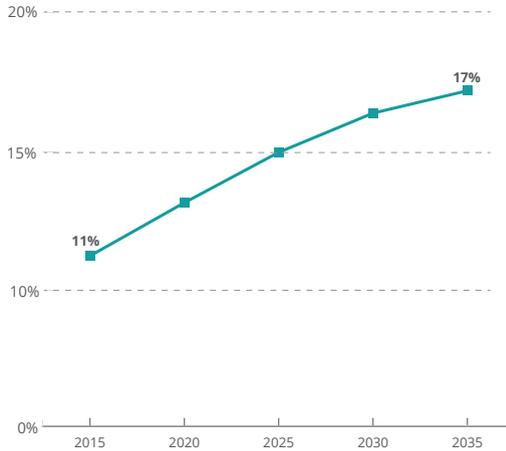
Israel faces a challenging prospect, one that is unique in the developed world, with regard to long-term care due to several key factors:

1. The lack of a universal insurance arrangement that is public in character (state or mandatory insurance or a combination of the two) that assures all residents basic long-term care, including institutional care. This results in inequities in access to care.
2. Fragmentation among public entities that hampers continuity of quality care, and efficiency. This system also inflicts bureaucratic hardships on a vulnerable population and their families.
3. Deficient preparedness for the projected increase in the share of those aged 65 and over in the population, and the aging of today's senior citizens, which will create a situation where funding needs to increase at a higher rate than what the current financing arrangements are likely to accommodate. Private funding will become more difficult as the share of the elderly in the population grows relative to the number of working age individuals (Figure 5). This change (referred to as the "dependency ratio") will also compromise public funding capabilities.

The sharp increase in needs is expected to intensify the problem of caring for elderly family members, and will impose a growing burden on households, with its associated economic implications (from a labor market perspective) and its impact on the wellbeing of household caregivers (Brodsky, Resnizky and Citron, 2011). In particular, an increase and worsening of the status of "intermediate groups" in the lower middle class is anticipated; these groups cannot afford to pay for private caregivers, but neither can they obtain government-subsidized assistance for institutional care, as they do not meet the eligibility test.

Figure 5. The number of those aged 70 and over relative to those aged 15-69

Projection



Source: Chernichovsky, Kaplan, Regev, and Stessman, Taub Center

Data: Central Bureau of Statistics, Projections of Israel's Population until 2035, Table 10 (calculations based on projections for the "middle option")

The challenges of private long-term care insurance

One approach to regulating long-term care — the one promoted by the Ministry of Finance — holds that problems in the field should be addressed by expanding private long-term care insurance. The authors maintain, however, that this cannot provide an appropriate answer to problems in the long-term care market. The private long-term care insurance sector is, for the following reasons, exposed to market failure (Pestieau and Ponthiere, 2010):

- Relatively high moral hazard. People tend not to buy private insurance, in the belief that some other party (in particular, the state) will see to their welfare should they require long-term care — even if they do not have appropriate insurance.
- A relatively narrow insurance base. On the one hand, low-income people may not be able to afford private insurance especially given the high cost of such insurance. On the other hand, high-income people may prefer to bear expenditures directly rather than buy an

insurance policy. Moreover, the demand for private insurance may be low due to the notion that public alternatives exist, although those options are likely to prove inadequate later on.

- A problematic actuarial situation. This is due to the difficulty of making long-term projections regarding the size of the population requiring long-term care, and regarding care needs. This uncertainty also contributes to the relatively high long-term care insurance premiums.
- The accumulation of high insurance reserves. Over long time periods, this entails capital market risks to the investments.
- Concerns regarding the development of adverse selection. Individuals at higher risk (especially those whose risks are harder to detect) tend to buy insurance at higher rates.¹⁰

The various causes of market failure are interrelated. The lack of desire among young people — especially those born in an era of state health insurance — to purchase insurance is due to shortsightedness, lack of awareness of future needs, and lack of familiarity with the long-term care insurance market — all of which lead them to assume that when the time comes they will be eligible for adequate, publicly funded care.

Another structural problem with long-term care insurance is that of substantial asymmetry in the balance of power between insured and insurer when the need to utilize the insurance arises: when there is need for indemnification, insured are in a situation that does not enable them to exercise their rights without assistance.

