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SENIOR CITIZENS IN ISRAEL

Hannah Weihl

In 1995, there were 528,600 elderly persons in Israel.¹ Although they account for less than 10 percent of the population,² the elderly utilize a large proportion of the social services: in 1987, 40 percent of income maintenance payments and 29 percent of health expenses.³

The 65+ Age Group

Eleven percent of Jews and 3 percent of Arabs are aged 65+.⁴

Forecast

According to a population forecast,⁵ the proportion of persons aged 65+ will hardly increase in the next ten years, but the share of those aged 75+ among the elderly will rise, foremost among women.

Israel's elderly population will grow unevenly—by 56 percent among Arabs and by 12 percent among Jews.

Life Expectancy

Life expectancy of Jewish and Arab men at age 65⁶ is almost equal—16.0 and 15.8 years, respectively. Life expectancy is greater among women than men (as it is worldwide) and greater among Jewish women than Arab women—17.9 years and 16.4 years, respectively.

Ratio of Women to Men

In 1995, women outnumbered men among the elderly by a ratio of 57:43.⁷

Ethnic Origin

Almost three-fourths of Jewish elderly in 1995 were of European or American origin.⁸

Marital Status

The marital status of elderly men and women is very different:⁹ a majority of men, including those over the age of 80, are married, while most of the women are widows. The proportion of widows rises from 44 percent in the 65-74 age

group to 82 percent in the 80+ cohort. Two percent of Jewish elderly were never married. In the Arab population, the proportion of elderly women who were never married is higher.¹⁰

Children and Grandchildren

Most of the elderly have children and grandchildren; a few have great-grandchildren.¹¹ The proportion of elderly without children is 11.3 percent. Among the Jewish elderly, 2.8 percent have no children in Israel, i.e., no children who can help them in daily life.¹²

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Average Household Size

The average household size is 1.65 persons among Jewish elderly and 2.37 among Arab elderly.¹³ Most seniors in both population groups (94 percent of Jews, 71 percent of Arabs) live in households of up to two persons—usually with a spouse and less commonly with a son or daughter. Among the Arab population, the proportion of elderly who live with minor children is about 20 percent.¹⁴ The share of seniors who live with adult married children appears to be similar among Jews and Arabs.

Mizrahi Jewish elderly are more likely than Ashkenazi elderly to live with children, partly because of differences in marriage patterns, fertility patterns, and income.¹⁵

Most widows do not live with children, and widows account for 77 percent of all elderly who live alone.

Schooling

In Israel, as worldwide, the elderly have less schooling than their children. Compulsory education—inssofar as it existed in countries where Israel's current elderly were born—covered fewer years in the seniors' generation than in the children's generation, and in some countries it was not the custom for girls to attend school. Jewish boys, in contrast, generally acquired some schooling.

Non-Jewish elderly have much less schooling than Jewish seniors and 62 percent of them (more women than men) are illiterate.¹⁶ This can be attributed to the absence of compulsory education during the British Mandate period.

Seniors (65+) in Localities with Populations of 10,000 or More, Percent of Population, End of 1995

Givatayim	20.1
Haifa	17.6
Ramat Gan	17.7
Tel Aviv	16.8
Qiryat Tivon	15.3
Bat Yam	14.0
Qiryat Yam	14.2
Nahariyya	13.3
Netanya	13.4
Qiryat Motzkin	13.4
Upper Nazareth	13.5
Qiryat Bialik	12.9
Rehovot	11.9
Holon	12.0
Petah Tiqva	11.9
Qiryat Ono	11.5
Qiryat Ata	11.4
Hadera	10.8
Ashqelon	10.7
Herzliyya	10.6
Pardes Hannah-Karkur	10.3
Beersheva	10.5
Hod Hasharon	9.6
Karmiel	10.3
Arad	10.3
Bene Beraq	9.8
Nesher	9.9
Tirat Hacarmel	10.2
Ashdod	10.0
Nes Tsiyyona	9.9
Acre	9.7
Migdal Ha'emek	9.6
Qiryat Gat	10.0
Kefar Sava	9.9
Afula	9.4
Ramat Hasharon	9.7
Rishon Leziyyon	8.6
Safed	9.2
Ra'anana	8.0
Jerusalem	8.0
Ma'alot-Tarshiha	8.6

Ramle	8.0
Yehud	8.0
Lod	8.0
Or Yehuda	7.9
Givat Shmuel	7.5
Or Aqiva	8.0
Dimona	7.4
Tiberias	7.5
Sederot	8.2
Qiryat Shemona	7.2
Ofaqim	7.9
Rosh Ha'ayin	5.5
Beit Shemesh	5.6
Beit She'an	6.0
Qiryat Malakhi	5.5
Netivot	5.8
Yavne	4.7
Ariel	4.3
Nazareth	3.6
Daliyat il-Karmil	3.5
Shifr-'Amr	3.7
Ma'ale Adummim	3.1
Tira	3.7
Mevasseret Tsiyyon	3.6
Kafr Qara	2.8
Reina	2.8
Eilat	2.8
Arara	2.7
Sakhnin	2.6
Tamra	2.6
Maghar	2.6
Yifya	2.5
Kalansawa	2.6
Taibe	2.9
Kafr Qasm	2.4
Baqa al-Gharbiyya	2.4
Kafr Kana	2.4
Umm al-Fahm	2.3
Jedida-Makr	2.3
Arabe	2.8
Kafr Manda	1.9
Rahat	1.8

Source: Central Bureau of Statistics, *Local Authorities in Israel, 1995, Physical Data, 1996*, Table 9.

Differences on Five Dimensions

There are five major differences among the elderly population.

Age

A distinction should be made between the “young old,” who have not yet reached the age of 75, and “old-old,” those aged 75+. Since the proportion of elderly who suffer from disability and illness rises with age, so does the share of those in need of medical services, medicines, assistance in functioning, and appropriate transportation. For this reason, the elderly need to spend much more on health than the young, but in most cases their income does not rise commensurably.

As the health of members of these age groups deteriorates, their living patterns change. They spend less time away from home and have to find activities to fill growing hours of leisure.

Obviously, then, the growth forecast for the senior population generally and the “old-old” particularly cannot but affect the planning of welfare and health services.

Availability of Children

The gerontology literature shows that family members (spouses, children and their spouses, and grandchildren) are the ones who meet most of the needs of the disabled elderly, even in countries with the most highly developed welfare services. Thus, those who lack this resource are worse off than those whose children are available. If these seniors also lack the wherewithal to purchase services, their situation is much more difficult.

Israel’s legally mandated services make no provisions for the special needs of the childless elderly. Lack of children¹⁷ is not a formal criterion in eligibility for services, and there are no

regulations that require affirmative action to provide for their special needs.¹⁸

Cultural Heterogeneity

The conventional taxonomy distinguishes among three population groups—Arabs, Mizrahi Jews, and Ashkenazi Jews¹⁹—who have different levels of income and education, different family values, and different household structures, especially among the elderly.

The distinction between elderly Arabs and Jews is important because, in addition to the difference in cultural background, a political factor is present. Arab wage-earners still find it hard to obtain “good” jobs that provide tenure, pension rights, and an adequate wage, and some of today’s seniors spent much of their working lives unemployed. Most Arab elderly held unskilled jobs that did not provide social benefits.

Length of Stay

Ashkenazi elderly are different from Mizrahi elderly in terms of their tenure in Israel—a difference that does much to dictate their current level of income. Tenure also reflects the degree of one’s social and cultural immersion and, in this sense, affects the sense of belonging to Israeli society.

Education

Education makes it possible to obtain economically and socially rewarding work and provides the tools needed to fill leisure time and cope with changes in physical functioning. Consequently, it stands to reason that highly educated pensioners will out-earn their poorly educated counterparts. This factor also affects lifestyle, since seniors with little schooling and low income must contend with more significant changes in their way of life after retirement.

The data presented here enable us to pinpoint the most vulnerable groups in the elderly population of Israel (and worldwide)—those who are “old-old,” are poorly educated, have low income,²⁰ have no children who can help them, and those who live alone (generally widows).

INCOME, EMPLOYMENT, AND RETIREMENT

Employment and income are interrelated even after retirement, as the level of one's pension is a function of income during working years. People who earned little and saved nothing while working will have a scanty income in old age, and unless their employers offered pension plans, they will depend on the National Insurance (Social Security) old-age pension.

Because Israeli law does not require citizens to contribute to a pension fund, it is the responsibility of working persons to assure themselves an income for old age. Too many workers do not or cannot tend to this necessity; 45 percent of men who were self-employed (as against 27 percent of former wage-earners) receive income maintenance supplements²¹ because they have no savings. Some placed themselves in this situation by exhausting their pension savings before they reached retirement age.

