LOOKING AT THE ISRAEL STATE BUDGET

Issues in Care for the Elderly

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The Israel Ministry of Health Budget for Hospitalization of the Elderly

In 1997, the Israel Health Ministry budget for long term hospital care is NIS 600.8 million, 25 percent larger in real terms than it was in 1996. The long term care budget, which accounts for 16 percent of the total Health Ministry budget, goes largely for inpatient care of the elderly.

The Health Ministry budget for 1997 includes a special supplement of NIS 80 million (in 1995 prices) for long term inpatient geriatric care. This supplement is part of a four-year plan that aims gradually to shorten the waiting line of elderly persons who need a nursing home but cannot afford it without financial aid from the Ministry of Health (Ministry of Finance, *Budget Proposal for Fiscal Year 1997 and Explanatory Remarks, Ministry of Health,* p. 70).

At the end of 1994, Israel had a total 23,200 beds for long term care for the elderly in 280 institutions, divided as follows (does not include beds for rehabilitative patients: about 750 in number):

Number of beds	Percent of total beds	Target population
6,670	29%	Seniors capable of independent functioning
5,790	25%	Physically frail elderly
8,990	39%	Elderly in need of nursing care
1,710	7%	Mentally frail elderly

Source: Shmuel Be'er, *Estimates of the Needs for Services for the Elderly in Israel, by Geographic Region: 1994-2005,* Brookdale Institute, 1996:5.

Like those in other countries, services for the elderly in Israel suffer from fragmentation. Even though housing, health, and social services are interrelated, they are planned and budgeted by different government offices:

The National Insurance Institute (Social Security) is charged with home care under the Long Term Care Insurance Law.

The Ministry of Labor and Social Affairs is responsible for placing physically frail elderly persons in homes for the aged or sheltered housing.

The Ministry of Health is in charge of care for mentally frail seniors or those in need of nursing homes.

It is difficult to draw a line between assistance in functioning (for which the National Insurance Institute and the Labor and Social Affairs Ministry is responsible) and

medical care (of which the Health Ministry is in charge). Frail elderly who reside in homes for the aged may subsequently require nursing care.

The following discussion focuses on the Health Ministry budget for hospitalization of elderly persons who are mentally frail or in need of nursing care.

Budget for Long Term Care of Illness and Its Share in the Total Health Ministry Budget, 1990-1997

(NIS thousands, constant prices for 1995)

	1990	1991	1992	1993	1994	1995	1996	1997
Long Term Budget	242,992	302,243	285,560	291,467	318,612	398,148	395,123	493,849
Percent of Health Ministry Budget*	19%	21%	18%	18%	16%	16%	15%	16%

* Percents are rounded.

Source: Ministry of Finance, 1996, *Health Ministry Budget Provisions,* various years

As stated, most of the Ministry of Health budget for care of long term illnesses is earmarked for geriatric hospitalization. As the 65+ age cohort grows, so does the number of potential users of hospitalization services for the elderly:

Year	Number of Elderly (65+)	Share of Elderly in Total Population
1975	277,400	7.9%
1985	372,500	8.8%
1995	537,500	9.6%

Source: *Statistical Abstract of Israel,* 1976*,* Table 15b; *Statistical Abstract of Israel,* 1986, Table 17/b; *Statistical Abstract of Israel,* 1996, Table 2.21.

The 75+ age cohort, too, is expanding steadily. The forecast points to a slow increase in the proportion of those aged 65 and over and a *very* substantial growth of the 75+ group-especially women in this group, whose life expectancy surpasses that of the men.

Today, 58 percent of persons aged 75+ and 70 percent of elderly inpatients are women. Thus, when we speak of services for the elderly, we speak of a user population composed largely of women.

As the oldest population group (those aged 75+) has grown, so has the demand for long term inpatient beds-the kind of hospitalization from which there is no recovery (except for rehabilitative patients. See the definitions on the next page).

Who Needs Long Term Hospitalization?

1. *The chronically ill* who can no longer function on their own and require continual medical surveillance. These include persons confined to bed or wheelchair because of illness or the complications of illnesses and persons who suffer from incontinence or cannot move from place to place.

2. *Patients with multiple problems*-those who, in addition to functional problems, suffer from pressure sores or metastasized cancer and need long term intravenous infusions or dialysis.

3. *Mentally frail patients who suffer from cognitive decline* and require full-time assistance in the activities of daily life (ADL).

4. *Long term rehabilitative patients,* whose functioning has declined substantially because of an acute medical problem such as a hip fracture, a cerebral event, an infectious illness, or surgery.

Who Pays for Hospitalization of the Elderly?