¹⁰ Researchers are divided on the degree of importance of this kind of market failure with regard to life insurance, pensions, nursing care, and inheritance insurance, as the information available to the individual is not necessarily greater than the forecast available to the insurance company, given an insured person's complete medical file (Hendel and Lizzeri, 2003).

In addition to these fundamental problems, there are several other issues that characterize Israel's private insurance market:

- **Selective insurance.** Since insurance companies are not required to accept all applicants, the neediest populations — the elderly and the infirm — are usually left without protection in terms of insurance. On the face of it, one could argue that today's seniors should have seen to insurance coverage earlier on; but the long-term care insurance market in Israel is new, making this argument untenable. Not only that, but so long as there is no mandatory universal insurance (even via a tax), one may always expect there to be a segment of the population that did not buy insurance when young; these people will remain without long-term care, or will receive care at public expense, should they need it.
- **Insufficient information to make educated choices.** The public does not, today, have the knowledge needed to make an educated choice between different insurance policies; in particular, people lack information on coverage and policy terms (exclusions, linkage of payouts to the CPI, etc.). Also, the public lacks information on the risk of becoming a long-term care patient. The scale of this inadequacy is reflected in a substantial percentage of insured who are entirely unaware that they have long-term care insurance, let alone knowledgeable about the policy terms or the scope of coverage they have purchased (or was purchased on their behalf).
- **Restrictions on insurance coverage.** Insurance payments are limited by a predefined ceiling. This method exposes the insured to the risk of rising long-term care prices with no guarantee that future insurance premiums will have real value (Brammli-Greenberg and Gross, 2003). Moreover, most long-term care insured are not covered for the entire period of need; they are limited to time periods of three to five years. When someone needs nursing care for a longer period, family members may be forced to finance the entire cost of care after the period covered by the insurance. The shorter time periods reduce the risk faced by the insurer — and thus the insured person's premium — but they greatly increase the uncertainty of the insured regarding their future rights should they need to utilize the insurance.

- **Compromised coverage continuity.** The problem of coverage continuity arises when an insured person in a group plan leaves the group (due to retirement, dismissal, and the like), and when the group's long-term care insurance is not renewed at the end of the coverage period. In such cases, the insured is left without coverage. This problem is especially serious for elderly or ailing insured, whose chance of another insurance company agreeing to insure them is low. Commissioner of Insurance intermediate directives have aimed to solve the continuity problem by requiring insurers to enable individuals to buy private policies without re-underwriting. However, these directives provide only a partial solution, as the high cost of a private policy compared with a group policy makes it impractical for many insured to buy a new insurance policy, meaning that they are effectively deprived of insurance protection.

5. The international approach to long-term care

International comparison shows that, due to the problems with relying on private insurance in the long-term care market, almost no countries use this option extensively. Even in the United States, whose private healthcare market is thought to be exceptionally well-developed, there were 8.1 million long-term care policies in 2012 – 3.9 percent of the population over the age of 25. That year, only 322,000 new policies were purchased.

Those developed nations that are similar to Israel in terms of funding for welfare services, not to mention the Scandinavian countries, have chosen universal-insurance solutions of a public character, sometimes in addition to limited private funding (Table 4).

Table 4. Models for financing nursing care, selected countries

	Financing source	Compensation method	Entitlement	Special characteristics
France	General tax	Cash only	Mostly universal	High income households must finance private insurance
Germany	Income tax	Services or cash	Universal	High income households do not have to purchase insurance, on the assumption that should they need it, they will be able to privately finance it
Japan	Income tax, general tax, premiums based on income	Services only	University for those aged 65 and over	None
Netherlands	Income tax, copayments (by ability to pay)	Services or cash	Universal	The government finances the compulsory insurance for low income individuals
Great Britain	General tax	Services or cash	Means test	None

Source: Chernichovsky, Kaplan, Regev, and Stessman, Taub Center.

Data: OECD.

Long-term care insurance systems in those countries have several noteworthy characteristics:

- Long-term care insurance is a separate sector in the welfare system, and is not part of the healthcare sector.
- Long-term care insurance is mandatory for all. The funding for payments to the insured comes from taxes or from mandatory insurance based on the ability to pay, and thus is characterized by cross-subsidies.

- Coverage is universal, sometimes subject to eligibility as determined by means testing – reinforcing the element of cross-subsidies.
- The systems are founded on the principle of “Pay-as-you-go” (PAYG), rather than on accumulation of funds.
- Indemnity for care is provided via in-kind services (benefits of equivalent monetary value), in cash, or a combination of the two.
- Paying for private insurance, mainly in the United States but also in Japan and Germany, confers a tax credit.