In many workplaces, agreements between employers and labor organizations stipulate pension fund contributions by both sides or pension payments from the national budget. Such agreements, however, are common only

in large workplaces (government, municipal authorities, former Histadrut enterprises, the Jewish Agency, and some large industrial firms). In many other sectors (agriculture, sales, domestics, miscellaneous services, and much of industry), there are no such collective agreements; working conditions are set forth by the employer, sometimes by means of time-limited personal contracts that do not include arrangements for retirement.

Some of the elderly—17.7 percent of men and 5.5 percent of women over age 65—participate in the labor force.²² This participation depends on the state of the labor market and various factors associated with the elderly themselves: the desire to continue working, the willingness to change occupations, the extent of need for a larger income, education level, and age upon arrival in Israel. The job status of the elderly also affects their employment rate: 37 percent of elderly (65+) participants in the labor force in 1985 were self-employed.²³

Level of Household Income

Twenty-one percent of urban households in 1992/93 were headed by people aged 65+.²⁴ In the low-income deciles, the proportion of urban households headed by people aged 65+ was slightly higher than that of households headed by younger people. In the upper income deciles, their share was lower.

The income of households headed by elderly is distributed more or less equally across the deciles of total net income per standard adult (Table 1).

Persons aged 65+ have a higher net income per standard adult than members of other age groups, because their households have fewer persons, on average, than households headed by younger people.²⁵

This does not mean that there are no poor elderly. According to the annual report of the National Insurance Institute,²⁶ 19.9 percent of elderly households had disposable income under the poverty line in 1996 (as against 16 percent of households in the population at large). A large share (39 percent) of National Insurance transfer payments went to these households.²⁷

Elderly women have lower income than elderly men. Fewer women continue to work after retirement age and fewer women worked before. Therefore, they seldom have pension rights and are dependent on their husbands' work pension and/or National Insurance old-age benefits.

**Table 1. Distribution of Three Age Groups by Income Deciles
Urban Households, Net Income per Standard Adult, 1992/1993**

Income Deciles	Age		
	45-54	55-64	65+
	100%	100%	100%
1-2	17	17	19
3-4	18	17	20
5-6	19	18	21
7-8	20	20	20
9-10	26	28	20

Source: *Statistical Abstract of Israel 1994*, Table 11.1

In 1985, the total income of more than half of elderly women was under one-fourth of the national average wage; only 20 percent of elderly men belonged to that income category. This disparity explains why a higher proportion of women than men receive income maintenance, for this benefit accrues only to those with the lowest income.²⁸

Significant differences are also evident in the income of elderly Arabs, Mizrahi Jews, and Ashkenazi Jews. The fraction of elderly households that failed to receive an income amounting to half of the national average wage in 1985 was 81 percent among Arabs, 66 percent among Mizrahi Jews, and only 46 percent among Ashkenazi Jews.

The income of 20 percent of elderly Ashkenazi households exceeded the national average wage; only 6 percent of elderly Mizrahi households and 2.5 percent of elderly Arab households did as well.²⁹ These differences in level of income explain why the rate of eligibility for income maintenance is 19 percent higher among Arab elderly than among Jewish elderly.

Over the years, the proportion of seniors entitled to income maintenance—those with the lowest income—has been declining.³⁰ In 1993, this rate was 33.8 percent of all recipients

of old-age and survivors' benefits (including women aged 60-64).³¹ The evident reason for the downtrend is an upturn in the share of seniors who qualify for pensions from their jobs.

Sources of Income

Elderly people have several sources of income: work, capital, savings, pensions, and income transfers under law (old-age and survivors' benefits, special entitlements for victims of Nazi persecution, income maintenance, and Defense Ministry benefits). Some also have pensions overseas, support from relatives, German reparations, and the like.

The gross income of households headed by elderly persons (65+) is distributed almost equally among four sources: (1) benefits and support payments, (2) pensions, (3) capital, and (4) employment.³² In other words, about one-fourth—28 percent—of the income in this age group, comes directly from the state.

The incomes of elderly men and women are differently composed. In 1985, more men than women had income from employment (47 percent vs. 21 percent, respectively) and pension income (27 percent vs. 10 percent).³³ Income from old-age benefits is also

differently apportioned. Until recently, the law did not entitle women who worked only at home to old-age benefits;³⁴ such women were dependent on their husbands' old-age entitlements. For this reason, more women than men required income maintenance.³⁵ Furthermore, age affects the composition of income sources. In 1985, the proportion of elderly with income from employment declined from 33 percent in the 65-69 age group to 7 percent among those aged 80+, and the proportion of seniors with a pension income fell from 46 percent to 22 percent, respectively.³⁶ As the proportion of elderly with tenured jobs in Israel has risen, so has the share of pension in the "basket" of income sources.³⁷

Different origin groups have different sources of income. In 1985, 75 percent of Arab elderly subsided on National Insurance benefits alone, as did 45 percent of Mizrahi elderly and 25 percent of Ashkenazi elderly.³⁸

Table 2 shows that the proportion of elderly who had income from pensions, employment, or capital in 1985 was much lower among Arabs than among Jews. Several factors explain the difference: a low educational level that barred Arabs from rewarding and "regulated" occupations (those that provide ample social benefits), lack of industrial development in Arab localities, and overt or covert discrimination in hiring practices, including those of the civil service.³⁹

Table 2 also illuminates differences in the composition of Ashkenazi and Mizrahi Jews' sources of income. The difference in the proportions of persons with savings and capital income—33 percent of Ashkenazim vs. 11 percent of Mizrahim—is especially salient. Among Ashkenazim, there are differences between old-timers and those who settled in the country at an advanced age. Some 95 percent of those who receive old-age benefits despite the fact that they

Table 2. Income of Elderly Households and Percent of Households Benefiting from Each Source of Income, by Ethnic Origin and Nationality

	Households (thousands)**	National Insurance	Pension	Work	Other (savings, capital, other)
Total	273.1	91	38	21	25
Jews	257.4	91	40	22	27
European-origin***	183.6	90	42	25	33
Asia-Africa origin	71.1	92	35	15	11
Non-Jews	18.4	94	12	7	3

Source: Central Bureau of Statistics, 1989, *Income Patterns among the Elderly in Israel*, Table 13.

** Households that include a woman aged 60+ or a man aged 65+.

*** Including America, Israel, and unknown.

HOUSING

are ineligible under the National Insurance Law because they failed to be employed for ten years or more (most of them are recent immigrants who arrived after age 60)⁴⁰ also receive income maintenance, because they have no other source of income.

Household Expenses

As people age, the makeup of their household consumption changes.⁴¹ The share of expenses for food, health, and housing rises; the share of health and housing in total outlays among the elderly is almost double that share among young people;⁴² and the proportion of expenses for clothing, footwear, culture, transport, and communications declines.

The 1992/93 *Family Expenditure Survey* reveals further differences, stemming chiefly from income level, between the 45-64 age group and the 65+ cohort (Table 3).

In the low income per standard adult group, the highest share of expenses goes

for food (irrespective of age of head of household). In such households headed by people aged 65+, food accounts for 30 percent of expenses; the next in order are housing and home maintenance.

In the group of high income per standard adult, in contrast, food expenses claim a much smaller proportion of household outlays (only 13 percent in the 65+ age group); larger fractions are allotted for housing, transport, and communications.

The rise in relative expenditure for health at all income levels reflects not only the increase in morbidity and the decline in functioning but also the flaws of the health system with respect to geriatric services. National health insurance does not cover the most frequent health needs of the elderly: medications for chronic illnesses (partial coverage only), eyeglasses, dental prosthetics, hearing aids, wheelchairs, walkers, dental care, visits to doctors when clinics are closed, and long-term inpatient care.

Table 3. Household Consumption, by Income and Age of Household Head (in declining order)

High net income per standard adult	Low net income per standard adult
Age 45-64	
1. Housing*, transport, and communications**	1. Food
2. Food, education, and culture***	2. Housing
3. Home upkeep****	3. Home upkeep
4. Education and culture	
Age 65+	
1. Housing	1. Food
2. Home upkeep	2. Housing
3. Transport and communications, health	3. Home upkeep, health
4. Food	

Source: Central Bureau of Statistics, *Survey of Household Expenditures 1992/1993*.

* Central-government taxes, rent, home insurance, and in-kind housing consumption.

** Use of public transport and private taxis, travel abroad, and motor-vehicle expenses.

*** Education services for children; newspapers and books; cultural performances; sports and entertainment; vacation, recreation, and outings; durable culture and entertainment products; and hobbies.

**** Water, electricity, gas, fuel for home consumption, home maintenance and improvements, assistance at home, and miscellaneous household needs.

About two-thirds of elderly Israelis reside in dwellings that they own; most of the others live in dwellings owned by children or other relatives. Some of these units are not suited to the needs of elderly people for reason of size or access. Some are apartments in old and poorly maintained buildings. Small dwellings for purchase and public dwellings for rental are not generally available. Many cannot afford to purchase housing or rent it on the free market. The Ministry of Construction and Housing has begun responding to the housing needs of the indigent elderly by building sheltered housing units countrywide, at relatively low rent.