1. Inpatient Care for Long Term Patients with Multiple Problems and Rehabilitative Cases

The basket of services covered by the Israel National Health Insurance Law includes inpatient care for chronically ill patients with multiple problems, and for those with rehabilitation needs. This inpatient care, however, is not provided free of charge: patients with multiple problems are charged a co-payment of more than NIS 100 per day. Under a special arrangement, the Health Ministry provides special assistance for the General Health Fund, many of whose members need this kind of care. In 1997, the assistance budget was NIS 5.4 million (current prices), 3 percent higher in real terms than in 1996.

2. Long Term Hospitalization for the Mentally Frail

The other two kinds of hospitalization-of chronically ill patients in need of constant care and of the mentally frail-are not insured. The Ministry of Health has a special budget to assist those who cannot afford this care. Pursuant to screening and a means test, the Ministry provides a monthly payment (based on the patients' income and assets and that of their spouses and children) that covers the difference between the actual cost of care and a co-payment determined on the basis of financial resources.

In 1997, the Ministry's assistance budget for this purpose was NIS 441 million (in current prices)-the lion's share of the budget for long-term care. This budget line is meant to subsidize a total of 7,100 beds, 1,320 more than in 1996. To add these beds, a budget supplement of NIS 132 million (in real prices) was allocated.

Although the Health Ministry assistance budget is sizable, it falls far short of covering everyone in need. In June 1997, 2,300 patients-about 25 percent of those in need-were waiting for government assistance. The Health Ministry itself states that "The extent of hospitalizations hinges on the budget stipulated for this purpose each year" (Ministry of Finance, *Budget Proposal for Fiscal Year 1996 and Explanatory Remarks, Ministry of Health*, p. 89).

Most people who need long-term care cannot afford it on their own. In 1990, 68 percent of long term care and mentally frail patients who received inpatient care in geriatric institutions did so with government assistance. The Health Ministry support was quite substantial: 65-75 percent of the total cost of long term care for the elderly in 1990-1995 (Katan, 1997). In 1997, the cost of such care in approved institutions ranged from NIS 6,000 to NIS 15,000 per month.

The budget constraints of the Israel Health Ministry give rise to an absurdity: seniors who need inpatient care because of an acute but transitory problem such as a fracture, pneumonia, or a cerebral event can obtain this care from their health fund as part of the schedule of insured services. In contrast, seniors who need long term care because they have become bedridden or have lost their memory or sense of orientation may find themselves footing the hospital bill themselves, because this service is excluded from the insured list. This is the plight of the aforementioned 25 percent of patients.

The Health Ministry subsidizes beds in both public and private institutions; the Health Ministry provides a list of approved nursing homes from which patients' families may choose.

Supplemental Insurance for Hospitalization of the Elderly

As we have seen, the Israel Health Ministry budget does not suffice to subsidize inpatient care for about 25 percent of those in need. This figure, however, should be considered an underestimate, since it reflects only senior citizens whose families find it hard to provide this care at home and decide to shoulder the co-funding burden. If hospitalization were included among the insured services, more seniors would surely apply for it. Many families-foremost those of low income-presumably dismiss the very possibility of arranging inpatient care for their chronically ill, aged relatives because of the high cost of such care and the constraints of the Health Ministry's assistance budget.

The problem of hospitalization of the elderly in Israel lends itself to two reasonable solutions:

1. One would be to include long term inpatient care in the basic basket of services covered by national health insurance;

2. An alternative would be to reconstitute the elective long term care insurance plans that health funds and private insurance companies offer their members in the form of *compulsory* supplemental insurance. If this is done, the cost and terms of the insurance should be standard among all health funds.

Both of these solutions require additional funding. The first solution could be funded by the state treasury through an increase in the Health Ministry budget or an upward adjustment of the health tax. Payment for compulsory supplemental insurance could be covered by imposing an additional tax that could be set as a proportion of the insured's income-say, 0.5 percent-or set at a flat rate, e.g., NIS 100 per health-fund member.

Voluntary Supplemental Insurance Through the Health Funds

Can healthy young people regard non-compulsory supplemental insurance, i.e., the existing situation, as their solution for the future? To answer this question, we should examine several matters:

1. *Access:* Are citizens given the information they need to take out supplemental insurance?

The scanty experience since 1995 elicits a mixed picture. A study by the Brookdale Institute found that about 40 percent of Israel's adult population has purchased supplemental insurance since January 1995. However, there are large differences among the health funds in the percentage of purchasers, as the authors of the study, Gross and Bramli, found:

Health Fund	
General	16%
Leummit	50%
Maccabi	more than 80%
Meuhedet	more than 80%

The researchers note that the differences in enrollment rates for supplemental insurance may originate in different methods of registration (Gross and Bramli, 1996). However, they may also stem from differences in income and state of health: the General Health Fund has the highest proportion of elderly and low-income members among all the health funds.

