PER DISCUSSION PAPER
USSION PAPER DISCUS

The Prevention of Institutional Placement of Disabled Elderly through the Provision of Long-Term Care Services in the Community

Denise Naon Haim Factor Jenny Brodsky Talal Dolev Miriam Cohen

This study was initiated and financed by ESHEL, the Association for the Planning and Development of Services for the Aged in Israel

JOINT (JDC) ISRAEL
BROOKDALE INSTITUTE OF GERONTOLOGY
AND ADULT HUMAN DEVELOPMENT

JDC HILL, P.O.B. 13087
JERUSALEM 91130, ISRAEL

D–185–92

THE INSTITUTE

is a national center devoted to research, experimentation and education in gerontology and adult human development. It was founded and is funded by the American Jewish Joint Distribution Committee (AJJDC) with the assistance of the Brookdale Foundation and the support of the Government of the State of Israel. Its research is policy- and program-oriented, multidisciplinary and, primarily, of an applied nature.

The Institute tries to identify socially relevant problems and to recommend alternative solutions to problems of the health and social services. It attempts to bring together academic and governmental experts and other public officials and citizens in order to link research findings with their implementation.

DISCUSSION PAPERS

are produced by members of the Institute for distribution to students of the social and behavioral sciences, professionals and elected or appointed officials who make decisions affecting social policies and programs.

Their purpose is to direct attention to issues of national importance in order to promote informed public debate for the development of sound policies and programs.

The findings and conclusions presented in such papers are those of the author or authors and do not purport to represent the views of the Institute, and of other persons or groups associated with it.

The Prevention of Institutional Placement of Disabled Elderly through the Provision of Long-Term Care Services in the Community

Denise Naon **Haim Factor** **Jenny Brodsky** **Talal Dolev** **Miriam Cohen**

This study was initiated and financed by ESHEL, the Association for the Planning and Development of Services for the Aged in Israel

Jerusalem September 1992

JDC-Brookdale Institute of Gerontology
and Human Development
P.O.B. 13087
Jerusalem 91130, Israel

Tel. (02) 618251
Fax (02) 635851

ISSN–0334–9012

Abstract

This paper reports on an in-depth survey of 600 elderly persons on waiting lists for institutional care in three major Israeli cities (Jerusalem, Tel Aviv and Beer Sheva) and a representative sample of another 600 elderly drawn from a population of over 2,400 elderly who were receiving home care from the public sector in the same three cities. The study examined the possibility of preventing institutionalization for disabled elderly through the provision of community services.

For each person in the sample, data were collected from the elderly person himself, the family member or person who provided the most help on an ongoing basis, and the social worker or nurse responsible for case management on behalf of the public agency responsible for institutional placement or home care services. This information was then presented to multidisciplinary teams of experts who assessed whether these elderly clients could remain in the community with adequate community care, and if so, what would be the type and extent of community services required. The clients, families and practitioners were also asked to make assessments on these issues; the responses of all the groups were compared.

According to the experts a large proportion of those elderly waiting for placement could, in fact, remain in the community if they received all of the services they required: 94% of those defined as semi-independent, 82% of the frail, 72% of the mentally frail and 67% of those requiring nursing care.

The experts recommended personal care for 37% of the semi-independent clients, 77% of the frail clients and 92% of the mentally frail and nursing clients, and homemaking services for approximately 75% of the elderly in all functional groups who were awaiting institutionalization. They also recommended a wide range of other home-delivered services. In all, providing adequate care according to the ideal care plan would require expanding current community services by 403% for the semi-independent, 532% for the frail, and 396% for the mentally frail and nursing clients. It was found that the cost of providing appropriate care via community services would be lower than the cost of institutional care for 82% of the independent elderly, 67% of the frail, and 63% of the mentally frail and nursing clients who were assessed as able to remain in the community. There is,

however, no guarantee that total public expenditures would decline if community services were extended, since elderly who would not otherwise apply for institutionalization would probably enjoy these services as well.

The experts were also asked to compose care plans which conformed to the current entitlements in the public sector: Only existing services could be recommended, in amounts not exceeding those stipulated in regulations at the time, and with the same degree of flexibility. Even with these restricted care plans, it was assessed that 87% of the semi-independent, 69% of the frail, 50% of the mentally frail and 37% of the nursing could remain in the community. However, the services recommended by the experts far exceeded those actually provided to these clients.

Considerable service expansion would also be required to ensure adequate care for the service recipients who did not apply for institutional placement, although the gap between services currently supplied and those recommended was not as great for this group as for the waiting list population. The experts also recommended that the families take responsibility for a significant amount of the help required, especially when they shared the same household with the elderly person.