The Ministry assists elderly persons who lack housing⁴³ by offering sheltered units and, for those who live under ordinary rental conditions, rent subsidies. However, the assistance programs available⁴⁴ are poorly suited to low-income elderly because the grants are too small.

The Housing Conditions of Senior Citizens

At first glance, home ownership seems no different in the 65+ cohort than in the 45-64 age group: 76 percent of dwellings inhabited by people in the 65+ age group are owner-occupied, 19 percent are rented, and 5 percent are owned by others and made available rent-free.⁴⁵ The term "owner-occupied" may be misleading because when elderly people live with adult children, title to the dwelling may be held by either the parent or the child.

A 1985 survey⁴⁶ showed that two-thirds of persons aged 60+ lived in dwellings that they owned, 22 percent in dwellings owned by their children, and 10 percent in rental housing. Living in dwellings owned by offspring is common among widows, more than 40

Table 4. Size of Dwellings, by Nationality (percent)

	Number of rooms				Households (thousands)
	1-1.5	2-2.5	3-3.5	4+	
Jews	9.4	39.6	40.7	10.3	100% 293.4
Arabs	25.3	31.4	28.9	14.4	100% 21.5

Source: Central Bureau of Statistics, 1994, *Housing Conditions Survey, 1991*, Special Publication 956, Table 19.

percent of whom live with sons or daughters. This is most common among elderly Arabs and Mizrahi Jews, 31 percent of whom fit this pattern as against 19 percent of Ashkenazi Jews.

Different origin groups have different rates of home ownership. The proportion of elderly persons who rent their housing is almost twice as high among Mizrahim as among Ashkenazim. The disparity originates in the different economic situations of the two population groups and in the housing policy in effect when the immigrant transit camps were evacuated. Public-housing companies built rental housing at that time, and although tenants were given an opportunity to purchase their dwellings, not all managed to do so. The data indicate that the proportion of elderly living in rented apartments increased between 1985 and 1991, evidently because of housing policies vis-a-vis elderly immigrants.

Dwelling Size

One-third of the elderly live in dwellings of one or two rooms; 49 percent occupy three-room dwellings.⁴⁷ On average, Jewish elderly (Ashkenazim and Mizrahim) have more rooms than the Arab elderly (Table 6).

Most elderly—married and non-married—who live with children reside in dwellings with three rooms or more. Among the unmarried who do not live with children, the rate of occupancy of small dwellings (up to 1.5 rooms) is high. Couples occupy larger dwellings, 86 percent of them having 2-3.5 rooms. These figures imply that some elderly persons move into smaller dwellings after their spouses die. Available information cannot confirm this conjecture but can support it by showing that the proportion of elderly who live alone and contend that their dwellings are too large for them exceeds the corresponding proportion of married couples.⁴⁹ Furthermore, 11 percent of

persons aged 65+ moved in 1985-1991 (not including those who relocated to institutions).⁵⁰

Eighteen percent of persons aged 60+ believe that their dwellings are too high up for them—a finding that reflects the difficulties that many elderly encounter in climbing stairs.⁵¹

Upkeep and Home Appliances

The proportion of unsound dwellings in 1985 was very high among elderly Arabs and very low among elderly Ashkenazi Jews. The Central Bureau of Statistics survey that elicited this finding also revealed that the elderly often cannot afford to maintain their dwellings and appliances. The following were reported to be unrepaired for more than a year: 78 percent of broken windows and shutters, 97 percent of moldy walls, and 55 percent of non-operating home appliances such as electric water heaters, refrigerators, and washing machines.⁵²

The Arab population is worse off in this respect. A survey among Arab elderly in rural localities (Weihl, Azaizeh, King, and Goldscher, 1986) found that some lived in old houses that lacked indoor plumbing. In 1983,⁵³ 12 percent lacked toilets and 35 percent lacked shower fixtures (not to mention bathtubs). A 1985 survey reported similar findings: in 37 percent of the dwellings there was no toilet and in 35 percent, no shower. Thirty-three percent lacked both of these and 10 percent lacked a separate kitchen room.⁵⁴ Most dwellings that lacked showers and toilets were inhabited by elderly persons who had no children.

A comparison of the findings of a 1995 survey among persons age 60+ with data of the 1991 *Housing Conditions Survey* (both by the Central Bureau of Statistics) sheds light on a favorable development: the proportion of elderly persons who own basic household appliances increased and the

Table 5. Home Repairs, by Population Group (percent)

Repairs needed in:	Kitchen	Conveniences	Windows	Cracked walls	Moldy Walls
Jews					
Ashkenazim	6	4	8	5	9
Mizrahim	14	11	19	10	21
Arabs	15	10*	20	21	34

* In about one-fourth of elderly-occupied dwellings in rural Arab localities, the conveniences are outdoors.⁴⁸
Source: Central Bureau of Statistics, 1987, *Survey of Persons Aged 60+ in Households, 1985*, Special Publication 4, 8, Table 1.

Table 6. Frequency of Household Appliances, Rural Arab Population, by Generations in Household (percent)

	Single-generation household	Multi-generation household	Total	Total Arab population (including urban)
Electric heater	21	36	30	
Kerosene heater	30	42	37	
Refrigerator	66	90	81	91
Stove	16	39	39	
Washing machine	17	42	33	44
Radio	46	79	66	
Television	27	76	57	83

Source: Weihl et al., 1986, Table 28.

disparity between the 65+ age group and the 45-64 cohort diminished. In 1985, 22 percent of the dwellings inhabited by the elderly lacked telephones;⁵⁵ six years later, this proportion had fallen to 8.1 percent.⁵⁶ The proportion of elderly who heated their water with solar fixtures rose by 5 percent,⁵⁷ and the share of elderly who owned home heating equipment also increased slightly.⁵⁸

The 1991 *Housing Conditions Survey* shows that relatively fewer elderly (65+) than younger people owned washing machines or vacuum cleaners. Even if the disparity traces to intergenerational differences in lifestyle, the lack of these appliances obviously makes household management more difficult.

Noam and Sicron (1990)⁵⁹ show that different types of households own different home appliances. Widows and widowers who do not live with their children have fewer appliances than married couples who do not live with children, and appliances are much scarcer in the homes of widowers than in those of widows. Elderly persons who live with their children have a higher standard of living than those who live alone.

Data from the 1983 Population Census show that the Arab elderly have

scantier household equipment than the Jewish elderly and Arab households generally.

An examination of appliances in households of Arab elderly who are entitled to long-term care benefits⁶⁰ showed that a considerable share of seniors' household appliances were in poor repair: 25 percent of refrigerators, 23 percent of solar or electric water heaters, 25 percent of washing machines, and 16 percent of television sets.

Housing of Elderly Immigrants⁶¹

Elderly immigrants, like all immigrants, are entitled to rent subsidies and subsidized housing loans. Both sources of assistance, however, are designed for working people who have sources of income from which they may repay loans or round up the sum needed for rent on the free market. Old-age benefits do not provide enough income for this. This probably explains why 86 percent of seniors who immigrated from the former Soviet Union between 1989 and the mid-1990s live with children or other relatives, even though two-thirds of them lived alone or with a spouse before immigration. Shared housing improves both generations' economic

circumstances but burdens the living conditions—congestion, change in lifestyle, and lack of independence in household management—of everyone involved. Some of these elderly may eventually seek other housing options, such as sheltered settings.

The proportion of elderly who immigrate without children has been climbing over the years; special housing options need to be arranged for them in the long term. One of the possibilities being considered is sheltered housing.

Sheltered Housing⁶²

At the end of 1994, Israel had 8,990 sheltered housing units for seniors.⁶³ About 35 percent were publicly owned; the rest were owned by volunteer organizations and private landlords (33 percent and 32 percent, respectively). The public settings are run by local associations for the elderly or are in apartment buildings owned by companies such as Amigour, which serve recent immigrants in the main. These dwellings are assigned to indigent elderly without entrance fees. In contrast, tenants of units under non-public ownership must pay entrance fees that are sometimes quite steep, along with commensurate monthly payments.

The number of public dwellings increased substantially in 1995.⁶⁴

Sheltered housing is not meant to be a substitute for independent housing, even though today there is evidently a tendency to regard it as a way of solving the housing distress of some indigent elderly. Sheltered housing is designed to offer an alternative to the institutionalization of independent elderly persons by providing support and protection in the form of basic services for seniors who are still able to live on their own.