The solution to the inter-fund differences is to make supplemental insurance compulsory under law.

2. *Price:* Is the premium low enough to avoid being a deterrent?

In 1996, the various health funds charged from NIS 5 to NIS 80 per month per insured person for supplemental insurance. Some of the difference reflects variations in the level of long term coverage, discounts for dental care, and additional services (Gross and Bramli, 1996:11-30).

3. *Voluntary insurance:* If supplemental insurance is allowed to remain non-compulsory, may a majority of citizens be expected to sign up for it?

The foregoing data on enrollment rates for supplemental insurance plans at the various health funds show that coverage is not universal. However, this may reflect faulty promotion by the funds. Perhaps, too, the National Health Insurance Law went into effect too recently to judge health consumers' behavior.

4. *Extent of coverage:* Is the supplemental insurance generous enough to assure full coverage of patients in need of long term nursing care?

Our assumption is that supplemental insurance suffices when it covers at least 80 percent of the expenses of long term inpatient care and remains in effect for an unlimited period of time.

None of the health funds' supplemental insurance plans meets these criteria:

The General Health Fund (through the Dikla Insurance company) covers inpatient care at 60 percent of costs up to NIS 1,306-5,225 per month (depending on the age of the insured at the time of enrollment). The insurance term hinges on the policyholder's years of tenure in the plan (Dikla, Ltd., July 1997).

The Maccabi Health Fund: "Keren Maccabi" and "Maccabi Magen" provide monthly indemnification of up to NIS 3,859 plus $1,000, on the condition that the sum not exceed 80 percent of inpatient expenses, for a maximum of five years ("Complemental Medical Insurance Through Keren Maccabi and Maccabi Magen," March 1997, and "Maccabi Magen, Statement of Entitlements and Obligations of Members of Maccabi Magen," updated to April 1, 1997).

The Leummit Health Fund provides monthly coverage from NIS 1,125 to NIS 6,667 for up to five years ("Leummit for the Pensioner, Long Term Care Insurance Policy for Members of Leummit

Health Fund," and "Leummit-The Israeli Phoenix, Complemental Medical Insurance Policy for Members of Leummit Health Fund").

The Meuhedet Health Fund offers a long term plan called "Meuhedet Zahav" that indemnifies policyholders at up to NIS 3,537 per month for the first three years and NIS 2,120 per month during the fourth and fifth year (Meuhedet Health Fund spokesperson, July 1997).

These are the basic plans; some of the funds offer additional units of coverage.

5. *Are the premiums realistic?* Do policyholders' co-payments enable the health funds or the commercial firms to bear the expenses in the long term? Not enough experience has yet accrued, and actuarial examinations have not yet been published.

Voluntary Supplemental Insurance Through Commercial Insurance Companies

Private insurance companies' revenues from the sale of health-insurance policies have been growing in the 1990s. For example, such revenue accounted for 3.4 percent of the total national health expenditure in 1993, as against 2.0 percent in 1991 (Gross and Bramli, 1996, 38). The proportion of adult Israelis ensured by commercial firms also rose-from 13 percent in 1990 to 16.7 percent in 1995 (ibid.; the sample included only Hebrew speakers aged 22 and over). These data pertain to all kinds of health insurance, of which long term geriatric care is only one. The proliferation of insurance companies that have recently gone into the private market for long term care indicates that this field has been burgeoning (ibid.).

The questions we posed with respect to the health funds' plans should also be asked with respect to commercial supplemental insurance plans:

1. *Access:* Are citizens given the information they need to choose a policy?

Studies in other countries have found that purchasers of commercial insurance are typically healthier, higher in status, and better educated than the average for their citizens. A Brookdale Institute survey elicited similar findings in Israel and noted the evident existence of "a limit to the accessibility of these policies for large population groups" (ibid., p. 64).

2. *Price:* Is the price low enough to avoid deterring prospective policyholders?

The American experience shows that the answer is negative. Only a small minority there seems able to afford commercial health insurance (OECD, 1996, 41-42).

3. *Voluntary insurance:* Can it be assumed that a majority of citizens would take out commercial policies?

An OECD position paper notes several lessons adduced in the United States with respect to commercial insurance for coverage of long-term hospitalization for the elderly.

a. Only a minority of seniors can afford private long term insurance.

b. Young people, who are subject to more immediate economic pressures, tend to put off preparing for the time in life when they will need long term care.

c. Most consumers do not understand the terms of the private policies (OECD, 1996:41-42).

4. *Extent of coverage:* Does commercial insurance provide enough coverage for patients in need of long-term care? The terms vary from one company to the next. For example:

a. The Shiloah-Harel company provides NIS 1,500 to NIS 3,000 per month for up to three years. One may buy two units of coverage by doubling the premium (ibid., 39).

b. The Klal company offers up to $4,000 per month for an unlimited term (ibid., 43).

c. The Zion company offers up to $5,000 per month for up to five years (ibid., 45).