Universal compulsory insurance is an important part of the ability to finance long-term care for the entire population. The need for it stems from the fact that, as pointed out earlier, that young people tend not to buy long-term care insurance. Mandatory insurance prevents situations like the current one in Israel, where people do not buy private insurance in time and are then forced to rely on the public system. It requires the younger generation to participate in funding, rather than placing the burden of care for their parents solely on the shoulders of those with private insurance.

As noted above, the role of private insurance in the comparison countries is marginal – except in the case of France, where high-income groups are required to finance private insurance (Francesca, Ana, Jérôme and Fritz, 2011).

6. Principles for reforming long-term care in Israel

As noted in the previous section, in other developed countries the private insurance market has not succeeded in becoming a substantial part of the solution to long-term care funding. Most of these countries (except for Switzerland and the United States), have effectively given up on this option.

As shown in Section 2, the main solution employed in Israel today is based on group long-term care insurance in the workplace and health fund frameworks. This solution does not meet the needs of large segments of the population, especially low-income people and people who are not employed at workplaces that offer group insurance. Not only that, but it does not address the increased need and demand for long-term care that is expected

to result from the aging of Israel's population. The Ministry of Finance's approach, which favors more extensive use of private insurance policies (by, for example, cancelling workplace group insurance) as the primary means of dealing with the population's future long-term care needs, threatens this arrangement, and runs counter to international trends. By contrast, the Ministry of Health's effort, which aspires to universality of institutional long-term care coverage, is consistent with international trends and fitting in terms of the public-funding principle that underlies it.

In this spirit, the present section will outline possibilities for reform based on the prevailing international trends, with a view to filling in the elements that are lacking in the Ministry of Health's current proposal.

Eligibility — basic service basket

It is proposed that universal entitlement aid by taxes and mandatory long-term care insurance be anchored in new, comprehensive legislation. Long-term care should be defined as a basic, all-encompassing basket of services, similar to the health services basket that is based on the National Health Insurance Law. As a first stage, the state could universally include the long-term care services that are already being provided through public funding in this health basket, beyond the medical services provided by the National Health Insurance Law (see Tables 1 and 2).

With regard to means testing for eligibility, countries have different approaches to this issue. It appears that, in order to conform to the universal approach of Israeli social security, according to which everyone is equally entitled to benefits (old age pensions, for example), eligibility for long-term care must be made universal as well. This approach would also be more politically popular than a selective policy, and hence easier to pass even as a legislation that requires an increase in funding.

On the other hand, due to the high cost of long-term care — which is expected to rise even further in the coming decades — it may be necessary to continue and even intensify the use of means testing, in order to ensure a sustainable financing solution. Moreover, the moral hazard issue — that of long-term care being overused (or abused) due to its public funding — is a serious challenge, and must be addressed in any proposal for public funding (Bakx et al., 2015).

Funding the basic tier

The financing of care would be based partly on existing public sources plus additional necessary sources. There are two options for added funding. One is the Ministry of Health's proposal to increase the health tax by 0.5 percent while cancelling the means test (the "codes"); the other is through mandatory earmarked insurance, taxes or a combination of the two.

The option proposed by the Ministry of Health should be considered on a substantive and practical level. On a substantive level, the option entails integrating long-term care funding into healthcare system funding. As noted, international experience does not support such a solution. In almost all countries similar to Israel, the long-term care system is separate from the healthcare system.

It should be emphasized that, even if financing were to come from a health tax increase, the budget for long-term care need not necessarily be transferred to the health funds.

The other aspect of the option to increase the health tax is practical; that is, the budgetary significance of raising the health tax. Health tax receipts amounted to NIS 19.73 billion in 2014 (Central Bureau of Statistics, 2016). If the Ministry of Health's proposal to cancel means testing is approved, a major portion of the additional funds collected will be devoted to replacing households' contribution (along with the State's) to funding institutional long-term care. While the change in approach — that is, in the direction of universal entitlement -- might be welcome, and would relieve households from privately funding some long-term care, it would not create a meaningful net addition of funds for institutional long-term care.