HEALTH AND HEALTH SERVICES

Health Needs of the Elderly

People's health-care needs increase with age, and the proportion of private and public expenditure required to meet them climbs commensurably.⁶⁵ The uptrend is manifested in many ways: persons in the 65+ group visit doctors more frequently than those in the 45-64 cohort,⁶⁶ their rate of general hospitalization is higher, and their average stay in hospitals is longer.⁶⁷ A large majority of the 13,706 patients in nursing wards in 1996 were over the age of 65.⁶⁸

The proportion of persons disabled rises with age. Only 70 percent of those aged 80+, as against 97 percent in the 60-64 group, report that they are able to leave home without assistance. Additionally, the proportion of bedridden persons rises from 0.2 percent to 2.0 percent.⁶⁹ The proportion of persons able to move around outside their homes decreases from 86 percent in the 65-74 cohort to 49 percent at age 80+. After age 80, 74 percent of persons find it difficult to use stairs and 70 percent have difficulty in getting on and off buses.⁷⁰ The proportion of those who have difficulty in carrying out personal functions (bathing, dressing, carrying objects) and those with hearing and vision disorders also rises with age.

These data point to the extent and type of needs that elderly citizens encounter as a result of health problems. Those who have functional disabilities but do not live in institutions need, in addition to health services, regular assistance in activities of daily life—including household management (if they live alone) and, at times, technical aids such as walkers, wheelchairs, special mattresses, and hearing and visual aids. Except for nursing and medical

supervision, these services are covered neither by compulsory health insurance⁷¹ nor by other public services, except for a nursing care benefit⁷² for those with a high degree of disability. The main victims of these omissions are the low-income elderly.

Admission to General Hospitals

In most general hospital wards except for pediatrics, obstetrics, gynecology, and oncology, the 65+ age group is over-represented relative to its share in the population.⁷³ As of 1996, seniors accounted for about one-third of hospital patients and 37 percent of inpatient days in general hospitals.⁷⁴

Geriatric Hospitalization

In addition to general hospitalization, many of the elderly need long-term inpatient care because of irreversible health problems. Forty percent of all hospital beds (as of 1996)⁷⁵ were reserved for long-term patients.⁷⁶ Between 1983 and 1996, the number of such beds increased by 134.8 percent⁷⁷ and the proportion of beds per thousand persons grew rapidly.⁷⁸ Although these rates point to large public and private investments in the development of these services, it is not clear whether the supply suffices for current needs, let alone for the anticipated increase in the number of "old-old" (75+) in the next few years.⁷⁹ The daily cost of long-term hospitalization is much lower than that of "ordinary" inpatient care, but the patient's stay is much longer—162 days on average in 1996, as against 4.4 days in regular wards.⁸⁰

Geriatric inpatient facilities are defined by law as hospitals and require a license from the Ministry of Health.

The Health Ministry has established three categories of patients in need of long-term inpatient care:⁸¹

1. Long-term (nursing) patients—those whose medical problems require prolonged and skilled medical supervision and whose condition meets one or more of the following criteria: bedridden or wheelchair-bound, incontinent, or virtually non-ambulatory because of pathologies or complications of various illnesses.

2. Long-term (nursing) patients with multiple problems—nursing patients who have illnesses that require constant medical treatment and supervision, e.g., pressure sores, cancer, or renal failure.

3. Patients who are mentally frail but not bedridden.

The list of services covered by National Health Insurance applies only to multiple-problem nursing patients, but even they do not qualify for full coverage of inpatient care. As of the end of 1996, they had to pay more than NIS 100 per inpatient day. According to a survey by the JDC-Brookdale Institute, multiple-problem nursing patients accounted for 3-4 percent of geriatric inpatient admissions in 1990.⁸²

There are no accurate statistics on the demographic structure of the geriatric inpatient population; the information below is derived from data on all residents of institutions for the elderly.⁸³

A majority of the institutionalized elderly are women, possibly because most widows have no one to take care of them at home. The share of Mizrahi Jews is much lower than that of Ashkenazim.⁸⁴ Although this seems to indicate that the Mizrahi group is less in need of "institutional arrangements"

outside the home, this explanation should not be accepted at face value because some Mizrahim, as members of a lower income group than Ashkenazim, find it hard to afford inpatient care even when the state shares the expense. Furthermore, the proportion of childless elderly who cannot arrange non-institutional care alternatives is lower in this group.⁸⁵

Until recently, the Arab population showed no interest in geriatric hospitalization and the number of Arab inpatients was negligible. Since the first geriatric ward for the Arab population was opened, Arabs have exhibited much greater willingness to be admitted to such institutions.⁸⁶ Demand for beds is on the rise, and public and private agencies are working on ways to meet it.

Nursing inpatient beds are owned by public agencies (central government, municipal government, several nonprofit organizations, and the General Health Fund), and private institutions (Table 7). Ostensibly, the difference in ownership is manifested in different terms of admission. Some nonprofit organizations and most private institutions set their own admission terms and prices.

However, most privately owned beds (90 percent, according to the chair of the Organization of Private Hospitals) are funded by the Ministry of Health and are accessible to nearly all elderly. Thus, in actuality, relatively few beds are allocated by means of market competition, as most of the population in need of this service cannot afford to purchase it on the private market.

Table 7 itemizes the increase in beds between 1983 and 1996 by type of ownership. The substantial growth in the nonprofit category reflects the policy of Eshel (Association for the Advancement of Services for the Elderly)⁸⁷ and, practically speaking, of the Israeli government, which encourages the development of institutional services for the elderly.

Data for 1990-1994 (JDC-Brookdale Information Center) show that the number of beds owned by private entities and nonprofit organizations that were not founded by Eshel grew more rapidly than beds under public ownership (those founded by Eshel). In other words, this service may be tending toward privatization.

Cost of Inpatient Nursing Care

The average daily charge for inpatient care⁸⁸ varies in accordance with the ownership of the institution (see Table 8). Institutions owned by the government and the General Health Fund are the most expensive, with their average current cost rising each year. Institutions owned by nonprofit organizations are much less costly, and private institutions are the least expensive.

Some of the high cost of inpatient care in government and General Health Fund hospitals can be attributed to the costliness of geriatric rehabilitation facilities and care for nursing patients with multiple problems, who account for a large proportion of inpatients in these institutions. There are no data that indicate that publicly owned institutions provide better service or quality of life than privately owned ones.

Patients and families who cannot afford inpatient care may apply to the Health Ministry for subsidies and receive assistance based on their income.⁸⁹ The Ministry bills the family for their share of the payment, makes up the remainder, and tenders payment to the patient's institution. In late 1994, the Ministry of Health participated in the inpatient expenses of 62 percent of persons who occupied beds reserved for long-term patients. In early 1996, the Health Ministry rate for inpatient care at private institutions ranged from NIS 180 to NIS 230 per day. The Ministry does not admit patients to all licensed facilities, due to the high rate that some charge.

Referral Procedures

Those who can afford the full cost of inpatient care may apply to any licensed institution and arrange admission without Health Ministry mediation. The Ministry has not issued regulations designed to prevent, to the extent possible, infringement of the rights of

Table 7. Hospital Beds for Long-Term Patients, by Hospital Ownership

Ownership	1983		1996	
	Beds	% of total	Beds	% of total
Central government	1,288	18.0	1,770	12.9
Central and local government	110	1.6	42	0.3
General Health Fund	551	7.6	694	5.1
Hadassah	32	0.4	14	0.1
Church missions	61	0.8	109	0.8
Other nonprofit institutions*	1,793	24.9	5,225	38.1
Private	3,349	46.7	5,419	39.5
Total	7,184	100	13,706	100

* Includes institutions founded by Eshel (Association for the Advancement of Services for the Elderly, jointly owned by the government and the American Jewish Joint Distribution Committee).

Sources: *Statistical Abstract 1985*, Table 24.8; *Statistical Abstract 1997*, Table 24.6.

helpless patients; it is up to the candidate for institutionalization and his/her family to work out an agreement concerning the terms of payment.

Patients who apply to the Health Ministry for financial assistance undergo medical and administrative screening that involves presenting proof of assets, income, and the income of spouses and children. The Ministry uses this information to work out the level of its subsidy. Candidates and their families undertake to remit the requisite sums to the Ministry. For its part, the Ministry makes no commitment to tender any service and signs no agreement that stipulates what the patient is to receive for his/her payment. Finally, all hospitalization candidates have to tender a one-time payment⁹⁰ equivalent to the cost of two months of inpatient care.

Ambulatory Services *Services Provided under Law*

Ambulatory services (visits to family physicians, specialists, or nurses, along with medicines and diagnostic tests) are covered by law. However, as stated, the elderly have many needs that are specific to them. The health funds meet some of these needs through home care plans that include medical and nursing supervision, paramedical services, and, at times, the personal services of auxiliary caregivers.

The *Long-Term Care Benefits Insurance Law* assures nursing and personal service to assist patients who live at home. The terms of eligibility for

this benefit are slightly broader than those pertaining to inpatients.

Services Not Assured by Law

The health funds provide a number of paramedical services, e.g., speech therapy, occupational therapy, and physiotherapy, that are not covered by national health insurance and, therefore, require payment.