Coverage is commensurate with policyholders' age and state of health when they join the plan. As can be seen, only one company offers a monthly benefit for an unlimited term.

5. *Are the premiums realistic?* Are they high enough for the commercial firms to shoulder the outlays? According to the aforementioned OECD policy study, commercial insurance for long term hospitalization for the elderly is "perhaps the riskiest product that insurance companies sell"-because of the length of time that passes before the insurance is utilized, coupled with limits to what is known about future health trends, the price of inpatient care, and use patterns for insurance for long term care (ibid.).

Israel's arrangements for geriatric hospitalization lag far behind those in other fields of health. For example, it is self-evident that men and women in their twenties, thirties, forties, or fifties who need inpatient care should obtain it. It is also taken for granted that people in these age groups should not have to pay for inpatient care to the point where they are economically ruined. Thus, their hospitalization expenses are covered by the national health insurance. However, when it comes to seniors (65+) who need long term inpatient care, the attitude changes: here, the financial burden is on the patients and their families.

This distortion should be corrected and the entitlements of the elderly aligned with those of younger citizens. The fact that fewer than 5 percent of Israel's elderly are institutionalized at any given time conceals another fact: geriatric beds have a high turnover. Thus, practically speaking, the proportion of Israel citizens who will need long term geriatric inpatient care sometime in their lives far exceeds 5 percent.

A computation in Germany, where only 5 percent of the 65+ population is hospitalized in geriatric institutions, found that 40 percent of men and 70 percent of women will need this kind of care at some point (OECD, 1996: 269). We do not know if there is such an estimate for Israel.

Caring for the Elderly in the Community: A Gender Perspective

In many countries, the trend today is to care for long term and mentally frail patients in community settings instead of in geriatric institutions. From the standpoint of the individuals involved, community care is considered superior because it avoids displacement from one's family and surroundings and preserves daily routines.

In most cases, "community care" means a one-to-one relationship between patient and caregiver. The caregiver is usually a woman, either unpaid because she is the spouse, daughter, or daughter-in-law of the patient, or remunerated if she is an Israeli or foreign provider of nursing care.

Community care in Israel received a boost in 1988 when the Long Term Care Insurance Law came into effect. The law entitles functionally challenged seniors to a long term care benefit through National Insurance after they pass functioning and income tests. The benefit may be used to hire a personal caregiver, visit a geriatric day center, purchase absorbent materials and laundry services, and lease alarm transmitters. In December 1996, 69,000 seniors were receiving benefits in this rubric; more than 70 percent of them were women (National Insurance Institute, *Statistical Quarterly,* 26, No. 4, October-December 1996, Table 2/c).

In January 1997, the basic benefit was NIS 1,261 per month for those largely dependent on assistance from others and NIS 1,892 per month for those totally dependent. Total outlays in 1996 under the Long Term Care Insurance Law exceeded NIS 1 billion. The law created a new economic sector: more than 400 personnel companies and nonprofit organizations that recruit personal caregivers and place them with patients. The law also ushered in a new social phenomenon: recruitment of thousands of foreign workers, mostly from the Philippines.

Notably, the National Insurance Institute provides the long term monthly benefit for employment of a caregiver *only* through caregiving nonprofit organizations or companies-not directly to the seniors. These enterprises peel off about half of the care benefit for themselves. This sum, calculated in accordance with the expenditures of the first and largest nonprofit association, Matav, includes about 40 percent to cover the expenses connected with caregivers and about a 10 percent margin.

All personnel companies and nonprofits obtain an identical sum from National Insurance per caregiver-hour (corporations get an additional 17 percent for Value

Added Tax)-but the caregivers' actual wages vary from one outfit to another (Ofer, 1997).

Geriatric Care: Family Members, Community Care, and Institutionalization

Geriatric care is delivered in three principal ways: a) by family members, b) by home assistance and other services provided in the community, and c) through long term institutional care. Each of these is discussed separately below.

a. Care by Family Members

In most countries, including Israel, most geriatric care is provided by family members (OECD, 1996:63; Walter-Ginzburg et al., 1997).

In Israel, the proportion of elderly who obtained assistance solely from family members was higher among the Asian- and African-born than among those born in America-Europe or Israel (ibid., 1997:15). The need for assistance is greater among women than among men, among the African- and Asian-born than among the American- and European-born (ibid.: 11), among former Soviet immigrants than among nonimmigrants, and among non-Jews than among Jews (Be'er, 1996).