In light of these arguments, a health tax increase option to fund institutional long term care should be reconsidered. There are several possibilities for implementing this option, including the following:

- General taxation, including social insurance taxes (the prevailing method among developed countries, as discussed previously).
- An earmarked tax. This option is similar to that of an expanded health tax, but disconnected from the healthcare system.
- Instituting mandatory accumulation-fund insurance, in the manner of the insurance purchased today through workplaces or the health funds. These policies may feature cross-subsidies, like those currently in operation.

Different funding sources can also be combined — for example, financing the rights that already exist today within the public system while also collecting mandatory insurance, even in the form of accumulation funds, for purposes of comprehensive universal long-term care.

A new potential source for augmented public responsibility for long-term care insurance involves raising the retirement age, first for women and later for men. Adjusting the retirement age in accordance with longer life expectancies would lead to an annual savings of billions of shekels for the state budget, both in National Insurance Institute funds and in the assistance granted to veteran pension funds within the arrangement. This savings could be used entirely for long-term care services. There is practical justification for linking a rise in the retirement age to the reform. Moreover, because both issues affect the same population, such linkage would increase the chance of political success in getting both measures approved, rather than seeking approval for each measure separately.

As indicated by the growing share of seniors in the population relative to working-age people, Israel's long-term care needs are expected to increase at a faster pace than the country's GDP. This will also likely slow the growth of resources that the state would be able to allocate for long-term care funding. Consideration should therefore be given to combining a public mechanism based on taxation and compulsory payments into the system through a pay-as-you-go method, with an additional mechanism of inter-generational adjustment that would make stable sources available to the system in the form of compulsory insurance payments accumulated over time. Cumulative insurance would create mechanisms for amassing a current surplus; these mechanisms would, in turn, constitute a financial reserve for funding the cost of long-term care in the future. At the same time, should it be decided to create a system that is fundamentally cumulative, a public mechanism should be devised that would prevent instability in funding due to possible fluctuations in the capital market.

It would be desirable for all of the funding for long-term care to be collected by the National Insurance Institute in a fund designated for that purpose. The National Insurance Institute already collects three-quarters of the system's public funding (Table 2), meaning that only the Ministry of Welfare and Social Services, and the Ministry of Health budgets allocated for long-term care would have to be transferred to the National Insurance Institute.

Supplemental long-term care insurance

Private individual insurance, if offered in the insurance market, can also supplement the universal basic service tier proposed above. In order to do this, it will be necessary to redefine the long-term care contracts offered by the health funds. In accordance with the proposed universal framework, some health fund payments would become compulsory insurance (the same is true with the conversion of the former uniform tax into the health tax). The remaining portion would be defined as voluntary group insurance (subject to the regulation of group insurance policies that include cross-subsidies).

In the proposed model, long-term care insurance by the health funds would remain valid (subject to the new arrangements and with compulsory insurance deducted as specified) until the end of the contracts between the insurance companies and the health funds. At an agreed-upon date, these policies would become voluntary supplemental insurance. The coverage that they would offer would be uniform for all of the health funds and there would be continuity of coverage during transitions from one health fund to another. The Commissioner of Insurance would set rules for the transfer of insurance reserves from one company to another when insured persons switch health funds.

It should be noted that such an arrangement would require the health funds to serve as agents between insured and insurers. If the health funds forego such involvement, they should be required to manage long-term care through a separate corporation that would be based on the financial resources designated for this purpose, and responsible for funding the services to which the health fund members would be entitled by law.

Organization and management of the service — budget holding

A central component of the Health Ministry proposal is the transfer of authority for fund-holding — as opposed to providing the services themselves — to the health funds (except for community care, for which the National Insurance Institute is responsible, and services for which the Ministry of Welfare and Social Services is responsible). That is, the Ministry's proposal does not feature integrating all of the services to seniors that are provided by public funding into the general health system, and the basic issue of the system being segregated, with all that that implies, remains unresolved.