The Health Ministry provides assistance in purchasing medical aids such as wheelchairs, special mattresses, and various orthopedic instruments, subject to doctors' recommendations and income testing. Hearing aids and dental prosthetics are not included in the lists of aids for which financial assistance may be provided.

Community centers for the elderly have been developing over the past fifteen years. At the end of 1995, 119 such centers (including six in the Arab sector) were attended by 7,500 seniors, half of them under the *Long-Term Nursing Care Benefits Law* and the rest referred by welfare agencies. Those in the latter group pay for this service on a sliding scale.⁹¹ All users of these centers are disabled to some extent; some are mentally frail. The services they obtain include medical supervision (in coordination with family physicians), nursing services, and supervised physical activity.

A number of volunteer organizations provide additional services. The most

important of them is Yad Sarah, a countrywide association that offers the disabled a wide variety of services such as rental of transport equipment, laundry service for the incontinent, and volunteers who visit the housebound and help them perform various activities. Most of the other volunteer activities are local.

Health Promotion and Preventive Medicine

The data available suggest that the elderly do not make efficient use of preventive services, perhaps for lack of awareness of their importance. According to a 1985 survey,⁹² the elderly made little use of the free vision and hearing tests that the health funds offered. In 1984, only 52 percent of persons aged 65+ took vision tests⁹³ and 55 percent reported that they had never had their hearing checked.⁹⁴

In contrast, the elderly are much more aware of the risks of hypertension: 87 percent of persons aged 65+ were examined within the year preceding the survey⁹⁵—perhaps at the initiative of their doctors.

Smoking among the elderly is not prevalent. Nineteen percent of elderly men smoke (but 43 percent smoked in the past) and only 8 percent of women do so (and a smaller proportion of women than of men are former smokers).⁹⁶

Table 8: Daily Charge for Inpatient Care for Patients with Long-Term Illnesses, by Ownership of Institution (Average cost for all hospitals = 100)

Years	1985/86	1987/88	1990	1991
Government, General Health Fund	61.2	63.1	65.5	65.7
Other nonprofit	39.3	39.9	38.1	38.1
Other	26.4	27.8	27.0	25.1

Source: *Statistical Abstracts*, 1986-1994, Table 24.4.

WELFARE SERVICES

Personal Services Provided by Welfare Bureaus

Welfare services are provided by the state—through the agency of municipal governments—and by volunteer organizations and private businesses. These services are not enshrined in law.⁹⁷ The *1958 Welfare Services Law* stresses this by stating that municipal governments are obligated to establish an organizational entity to which the needy may apply, but “this means neither an obligation to provide services of any defined extent and substance nor a legal entitlement of the needy to specific assistance.”⁹⁸

To qualify for welfare services through municipal bureaus, one must meet criteria set forth by the Ministry of Labor and Social Affairs. Practically speaking, services are available only when the welfare bureau in the applicant’s locality has budget provisions for them. Most municipal authorities are required to cover 30 percent of their welfare outlays from their own budgets; the Ministry of Labor and Social Affairs makes up the rest.

In addition to the central-government allocation, welfare services for the elderly can call on extra-budgetary sources. The American Jewish Joint Distribution Committee participates with the state in budgeting Eshel (Association for the Advancement of Services for the Elderly) and Mifal Hapayis, the state lottery, subsidizes the construction of old-age homes and community facilities such as day centers. Additionally, welfare services may avail themselves of private sources such as assistance funds and charitable loan funds of various kinds.

Volunteer activities in the old-age

field focus on building and managing residences for the independent elderly and operating social clubs and sheltered housing. Private businesses deal mainly in institutional services and sheltered housing.

These services are administered under guidelines set up by the Ministry of Labor and Social Affairs (social work regulations) concerning the services that the bureaus may provide and the manner of their provision. Eligibility for services such as home assistance, home repairs, hot meals, and placement in geriatric day centers and old-age homes hinges on an income test.⁹⁹ In contrast, advisory services and personal care by a social worker are provided irrespective of the applicant’s income level.

The Ministry of Labor and Social Affairs does not release information on the extent of personal services offered by the welfare bureaus, although all the bureaus keep records.¹⁰⁰ Thus, the following discussion of welfare services is based on data obtained from the bureaus of Jerusalem¹⁰¹ and Tel Aviv.¹⁰²

In 1994, 50 percent of applicants’ files in Tel Aviv and 38 percent in Jerusalem pertained to the elderly (men aged 65+ and women aged 60+). Fifteen percent of seniors in Tel Aviv and 9 percent of those in Jerusalem had active files.¹⁰³ These differences are interesting because the share of elderly in the lowest income bracket (those who receive income maintenance in addition to the old-age benefit) was higher in Jerusalem than in Tel Aviv (31 percent vs. 25 percent).¹⁰⁴ In both cities, the share of the elderly among clients at the neighborhood bureaus is different: from 38 percent to 73 percent in Tel Aviv¹⁰⁵ and from 36 percent to 46 percent in Jerusalem. These differences¹⁰⁶ indicate that the size of the

welfare clientele depends not only on the population’s needs but also on working procedures, the overt and covert priorities of each bureau, available resources, clients’ information about services, the public image of the service, and people’s willingness to request assistance and endure the inconvenience of the administrative procedures. On the basis of the data that the Tel Aviv and Jerusalem welfare departments shared with us, we may adduce the following:

a. The share of elderly among welfare clients is evidently in the vicinity of 50 percent,¹⁰⁷ much higher than the proportion of this age group countrywide. This reflects the vulnerability of the elderly population and its lack of basic resources.

b. The average caseload of geriatric social workers is twice that of social workers who deal with other population groups. This indicates that personnel are being allocated disproportionately, probably on the assumption that care for the elderly is less time-intensive than care of other clients. We do not know if this assumption has ever been examined; in any case, the information we were given places it in doubt. Data from the Tel Aviv Municipality for 1995 show that 59 percent of new clients at the municipal welfare departments were elderly: reviewing the needs of new applicants is a painstaking process.

c. According to data from the Tel Aviv Municipality, 56 percent of elderly welfare clients have serious health problems: 39 percent are defined as very physically frail, 9 percent as nursing patients, and 8 percent as mentally frail. The high rate of “very physically frail” in the caseload illuminates the limitations of the *Long-Term Care Benefits Insurance Law*, attesting to the

existence of a seriously disabled population group that does not qualify for nursing benefits but needs support services, especially if family support is not available.

Personal Services under the Long-Term Care Insurance Law

The *Long-Term Care Benefits Insurance Law*, activated in 1988, creates nursing benefit eligibility for men over age 65 and women past age 60 if they have severe disabilities, and live at home. The size of the benefit corresponds to the extent of the patient's inability to perform personal care actions on his or her own. The rate thus computed is weighted for the availability (or non-availability) of family assistance. Except for special cases, the benefit is not given directly to eligibles; rather, it is translated into eligibility for hours of service that are provided by outside agencies which receive payment from the National Insurance Institute.

Eligibility for the benefit is contingent on an income test. At the beginning of 1998, the threshold for an individual was NIS 5,605 per month (the national average wage). The cut-off point for a couple was NIS 8,408.

The proportion of the relevant age group qualifying for benefits under the *Long-Term Care Benefits Insurance Law* has been rising: from 5.3 percent in early 1990¹⁰⁸ to 9.8 percent in 1996.¹⁰⁹

Community Services

Community services for the elderly have expanded considerably in the past ten years, foremost thanks to Eshel¹¹¹ and the Israel Community Centers Corporation. Eshel delivers its services by means of municipal associations for the elderly, which sponsor and operate services at the local level. In 1995, some 100 local associations were operating under the Eshel umbrella.¹¹² The

Community Centers Corporation offers programs for some 30,000 elderly persons in two-thirds of its facilities, including some in the non-Jewish sector. This activity, unlike that usually offered in social clubs, includes programs for independent activity¹¹³ and empowerment.

Day Centers

Day centers are for disabled elderly who live at home and need activity, human contact, nursing care, and medical supervision. Because more than half of their clients are eligible for this service as part of the long-term care benefit, a high proportion of attendees have severe disabilities.

The proportion of disabled elderly who attend day centers varies geographically: 10 percent in Tel Aviv and Jerusalem, 15 percent in Haifa, and 20 percent in the Central District.¹¹⁴ These differences point to different patterns of use and raise questions about local operating and attendance policies and the availability of services in different parts of the country.

Day center services have expanded vastly in the past few years. In 1990, 53 centers served 3,875 elderly; at the end of 1994, 119 centers, including 6 in Arab localities, served 7,500 seniors, 1.5 percent of the entire elderly population.¹¹⁵ By the end of 1997, 147 centers served nearly 11,000 seniors, approximately 2 percent of the relevant population group. Nevertheless, a shortage of 1,400 places is expected by the year 2000.¹¹⁶

Community services are not available to the entire population because their formation depends on the initiative and size of the municipal government. A small municipal government cannot sustain community geriatric services because its population of seniors is not large enough.