A survey conducted in 1989 (Walter-Ginzburg et al., ibid.) among a sample of Jews aged 75+ showed that half of respondents who were disabled in one or two activities of daily life (ADL: eating, bathing, dressing, transferring, and use of the lavatory) obtained assistance from family members only. About one-third of seniors disabled in three to five ADL availed themselves of family members only (ibid., 19). Elderly who obtained assistance outside the family continued to avail themselves of family members for various purposes.

b. Community Care under the Long Term Care Insurance Law

Most of the aged who need ADL assistance from agents outside the family obtain it in the community: 70 percent according to Walter-Ginzburg et al. (1997) and 75 percent according to Brookdale Institute estimates (Be'er, 1996:3).

In 1996, 69,000 seniors obtained home assistance under the Long Term Care Insurance Law-9.8 percent of the 65+ age cohort. [Lacking a figure for 1996, we added 3 percent to the aforementioned population of this age group in 1995, 537,500. (Central Bureau of Statistics, *Statistical Abstract of Israel,* 1996, Table 2.21.) This estimate corresponds to that of the Brookdale Institute for 1994 (Be'er, 1996:3)].

Our estimate does not include elderly who pay out of pocket for home nursing care. Since all seniors whose monthly income falls short of 150 percent of the national average wage (NIS 7,500 in June 1996) qualify for home care under the Long Term Care Insurance Law, a majority of elderly who obtain this kind of assistance presumably receive benefits.

Relative to other countries, Israel has a high proportion of persons receiving home care. Among the OECD countries as a whole, only those in Scandinavia-Finland, Norway, Sweden-and the United Kingdom exceed Israel's rate of home assistance.

Comparative figures are provided in the table below. Note that the data for most other countries are not updated to 1996.

Percent of Seniors (65+) Who Obtain Home Assistance, Israel and OECD Countries

Country	Percent of 65+ who obtain home assistance	Year
Finland	24	1990
Denmark	17	1991
Norway	14	1991
Sweden	13	1990
United Kingdom	13	1991
Israel	9.8	1996
Netherlands	8	1990
France	7	1985
Australia	7	1988
Belgium	6	1989-90
United States	4	1990
Austria	3	1991
Ireland	3	1990
Japan	2	1993
Spain	2	1994
Italy	1	1988
New Zealand	1	1993
Portugal	1	1992

Source: OECD, *Caring for Frail Elderly People. Policies in Evolution,* 1996, p. 62

Is Home Assistance a Substitute for Institutional Care?

About one-fifth of the elderly who obtained home care under the Long Term Care Insurance Law in December 1996 received the maximum benefit. This group of patients (14,700 in number) bears the strongest resemblance to those who reside in long term care institutions. Is home care a substitute for institutionalization? Probably not: There is no evidence that home care occasions a decrease in the demand for nursing-care beds. Therefore, home care may be of assistance to a different population group from that availing itself of institutional care (OECD: 1996: 75).

c. Long Term Care in Institutions

In 1995, Israel had 537,500 persons aged 65+. At the end of 1994, there were 23,950 beds in long-term care institutions (Be'er, 1996:5: does not include about 750 rehabilitation beds; Ministry of Health, 1996:18). Assuming that all of these beds were occupied, seniors in long term care institutions accounted for about 4.5 percent of the total elderly population-as against an average rate of 5.5 percent in twenty OECD countries (OECD, 1996: 47). Notably, these data do not include seniors who live in sheltered housing, where they lead more independent lives. In 1996, Israel had 9,000 sheltered-housing units (Be'er, 1996).

Proportion of Seniors (65+) in Long Term Care Institutions, Israel and OECD Countries

Country	Percent of 65+ in long term care institutions	Year
Netherlands	9.1	1990
Luxembourg	7.4	1991
Canada	7.1	1991
Finland	7.0	1990-1991
New Zealand	6.7	1991
Norway	6.5	1992
Australia	6.2	1991
Japan	6.2	1993
Germany	5.4	1992
Sweden	5.3	1988-90

United States	5.2	1990
Denmark	5.2	1992
Belgium	5.2	1991
United Kingdom	5.1	1990
France	5.0	1990
Ireland	5.0	1991
Israel	4.5	1994
Austria	4.6	1988
Italy	2.4	1987-88
Spain	2.4	1988
Portugal	2.0	1992
Turkey	0.2	1991
Greece	0.5	1985

Source: OECD, *Caring for Frail Elderly People. Policies in Evolution,* 1996, pp. 48-49. The figure for Israel was computed by dividing the number of 65+ (according to *Statistical Abstract of Israel*) by the number of long term institutional patients in 1994 according to Shmuel Be'er, 1996, *Estimates of Needs for Geriatric Services in Israel, by Geographic Area: 1994-2005,* Jerusalem: Brookdale Institute, p. 21.

Is Institutional Care Less Expensive than Community Care?