Such a transfer would mean that the fund-holding would take place in a managed-competition market, and this has a number of ramifications (Bakx et al., 2015). Firstly, seniors have to choose the health funds to which they want to belong, and due to convenience considerations there is a high chance of the elderly remaining with the funds that they already belong to for their health care, even if they are not optimal in terms of long-term care. Secondly, integrating long-term care financing into the healthcare system would give rise to the possibility of cross-subsidies between long-term care insurance and the other medical services included in the basic healthcare basket. There is a high risk of this given the health funds' current deficits and the senior population's lack of political power. Thirdly, it would be necessary to develop an allocation formula for calculating the sum to be transferred to the health funds for long-term care financing, or to upgrade the existing formula, which in its current form is problematic and underdeveloped relative to the rest of the world. Switzerland and Belgium, for instance, have tried to come up with a suitable formula but without much success, even though their capitation formula for allocating funds to health plans (sickness funds/insurers) are highly developed compared with the Israeli formula. This presents a fourth implication: the health funds could discriminate against seniors based on financial considerations. In addition to these issues, and to the fundamental dilemma of making long-term care medically-based, rather than socially based, another question arises: to what degree are Israel's health funds prepared to cope with long-term care today, and with the complete system as envisioned for the future?

Given these issues, consideration should be given, within the new legislative framework, to assigning responsibility for all public elements of long-term care to one dedicated national authority. In addition to preventing the problems related to management by the health funds, such a measure would have several advantages:

It would be best to handle the long-term care population and the semi-independent population together, both from a social-economic perspective and from a professional perspective that takes into account continuity of care or transition from one stage to another. It is only natural that the health status of some of those eligible for nursing care deteriorates gradually to the point of total dependence on others and, therefore, to being classified as long-term care patients.

Unified management of universal long-term care insurance would, in the long term, lead to financial savings and improve the welfare of the relevant population, which currently faces bureaucratic hurdles due to the fragmented system (Chernichovsky and Kore, 2009).

The Population and Immigration Authority would have an easier time supervising foreign caregivers' terms of service in Israel, and all aspects of the home assistance sphere would be regulated: there would be rules for obtaining permits for assistance, foreign workers would be found for those eligible, and the employment of foreign workers in nursing care institutions would be regulated.

Home-based long-term care entails a variety of nonmedical expenditures, such as foreign worker wages and the purchase of materials such as diapers and medical accessories. The health funds are able to provide some of these services and products, or to buy them from external service providers, but they are not able to reimburse their members for such services on a large scale. Making a special authority responsible for these issues would constitute an appropriate solution.

Service provision

In contrast to the financing and fund-holding issues, the service provision function does not require structural reform. The format that is currently in place — care provision by both private parties and the health funds — can remain as it is. The challenge is to choose a comprehensive budget holder that would buy the services as needed.

Conclusion

Israel's population is expected to age substantially over the coming two decades. As a result, functional impairment — which naturally is higher among the elderly — is expected to rise at a faster pace than the growth of the country's population ages 70 and above. This development, along with a change in the ratio between age groups — an increase in the number of those aged 70 and over relative to those aged 15-69 — is expected to increase the challenges associated with long-term care in Israel.

International comparison suggests that the Israeli long-term system is inequitable and inefficient. A notable feature of Israeli long-term care is its particularly high share of private funding, which amounts to nearly 50 percent — three times the private funding share of the OECD countries, on average. Israel also has an especially high percentage of people aged 65 and over who are cared for in the community and at home: 19 percent versus an average of 9 percent in the OECD nations. This figure may indicate greater Israeli commitment to community and home-based care, but it might also

point to relatively limited options for access to institutional care. If this is the case, a large proportion of the burden falls on households, which leads to inequity between families of different income levels, and adversely affects family caregivers' participation in the labor market.

This relatively strong dependence on private funding produces a system that is unsustainable and cannot support the aging population in the long term. Based on international experience, and in response to proposals by the Ministries of Finance and Health for regulating long-term care, the authors propose the following measures be used to arrive at a solution to the challenge of funding and organizing long-term care:

- Defining a universal basic basket of long-term care services. The basket would be funded by pooling all of the public resources currently allocated to the long-term care area by the Ministry of Welfare and Social Services, the National Insurance Institute, and the Ministry of Health into a designated account at the National Insurance Institute.
- Instituting state long-term care insurance managed by an authority established precisely for this purpose.
- Converting some of the private insurance policies sold by the health funds into state insurance and some into supplemental insurance policies.
- Reexamining the definition of long-term care patients, given the large number of complaints (the definition employed today by the private insurance companies is a good place to start).
- Activating a professional mechanism (on behalf of the future fund-holding authority) to assess the eligibility of long-term care patients for a "long-term care benefit."
- Increases to the long-term benefit would be considered periodically, based on long-term care patient needs and on the ability of the public fund to finance the payments for all of the insured.

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