Most of the centers (84 percent) were

founded by Eshel and are run by local associations backed by the municipal government. Payment for service is graded by degrees of eligibility for the services of municipal welfare bureaus.

A few day centers are administered by volunteer organizations; 6 percent are run by private agencies.¹¹⁷

Convalescent Centers

Convalescent centers provide a therapeutic-rehabilitative service for seniors following hospitalization. They also provide a warm home for those in need of a sheltered setting for limited periods of time. Such centers are available today in six localities, sponsored by public associations and municipal governments in conjunction with the Ministry of Labor and Social Affairs.¹¹⁸ Payment for this service is on a sliding scale.

In Jerusalem, 454 seniors used this service in 1995.

Social Clubs

In 1994, there were roughly 700 social clubs for the elderly, including 400 in urban localities. They were run by municipal governments and volunteer agencies such as Mishan, WIZO, Emunah, the Community Centers Corporation, and smaller local organizations. The clubs' hours of activity are not uniform. Four to six percent of the clubs' clients are disabled seniors.¹¹⁹ The clubs offer diverse activities for men and women together, except in the Arab sector, where most activities are separate.¹²⁰

Volunteer Activity

Volunteer organizations offer regular services for the elderly, sometimes on a large scale. Yad Sarah, for example, serves a large population of seniors including button-activated alarm systems and laundry service for the incontinent. Yad la-Qashish in Jerusalem provides sheltered employment and related

services, and the National Insurance Institute engages many retirees in assisting other elderly persons. Miscellaneous volunteer agencies provide the elderly with many services in coordination with municipal welfare departments. (A network of neighborhood centers in Jerusalem, for example, has 884 volunteers.) Finally, Magen David Adom (emergency services) runs a telephone contact system for seniors who require such care.

Institutional Services

The Inspection of Residences Regulations (Upkeep of Independent and Frail Elderly in Old-Age Homes, 1986) charge the Ministry of Labor and Social Affairs with licensing and inspecting old-age homes. The regulations set compulsory standards in most fields of the institutional system. In the middle of 1996, the country had 102 licensed old-age homes and another 100 in the midst of the licensing process. The number of beds in licensed homes was 12,460 at the end of 1994, and 46 percent of them were reserved for the frail.¹²¹ Additional homes that have not applied to the Ministry for licenses also exist.¹²²

Report 46 of the Israel State Comptroller deals at length with the problem of licensing and inspecting old-age homes and the process of shutting them down. According to the report, 69 percent of the 226 residences that were active in 1995 were unlicensed. Thirty-two of them had been targeted for closure but continued to operate because of the difficulty in closing old-age homes whose tenants have nowhere else to go. Additional unlicensed homes continue to operate because most of their tenants have become nursing patients; in such cases, the Ministry of Labor and Social Affairs is not allowed to issue them a license, and the Ministry of Health does

not do so for budgetary reasons.

Population of Old-Age Homes

Tenants' level of physical functioning: Tenants of old-age homes are categorized as independent or frail, depending on their ability to function physically. The legal definition of physically frail elderly¹²³ indicates that this category is variable. There are different levels of frailty, from persons who need assistance in a few activities of daily living to those whose independence is very seriously constrained. Fifty-four percent of tenants of homes for the aged were independent in 1994 (Table 8), as against 60 percent four years previously.¹²⁴ The decrease reflects the Ministry's policy of minimizing the institutionalization of independent elderly and the growing tendency of the independent elderly to prefer sheltered housing over old-age homes.

The inspection regulations require old-age homes to provide special settings or departments for frail tenants because these seniors' needs are different from those of the independent. Small facilities sometimes lack such settings even though frail elderly live there. Some homes allow frail tenants to hire private caregivers.

Tenants' age: Available data¹²⁵ show that about two-thirds of institutionalized elderly (including those in inpatient facilities) are past the age of 80. This figure reflects the new tendency¹²⁶ to seek institutionalized service only after all other possibilities have been exhausted. Community services, including those provided under the *Long-Term Care Benefits Insurance Law*, give the elderly many more ways to meet their needs than in the past.

More than 70% of institutionalized seniors are women—nearly all of them widows—and the number of married

couples is negligible. It stands to reason that institutional settings become more attractive after the death of one's spouse.

The number of institutionalized seniors who lack available offspring is not known but is presumably considerable.¹²⁷ Without relatives who can provide assistance, elderly people find it very difficult to maintain a reasonable quality of life in an old-age home.

Be'er and Factor (1993, Table 13) show that the share of Mizrahi tenants in institutions (including inpatient facilities) is much lower than their share among the elderly at large. The disparity is likely greater among tenants of old-age homes than among nursing-home patients because most nursing homes, unlike old-age homes, do not have particularistic admission criteria (like, for example, homes for senior citizens who come from Germany), and because most nursing-home patients qualify for state funding assistance.¹²⁸

Ownership of Old-Age Homes

The distribution of beds in old-age homes by type of ownership (Table 9) shows that relatively few beds are owned by the public sector (including national and municipal governments) and that most beds owned by such agencies—84 percent—are earmarked for the frail elderly. The volunteer nonprofit sector focuses on institutional services for independent elderly. Private businesses cater to both categories almost equally. This situation reflects the Ministry's long-standing policy of avoiding direct provision of services and encouraging service development by other agencies, with the accent on service quality.

This policy is manifested foremost in the essence of Eshel's activity, the development of relatively inexpensive institutional and community services for the entire population of frail and nursing

LOOKING AHEAD

elderly. Eshel's modus operandi, which entails extensive involvement of community representatives in service planning and operation, also enhances the community's awareness of its responsibility for maintaining and supervising welfare services. The policy of the government (and the JDC) with respect to the development of institutional services is reflected in Table 9, which shows that between 1990 and 1994, the steepest increase occurred in the number of beds for the physically frail; the number of beds for the independent decreased in the public and the volunteer sectors.¹²⁹ The table also shows that the private market (and the volunteer sector¹³⁰) has been developing more quickly than the public sector despite the vigorous activity of Eshel.

Size of Old-Age Homes

There is a strong correspondence between the type of ownership and the size of an old-age home. Be'er and Factor (1993, Table 3) show that, on average, privately owned homes have much fewer beds than homes under other ownership. A large home facilitates optimal use of staff and space and diversification of services, including leisure activities. The size of the home is especially significant for frail tenants, who need many special services. The 1986 regulations for the

inspection of old-age homes, which include provisions for meeting the therapeutic and physical needs of frail tenants, apply to large homes only. Only facilities with 100 tenants or more, for example, must have a bathroom tailored to the needs of the physically frail. The provisions omit such stipulations for smaller homes, even though frail seniors also live there.

Paying for Institutionalization

Most tenants of old-age homes—some 70 percent—cover the full cost of their institutionalization by themselves; the rest need assistance from the state.¹³¹ The level of state assistance depends on applicants' financial resources, including those of their spouses and children. The share of payment assigned to the admission candidate and his/her children is determined by an income test; the state makes up the difference.

Israel belongs to the group of countries that have a high proportion of pensioners (age 65+) relative to the share of breadwinners. This fraction will grow steadily as life expectancy increases and birth rates fall, and as it does, so will the economic burden on society. In view of this predictable development, it is necessary to examine and improve the array of geriatric services and to adjust it—to the extent possible—to future developments. In this context, several remarks are in order:

* The proportion of seniors who live solely on National Insurance (Social Security) old-age benefits (including income maintenance) has fallen in the past few years but remains high. As long as retirement saving is not compulsory, many people will reach this stage of life without an income of their own and will fall into the lowest income category.

* The post-65 period amounts to about one-fourth of an adult's lifespan (Life expectancy at age 65 is 15.8 years for men and 17.9 years for women¹³²). During this lengthy period, significant changes take place in various areas of personal life, as manifested, especially in older age groups, in the deterioration of health and independence. The result is an increase in the share of expenses for health and household services. In the low income brackets, this increase comes at the expense of other vital needs, such as replacing worn household appliances, travel for social-contact purposes, leisure activity, and even food. The shapers of the income maintenance policy have treated this period of life as one in which needs and expenses do not change, ruling that the level of income maintenance for

Table 9. Distribution of Beds for Independent and Frail Elderly, by Ownership, 1990-1994

Ownership	1990			1994		
	Type of bed					
	Independent	Frail	Total	Independent	Frail	Total
Public (state and Eshel)	545	1,556	2,101	333	1,737	2,070
Volunteer organizations	4,425	1,190	5,615	4,201	1,447	5,648
Private	1,838	1,831	3,669	2,134	2,548	4,682
Total	6,808	4,577	11,385	6,668	5,732	12,400

Source: Information Center, JDC-Brookdale Institute

the elderly should remain constant throughout the period.