The experience of the OECD countries shows that community care-if adequately fostered and equipped with a wide range of services (hot meals, personal care, hygiene, home repairs, and geriatric day centers)-is not necessarily less expensive than institutional nursing care (OECD, 1996: 74, 75).

Long Term Care of the Elderly: A Few Gender Remarks

In Israel, a majority of the elderly are women: 57 percent of those aged 65+ and 58 percent of those aged 75+. Women account for 70 percent of recipients of the National Insurance long term care benefit. The proportion of women among patients in long term care institutions is similar.

Women have a biological advantage in that they outlive men. However, elderly women have a higher incidence of illness than elderly men. It is not known whether this stems from genetic factors or from factors associated with the roles that women play during their lives (Salzberger, 1990).

Women are in the majority not only among care recipients but also among *caregivers.* Because of their longer life expectancy, elderly wives usually care for elderly husbands and, when their own time comes, generally find themselves without a spouse to care for them, and are tended by a daughter or daughter-in-law.

Care for the elderly is not considered "work"; it is deemed one of the family functions of the wife, daughter, or daughter-in-law. Women are therefore not remunerated for their services-just as they are not remunerated for the care of children or grandchildren, or for housework. From the standpoint of the architects of social policy, caregiving is invisible work and "doesn't count" in the national product.

In Israel, proponents of the advantages of home care overlook the cost of women's caregiving labor-a cost that includes not only uncompensated labor hours but also the loss of service time in computing seniority for old-age benefits and pensions. This situation is not inevitable; it originates in an inequitable social policy, as one may discern by comparing the situation in Israel to that in some other countries:

In *Germany,* women's time off from work for care of children or seniors is considered full-fledged service time for pension accrual (Alber, in OECD, 1996:263).

In *Sweden,* women who quit their jobs or reduce their hours of work to care for family members are entitled to payment from the municipal authority for their caregiving efforts. If they leave a job to care for a terminally ill relative, they qualify for up to thirty days' paid leave from their place of work (OECD, 1996:173).

In *Denmark,* care of a terminally ill family member entitles the caregiver to partial compensation for income lost due to furlough from work (OECD, 1996: 126).

Israel has an arrangement utilized mainly in the Arab sector: family members who do not live in the same household (usually granddaughters) can be remunerated for geriatric care under the Long Term Care Insurance Law. This arrangement corresponds to local custom, since it is not acceptable in Arab society to hire extra-familial caregivers for the home care of relatives. The remuneration adds to the young caregiver's prestige: although she does exactly the same work that she had done before the law was passed, the state now compensates her for it and thereby allows her to contribute to the family income (Weihl, 1995).

In other words, today's policy remunerates women on the condition that they perform their caregiving labors outside their own household. Otherwise, their efforts are perceived not as work but as a family duty. To categorize their activity as work, they must move from the "private domain" into the "public" one.

This perspective originates in a more fundamental philosophy that defines the basic unit of social reference as the family, not the individual. Were the individual the unit of reference, a woman could be remunerated for any work she performed-at home or

elsewhere. Sweden has adopted this approach, defining care of the elderly as a service that the state owes its citizens. Women who choose to care for a senior in their own home are remunerated equally to those who do so in the home of another family.

A Hierarchy of Women

The table that follows shows the existence of an explicit hierarchy of women in the provision of care for the elderly. This hierarchy is determined by three criteria: a) kinship between the patient and the caregiver; b) the venue of caregiving; and c) the need for professional training and certification as prerequisites for hiring. These criteria determine whether caregiving is defined as work, the level of remuneration, and, to a large extent, the national and/or class origin of the women employed at each of the rungs of the hierarchy.

Women Caregivers for the Elderly: Terms of Work and Remuneration

Caregiver	Kinship vis-a-vis patient	Place of work	Occupational training	Wage
Daughter or daughter-in-law	Daughter or daughter-in-law	Patient's home	None	None
Granddaughter (Arab sector, mostly)	Granddaughter	Patient's home	None	Minimum or subminimum wage, by the hour
Filipina caregiver	None	Patient's home	None	Sub-minimum
Personal caregiver: Israeli employee of caregiving company	None	Patient's home	Usually none. Some caregiving companies provide in-service training activities.	Hourly minimum wage
Nursing-care worker in long term care institution	None	Nursing home	Usually none. A quasi-governmental association, Eshel, provides in-service training activities.	Minimum wage

Registered nurse in long term care ward of general hospital	None	Hospital	Nursing certification	In accordance with collective bargaining agreement
Social worker	None	Office of nursing-care company	Academic degree	According to collective bargaining agreement
Relative who supervises caregiving	Relative	Home of caregiver or patient	None	None

Daughter or Daughter-in-Law

A daughter or daughter-in-law who cares for a mother or mother-in-law is not deemed to be "working." She is given neither occupational training nor certification, and is not recompensed for her services. In Israel, this pattern of care is especially prevalent among Mizrahi Jewish families (Walter-Ginzburg, et al., 1997).