* Three government offices—the Ministry of Health, the Ministry of Labor and Social Affairs, and the National Insurance Institute—are responsible for planning and delivering services for the disabled elderly, each in its own domain. This fragmentation works to the disfavor of the elderly population. Each agency operates on its own “turf,” within its own budgetary and political constraints, and under its own priorities. For this reason, services for this population have become segmented, and in some areas the response to needs is deficient. An example is the dividing line between the frail elderly (those who live at home as well as those who live in institutions) and nursing patients. For lack of an inclusive approach toward service planning and resource allocation, no meaningful effort is being made to prevent the hospitalization of patients who need nursing services. Some of these patients could remain at home if more extensive assistance for housebound patients were available, but it seems that this goal will be attained only when the geriatric care budget is assigned to a single agency.

* The high proportion of elderly among consumers of welfare services (health, income maintenance, and social services) is the inverse of their share of the population and is not reflected in the service systems’ priorities. A typical example is the array of geriatric inpatient services. The need for inpatient care is widespread (chiefly in the oldest age groups). Despite the fact that it is relatively inexpensive and that those in need have paid health insurance premiums for many years, it is not covered by National Health Insurance.¹³³ Obviously, full funding of this service from the state budget would create a heavy economic burden,¹³⁴ but there is reason to ask why, of all health-system services, this one was singled out for

omission from the *National Health Insurance Law*. Ignoring the needs of an entire age group, while the *National Health Insurance Law* covers all the needs of young people, appears to be an act of discrimination. Such a policy can come about only where the state considers the elderly a burden that society need not bear and where the elderly lack the political clout to defend their rights. The establishment’s stance on this matter is questionable, especially in view of the investments being made in the development of medical knowledge, which has extended life expectancy and the term of need for nursing care services.¹³⁵

References

¹ The definition of elderly as persons aged 65+ is accepted in international publications and in UN statistics.

² Central Bureau of Statistics (hereinafter: CBS), 1995, *Statistical Abstract of Israel, 1996*, Table 2.10. Israel's population is young in comparison with Europe, North America, and Japan.

³ Jack Habib, 1992. *Policy Issues in an Aging Society*. JDC Israel, Brookdale Institute of Gerontology and Human Development, R-62-92, p. 1.

⁴ The high proportion of children in the Arab population explains the significant difference between the population groups.

⁵ CBS, *Statistical Abstract of Israel 1994*, Table 2.22. The principal source of data in this section is CBS, *Statistical Abstract of Israel, 1996* (hereinafter: *Statistical Abstract*).

⁶ *Statistical Abstract*, Table 3.20.

⁷ *Statistical Abstract*, Table 2.21.

⁸ *Statistical Abstract*, Table 2.22.

⁹ CBS, 1989, Special Publication 840, *Survey of Persons Aged 60+ in Households, 1985*, Part B, p. 18.

¹⁰ *Statistical Abstract*, Table 2.19.

¹¹ There are no precise data on grandchildren and great-grandchildren. A study based on the 1966 population showed that 13 percent of Jewish elderly had either no children or children who had died (Weihl et al., 1970, Table I-2, p. 28). About 90 percent had grandchildren and more than 10 percent had great-grandchildren. A survey of the Muslim rural elderly (Weihl et al., 1986, p. 37) showed that 3 percent had no children, 94 percent had grandchildren, 44 percent had great-grandchildren, and 9 percent had great-great-grandchildren.

¹² CBS, 1989, *Survey of Persons Aged 60+ in Households, 1985*, Special Publication 840, Part B, Table 56.

¹³ CBS, *Statistical Abstract of 1997*, Table 2.8.

¹⁴ Weihl et al., 1986, p. 12. About 20 percent of multigenerational households include children who are still minors.

¹⁵ National Insurance Institute, 1989, *Income Patterns among the Elderly in Israel*, Survey 63, p. 13. Because Mizrahi Jews have relatively low income on the average, some cannot help adult children purchase a home. Thus, many young Mizrahi couples live with their parents.

¹⁶ Weihl et al., 1986, p. 9.

¹⁷ The following should be included in this category: elderly persons who have no living children (even if they have grandchildren); elderly who have no children living in Israel and, therefore, cannot call on them for services; and elderly whose children cannot provide them with services because of chronic illness (mental illness, physical disability, mental retardation).

¹⁸ With the exception of:

1) Provisions of the *Long-Term Care Benefit Insurance Law* that give childless eligibles a few extra eligibility points.

2) Health Ministry provisions that move childless patients to the head of the queue for admission to long-term inpatient facilities.

¹⁹ These groups are also quite heterogeneous: Christian and Muslim Arabs; Jews of western European and eastern European origin; and Jews of Yemenite and Moroccan origin.

²⁰ For the most part, there is a high correspondence between level of schooling and level of income.

²¹ CBS, 1989, *Survey of Persons Aged 60+ in Households, 1985*, B., Table 13.

²² CBS, *Statistical Abstract of Israel 1997*, Table 12.3.

²³ *Ibid.*, Table 37b.

²⁴ CBS, *Statistical Abstract of Israel 1994*, Table 1.11.

²⁵ CBS, 1995, *Survey of Households, 1993, 1992*, Special Publication 993, pp. 18-19; and CBS, 1994, *Survey of Family Expenditures, 1992/93* p. 14.

²⁶ National Insurance Institute, 1996/97.

²⁷ Zvi Zussman, *Ha'aretz*, February 3, 1997.

²⁸ National Insurance Institute, 1992, Survey 91, p. 6.

²⁹ National Insurance Institute, 1989, Survey 63, Table 15.

³⁰ National Insurance Institute, 1992, Survey 91, p. 6.

³¹ National Insurance Institute, 1994, *Insured Persons and Benefit Recipients by Locality, 1992-1993*, Survey 120, Table 1.

³² CBS, *Statistical Abstract 1994*, Table 11.3.

³³ National Insurance Institute, 1989, *Income Patterns among the Elderly in Israel*, Survey 63, Table 3. This table also includes women aged 60-64.

³⁴ The change in the law is not retroactive and it applies only to those newly entering the age group.

³⁵ *Recipients of Income Maintenance among the Elderly in Israel*, Survey 91, p. 6; and *ibid.*, Table 4. This table includes women aged 60-64.

³⁶ National Insurance Institute, 1989, Table 5.

³⁷ CBS, *Household Income 1991, 1990, 1989*, Special Publication 933, Table 18. See also National Insurance Institute, 1992, *Recipients of Income Maintenance among the Elderly in Israel*, Survey 91, p. 5.

³⁸ National Insurance Institute, 1989, *Income Patterns among the Elderly in Israel*, Survey 63, Table 14. The table includes women aged 60-64.

³⁹ Weihl et al., 1986, p. 133; nearly 20 percent of the male population in that study retired before they reached age 65.

⁴⁰ National Insurance Institute, *Statistical Quarterly*, April-May 1995 (Tables A/2-B/16), pp. 16-56.

⁴¹ CBS, 1994, *Survey of Family Expenditure, 1992/93*, B, p. 23.

⁴² Young people in this context are those aged 20-30.

⁴³ "Lacking housing," as the Ministry of Housing and Construction defines the term, are those who neither own nor have ever owned a dwelling in Israel.

⁴⁴ Ministry of Construction and Housing, Tenancing Division, procedures.

⁴⁵ CBS, 1991, *Survey of Housing*

Conditions, Special Publication 956, Table 6.

⁴⁶ CBS, 1989, *Survey of Persons Aged 60+ in Households, 1985, A. Conditions of Housing and Household Management*, Table 1.

⁴⁷ CBS, 1994, *Survey of Housing Conditions, 1991*, Special Publication 956, Table 19.

⁴⁸ CBS, 1987, *Survey of Persons Aged 60+ in Households, 1985*, Special Publication 814, Table 3.

⁴⁹ CBS, 1994, *Survey of Housing Conditions, 1991*, Special Publication 956, Table 27. The rate of those changing dwellings is greater in younger age brackets: 15 percent in the 55-64 cohort and 25 percent in the 45-54 cohort.

⁵⁰ Ibid., Table 20.

⁵¹ Ibid.

⁵² CBS, 1988, *Survey of Persons Aged 60+ in Households, 1985*, Special Publication 840, Table 54.

⁵³ CBS, 1983, *Publications of the Population and Housing Census*, 11, Table 33.

⁵⁴ Weihl, Azaizah, King, and Goldscher, 1986, Tables 17 and 18.

⁵⁵ CBS, 1989, *Survey of Persons Aged 60+ in Households, 1985*, Special Publication 840, Table 50. The proportion of those lacking a telephone rises with age to 31 percent in the 80+ cohort.

⁵⁶ CBS, 1994, *Housing Conditions Survey, 1991*, Special Publication 956, Table 48.

⁵⁷ Electrical water heaters are also used. In 1948, such heaters were installed in 33.4 percent of dwellings of the elderly, meaning that 10 percent of dwellings inhabited by persons aged 65+ had no water heating fixture. The extent of this phenomenon in 1991 is not known.