Granddaughter (mainly in the Arab Sector)

A granddaughter who cares for an elderly Arab citizen may be recompensed for this care, which is defined as "work" because the patient lives in a household other than the caregiver's. The wage is minimum or subminimum and is paid by the hour.

Filipina Caregiver

In 1996, Israel had 7,755 documented nursing caregivers from abroad, foremost from the Philippines (Ministry of Labor and Social Affairs, 1997). The employers do not acknowledge Philippine occupational certification such as that of a practical or registered nurse. Certification, insofar as it exists, does not elevate its holder to a higher occupational grade. The wage is stipulated in a personal contract between the caregiver and the patient or the family member who employs her; it ranges from $500 to $700 per month plus $30-45 for health insurance and about NIS 60 per week in pocket money. By an hourly reckoning, a wage of less than $600 per month falls below the customary Israeli minimum. Because these personal contracts are not subject to collective bargaining agreements, employers set caregivers' social benefits, as well as hours of work and rest, at their discretion.

Workers from the Philippines are defined not by the work they do but rather by their origin. In other words, they are neither "workers" nor "caregivers" but rather simply "Filipinas." Practically speaking, they may be likened to relatives who serve as

caregivers, since the geriatric care provided by both groups is not recognized as "work." Filipina caregivers' services are perceived as the result of the fact of their having come from a poor country, and their very stay in Israel depends on their employers' willingness to equip them with legal residency permits. Caregivers from the Philippines are remunerated, but not in the manner of an ordinary "wage" in the formal economy.

Israeli Caregiver

An Israeli woman who provides care in the patient's home is indeed perceived as "working." However, since this care has not yet been recognized as a profession, caregivers are not asked to obtain training that would entitle them to professional certification of any kind (with the exception of a small number of unemployed women or recent Ethiopian or former Soviet immigrant women who took courses offered by the Ministry of Labor and Social Affairs). The wage is low, usually set at the minimum and paid by the hour. Because the work is usually divided among several patients, few caregivers attain full-time status. Social benefits are paid only for workers who have the good fortune of being employed by a nonprofit association or a company that operates in accordance with labor laws or under collective wage agreements. Typical Israeli caregivers are women aged 40-64 with scanty formal education; most are of Mizrahi or former Soviet origin. Some of the latter have occupational credentials but cannot find other employment in Israel.

Nursing Care Worker in a Long Term Care Institution

The terms of labor of nursing care workers in long term care institutions depend on whether the institutions are signed to collective wage accords. Ordinarily, the wage paid is the minimum. The work is not defined as professionally skilled; workers require neither schooling nor training to get their jobs. The Eshel association offers courses for caregivers, but few caregivers in institutions have enrolled in them thus far. Most workers in this sector are Mizrahi, Arab, or recent former Soviet immigrant women.

Nurse in a Long Term Care Ward of a General Hospital

In contrast to other caregivers, nurses who work in a nursing home or a long term care ward of a general hospital are considered professionals. Their patients are not relatives, they work for public or private institutions that are recognized as providers of professional services, and they require nurse's certification to be hired. Certification confers membership in a professional association that negotiates with employers to assure good wages and working conditions. Indeed, registered nurses who work in general hospitals at 150 percent of a full-time position typically earn NIS 9,000 per month. The older nurses are middle-class Ashkenazi and Mizrahi women, because the nursing profession was a respected choice in the 1960s and 1970s. Subsequently, middle-class women preferred to pursue academic professions and left the nursing field to women of lower socio-economic status-Mizrahi, Arab, or former-Soviet.

In the OECD countries, the prevalent trend today is to downscale the long term care departments of general hospitals and replace them with long term care beds in specialized institutions. This is because such beds are less costly in nursing homes

than in general hospitals. The trend in Israel is similar. This may save on expenses, but some of the foreseen saving will be at the expense of the women who provide geriatric care. This is because private nursing homes-a rapidly developing sector-generally employ unqualified women at low wages.

This development does not bode well for patients. There is much evidence of faulty performance, and the Labor and Social Affairs Ministry is striving to improve or close private institutions that do not meet the minimum standards set forth in the new Supervision of Day Centers Law (Fleischman et al., 1996). Notably, however, some private institutions provide their clients with appropriate care even though they do not meet the government criteria (Sa'ar, 1997).

Social Worker

When personnel companies or nonprofit associations wish to maintain high standards and supervise their caregivers, they hire social workers.