⁵⁸ The phrasing is cautious because the questions in the two surveys were not identical.

⁵⁹ Noam, G., and Sicon, M., 1990, *Socio-Demographic Changes among the Elderly in Israel, 1961-1983, Analysis of Data from the Population and Housing Census*, JDC Israel-Brookdale Institute of Gerontology and Human Development in Israel, p. 66.

⁶⁰ Weihl 1995, Table 1, p. 10.

⁶¹ Source: Naon, D., and Straussberg, N. *Needs of Elderly Immigrants in Housing and Protracted Care*, Eshel, Five-Year Plan, 1996-2000, 1996, pp. 145-148.

⁶² Source of statistical data, Be'er, S., *Estimates of Needs for Services for the Elderly in Israel, by Geographic Region, 1994-2005*, Eshel, Five-Year Plan, 1996-2000, pp. 64-65.

⁶³ The population of tenants grew more rapidly. A survey of tenants in 1990 showed that about one-fourth of the dwellings were tenanted with married couples (Be'er, S., op. cit., p. 64).

The number of units under public ownership increased significantly in 1995.

⁶⁴ Starkschall, M., 1996, *Guide to Sheltered Housing*, Eshel.

⁶⁵ Habib, J., p. 1. In 1987, 29 percent of health-service expenditures were for the elderly.

⁶⁶ CBS, *Health Survey 1996/97*.

⁶⁷ CBS, 1993, *Diagnostic Statistics on Inpatient Admissions*, Special Publication 941, p. 16.

⁶⁸ CBS, *Statistical Abstract 1996*, Table 24.6.

⁶⁹ CBS, 1989, *Survey of Persons Aged 60+ in Households, 1985, B.*, Special Publication 940, Table 2.

⁷⁰ Ibid., Table 4. The share of people who say they do not use buses climbed from 17 percent in the 65-74 cohort to 40 percent in the 80+. They did not explain whether their not riding buses was due to the inability to use buses or the use of taxis or private cars.

⁷¹ Health funds provide home-care services comprised essentially of medical, paramedical, and social supervision but do not provide personal assistance services.

⁷² For a discussion of services provided under this law: see the chapter on welfare services.

⁷³ CBS, 1997, *Health Survey 1996/97. Advance Data for the Period April-September 1996*.

⁷⁴ In 1992, this age group accounted for 45 percent of inpatient days in general hospitals of the General Health Fund. Shmueli, E., and Levy, Y., "Distribution of Consumption of Services in Israel by Age," *Social Security*,

December 1996, p. 146-153.

⁷⁵ All geriatric inpatient institutions (including nursing departments in homes for independent elderly) are defined as hospitals.

⁷⁶ Long-term illnesses include rehabilitational and nursing geriatrics, mental frailty, nursing oncology, and tuberculosis. Almost all beds are taken up by elderly persons. *Statistical Abstract 1997*, Table 24.6.

⁷⁷ CBS, *Statistical Abstract*, 1985 and 1996, Table 24.8 and 24.6.

⁷⁸ CBS, *Statistical Abstract 1997*, Table 24.7.

⁷⁹ CBS, *Statistical Abstract*, 1994, Table 2.22.

⁸⁰ CBS, *Statistical Abstract 1997*, Table 24.8. The rate of nursing inpatient admissions is rising commensurate with the aging of the population. The Eshel five-year plan (Eshel, 1990) speaks of a shortage of 3,700 beds in the year 2000.

⁸¹ Ministry of Health, 1994, *Procedures of the Long-Term Illness and Old-Age Division*. Geriatric rehabilitation beds are not included in the category of "Long Term Illness Beds."

⁸² JDC-Brookdale Institute, 1996. Bentur, N., Brodsky, J., and Habot, B., *Nursing Patients with Multiple Problems in the Geriatric Inpatient System*, p. 4.

⁸³ Be'er, S., and Factor, H., 1993, "National Census of Residents of Long-Term Care Institutions and Sheltered-Housing Programs," *Gerontology* 62, pp. 16-36.

⁸⁴ Ibid., Table 12.

⁸⁵ Weihl, 1970, Table 1/2. Seven percent of elderly persons of European origin and 16 percent of those of Asian-African origin do not have living children.

⁸⁶ Source: Eshel, verbal communication.

⁸⁷ This association provides services within local government jurisdictions on the condition that the local governments incorporate the service into their budgets after three to five years.

⁸⁸ Current average cost per inpatient day = the total expenditure in each type of hospital divided by the number of inpatient days. *Statistical Abstract 1994*, p. 730.

⁸⁹ A family, for this purpose, includes spouse and children.

⁹⁰ Ministry of Health, Long-Term Illnesses and Old Age Division, January 11, 1995, update of provisions in funding procedure for nursing inpatient admission, "Entrance Charge."

⁹¹ Source: Information Center, JDC-Brookdale Institute.

⁹² CBS, 1989, Special Publication 840, *Survey of Persons Aged 60+ in Households, 1985*, B, Special Publication 840.

⁹³ *Ibid.*, Table 12.

⁹⁴ *Ibid.*, Table 21.

⁹⁵ *Ibid.*, Table 22.

⁹⁶ *Ibid.*, Table 30.

⁹⁷ Except for services provided through the National Insurance Institute.

⁹⁸ Shnit, D., 1988, p. 22.

⁹⁹ Every applicant, however low his/her income, must share the expense of the service. The level of participation depends on income.

¹⁰⁰ Our request for information on the number of elderly applicants to the welfare bureaus was not answered.

¹⁰¹ Data from the Planning Department of the Jerusalem Municipal Welfare Bureau.

¹⁰² Municipality of Tel Aviv-Yafo, Welfare Service Division, 1995, *Analysis of Data on Clients and Service Recipients at the Welfare Service Division for 1994*.

¹⁰³ This rate was computed according to data on the population of urban localities as shown in *Statistical Abstract 1994*, which presents data from 1993.

¹⁰⁴ CBS, 1997, *Local Authorities in Israel, 1995, Physical Data*, Special Publication 1046, Table 55.

¹⁰⁵ Municipality of Tel Aviv-Yafo, 1995, p. 2.

¹⁰⁶ In the material gathered for this and other studies (Weihl, 1990), differences were found among bureaus in the ratios of clients to local population and of the elderly to all clients of the department.

¹⁰⁷ This conjecture is based on partial data obtained from the bureaus of Tel Aviv and Jerusalem and on information obtained verbally

from the Ministry of Labor and Social Affairs.

¹⁰⁸ National Insurance Institute, 1991, Table 1.

¹⁰⁹ Swirski, Barbara, 1997, *Looking at the Israel State Budget: Issues in Care for the Elderly*, Adva Center: 16.

¹¹⁰ See Note 12.

¹¹¹ This association, founded by JDC-Israel, operates in administrative and financial coordination with the Government of Israel.

¹¹² Eshel, 1996, *Five-Year Plan, 1996-2000*, p. 18.

¹¹³ Verbal communication.

¹¹⁴ Eshel 1996, Table 22, pp. 89.

¹¹⁵ *Ibid.*, p. 65.

¹¹⁶ *Ibid.*, p. 65.

¹¹⁷ *Ibid.*

¹¹⁸ *Ibid.*, p. 26.

¹¹⁹ Source: Information Center, JDC-Brookdale Institute.

¹²⁰ We did not obtain statistical data on the extent of activity.

¹²¹ Source: Service for the Elderly, Ministry of Labor and Social Affairs.

¹²² Source: Information Center, JDC-Brookdale Institute.

¹²³ Independent elderly are those capable of carrying out activities of daily life without assistance. A frail senior is one whose level of functioning necessitates partial assistance in the activities of daily life. *Regulations for Inspection of Homes for the Independent Elderly*, 1986, Chapter 1.

¹²⁴ Be'er, S., and Factor, H., 1993, Table 5, p. 20.

¹²⁵ Be'er, S., and Factor, H., 1993.

¹²⁶ Weihl, H., 1974.

¹²⁷ In the early 1970s, they accounted for more than one-third of the population (Weihl, 1973). More recent data are not available.

¹²⁸ See chapter on Health.

¹²⁹ The contraction occurred because of redesignation of beds, sometimes after the departments underwent physical changes.

¹³⁰ Some nonprofit organizations charge high prices for institutionalization, sometimes

higher than those in the private sector.

¹³¹ End of 1994. Source: Information Center, JDC-Brookdale Institute.

¹³² CBS, *Statistical Abstract 1997*, Table 3.20.

¹³³ Some coordination is achieved by means of Eshel.

¹³⁴ Admissions of nursing inpatients with multiple problems are included in this "basket," but only partially: patients and/or their families are charged a high fee for each inpatient day.

¹³⁵ Most geriatric inpatients already receive partial funding from the Ministry of Health.

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