Social workers, like nurses, obtain academic degrees and professional certification. The average monthly wage of a social worker in 1997 is about NIS 7,000, plus expenses and car allowance. Social workers (75 percent of whom are women) belong to a professional association that negotiates with employers. The profession is predominantly female-staffed by middle-class Ashkenazi and Mizrahi women-and academic. A career in social work is common in social groups among which academic education is still the province of a minority: Arab and Ethiopian-immigrant women.

Family-Relative Supervisor

The hierarchy of women who provide long term care for the elderly includes one more category of service that is not defined as "work": patients' female relatives who supervise caregivers' work. These are the family members who apply to nursing-care companies, the National Insurance Institute, and the Ministry of Labor to hire a caregiver. They are the ones who devise the senior's "caregiving program" and monitor its implementation. They are the ones who make certain that there is a surrogate caregiver when the permanent caregiver is on vacation or ill, and they are the ones who decide whether the patient is to be cared for at home or in an institution.

BIBLIOGRAPHY

Hebrew

Be'er, Shmuel, 1996. *Estimates of the Needs for Services for the Elderly in Israel, by Geographic Region: 1994-2005,* Jerusalem: Brookdale Institute.

Gross, Revital, and Shuli Barmli, 1996. *Supplemental and Commercial Health Insurance in Israel-1996, A Comparative Survey, Analysis of Changes in the Market and Examination of Policy Alternatives,* Jerusalem: Brookdale Institute.

Spokesperson of Meuhedet Health Fund, July, 1997.

Spokesperson of Dikla-Kelalit, July 1997.

Central Bureau of Statistics, various years. *Statistical Abstract of Israel.*

National Insurance Institute, 1996. *Statistical Quarterly,* Vol. 26, No. 4, October-December.

Salzberger, Lotte, 1990. *Social Privation Over Time: The Effect of Heightened Social Opportunity Inputs on Deprived Families,* Ph.D. dissertation, School of Social Work, The Hebrew University of Jerusalem.

Chen, Shoshana, 1997. "City of Elders," *Yedioth Ahronoth,* May 23, 1997.

Korazim, Malka, and Paula Kahan-Strawczynski, 1995. *Training Program for Home Care Workers for the Elderly: Evaluation of Contents, Structure, and Outcomes,* Jerusalem: Brookdale Institute.

Ministry of Finance, 1996. *Budget Proposal for Fiscal Year 1997 and Explanatory Remarks, Ministry of Health.*

Ministry of Finance, various years. *Budget Provisions, Ministry of Health.*

Ministry of Labor and Social Affairs, 1997. Communication from Yekutiel Sabba (July).

Sa'ar, Reli, 1997. "The Good, the Bad, and the List," *Ha'aretz,* July 23, 1997.

Fleischman, Rachel, Ilana Holzer, Dror Walk, Jenny Mandelson, Gad Mizrahi, Miriam Bar-Giora, and Fanny Yuz, 1996. "Institutions for the

Elderly Operating Without a License: Quality of Care and the Surveillance Process," *Social Security* (December).

Ofer, Aliza, Director-General of Matav, 1997. Personal communication (June).

Katan, Joseph, 1997. "Institutional Services for the Elderly: a Partial Privatization Model," *Gerontology* (spring).

Maccabi Health Fund, 1997. "Maccabi Magen, Statement of Entitlements and Obligations of Members of Maccabi Magen," updated to April 1, 1997, and "Supplemental Medical Insurance Through Keren Maccabi and Maccabi Magen" (March).

Leummit Health Fund and the Israel Phoenix Insurance company, undated. "Supplemental Medical Insurance Policy for Members of Leummit Health Fund," and "Long-Term Nursing Insurance Policy for Members of Leummit Health Fund."

English:

Alber, Jens, 1996, "The Debate About Long-Term Care Reform in Germany," in OECD, pp. 261-276.

Bhattacherjee, Annanya, 1997, "The Public/Private Mirage: Mapping Homes and Undomesticating Violence Work in the South Asian Immigrant Community," in Jacqui Alexander and Chandra Talpade Mohanty, *Feminist Genealogies, Colonial Legacies, Democratic Futures*, New York: Routledge.

Walter-Ginzberg, Adrian, Jack Guralnik, Tsvia Blumstein, Zahava Fuchs, and Baruch Modan, 1997, *Assistance With Personal Care Activities Among the Old-Old in Israel: A National Epidemiological Study*, unpublished manuscript.

European Commission, Directorate-General for Economic and Financial Affairs, 1996, *Aging and Pension Expenditure Prospects in the Western World*, Brussels.

Organization for Economic Cooperation and Development (OECD), 1996, *Caring for Frail Elderly People, Policies in Evolution,* Paris.

Sainsbury, Diane, 1994, *Gendering the Welfare State*, London: Sage.