Under the ideal care plan, day care was recommended for 25% of the frail, 15% of the mentally frail and 16% of the nursing clients who had applied to enter institutions. Sheltered housing was recommended for 43% of the semi-independent who had applied to enter institutions. However, these services would prevent institutionalization for only a very small proportion of those who were assessed as unable to remain in the community even with maximal home-delivered services. At the same time, the impact of both frameworks – day care and sheltered housing – in preventing institutionalization may be far greater when some of the home-delivered services are unavailable or are not provided in sufficient amounts.

It should not be assumed that provision of community services will prevent institutionalization on the scale reported here, since clients with the most severe problems usually enter institutions far more quickly and were probably not adequately represented on the waiting lists. Moreover our data are based on hypothetical assessments. The fact that they were collected from all of the relevant people, who confirmed each other's evaluations, provides strong evidence for the validity of the assessments. But final conclusions regarding the feasibility of alternative community care in Israel await demonstration in the field.

Acknowledgments

We wish to thank all the individuals and organizations who enabled us to carry out this study.

We thank the members of the study's steering committees: Uri Laor (Chairman), Miriam Bar-Giora, Hemda Cohen, Jonathan Lemberger, the late David Mor, Miriam Shtarkshal and the late Professor Itzhak Margulec – who followed the study through all its stages and contributed to its success. Special thanks are due to Hemda Cohen and Ayala Shapira for their contributions.

To our colleagues Juliana Pakes and Amir Shmueli, who participated in various stages of the study, we owe special thanks.

The present stage of the study would not have been possible without the cooperation of a group of social workers and nurses – Judith Horowitz, Tzippora Naeh, Esther Oded, Shoshana Ozer, Sara Azrieli, Esther Pleban, Birota Stern. In addition to carrying out evaluations and making care plans as part of the study, they also offered advice during planning, data analysis and interpretation. We are especially indebted to them for all their time and effort.

We are grateful to Avigail Dubani for coordinating the field work, to Orna Lisai who assisted in data collection and analysis, to Malka Jossot and Ilana Kurtzweil who helped with the programming, to Bilha Allon who typed the report, and to Terry Benninga for editorial assistance.

This study was carried out thanks to the staff of the Social Services Offices in the Municipalities, the Health Offices and the Continuing Care Units of the General Sick Fund of the Federation of Labor in Jerusalem, Tel Aviv and Beer Sheva. We owe them a special vote of thanks.

The study was initiated and financed by ESHEL – The Association for the Planning and Development of Services for the Aged in Israel.

Contents

List of Tables:

I. Introduction

A. Literature Review: Alternatives to Institutionalization

During the past twenty years we have witnessed great interest in the possibility of providing services for disabled elderly which will enable them to continue to live in the community, as a viable alternative to institutional care. Studies demonstrated that a considerable proportion of the elderly receiving institutional care may have been forced to apply for it due to the unavailability of adequate community services (Knowlton et al. 1982; Kraus et al. 1976; Bell 1973).

Since the bulk of resources devoted to long-term care have been channelled to institutional services, this type of care has also been more available to practitioners in need of care solutions (Sager 1979). In addition, there has often been insufficient dissemination of vital information regarding the type and availability of various community services (Kraus et al. 1976). Problems of coordination resulting from a cumbersome and fragmented service delivery system may impede appropriate utilization (Brodsky et al. 1986). Supporters of community care proposed that re-directing funds from the institutional sector to community care, re-organization of the community service system, and more effective dissemination of information would enable transferring the locus of care for many elderly from institutional to community settings.

Moreover, there has been growing awareness of potential negative effects of institutional placement on the welfare of residents, and research has found that providing care for disabled elderly may prevent the deterioration in their functional state which often accompanies entrance to an institution (Katz et al. 1972; Mitchell 1978). The development of alternatives to institutionalization also represents an attempt to achieve a more humane service system, since it seems that most elderly would prefer to continue to live in their own homes with the aid of services or family support (Bell 1973; GAO 1979; McAuley and Blieszner 1985).

Community service programs have also received special attention due to budgetary considerations. Planners and policymakers coping with restricted budgets and concerned by increasing public expenditures for institutional nursing care saw community services as a possible way to provide care at reduced costs (Doty 1984). Cost containment is a particularly crucial issue in the area of long-term care since expenditures are expected to continue to rise in order to match the increase in the

rate of disabled elderly in the general population of the western countries and Israel, due to the rising proportion of "old-old" (Factor et al. 1988).

Demonstration Projects

During the last fifteen years numerous demonstration projects have sought to assess the effects of community care programs for disabled elderly (see reviews in Kemper et al. 1987; Weissert et al. 1988). Most of the programs involved case-management whereby professionals, individually or in a team, assessed the client's needs, formulated an individualized care plan, and took responsibility for arranging and monitoring service provision. The main services typically expanded were homemaker services and personal care, but other services commonly provided were household services, companions, transportation, home-delivered meals, and home nursing visits. Some programs also included adult day care, foster care, escort services, housing improvements, respite care, medical equipment, mental health counselling and prescription drugs (Kemper et al. 1987). The clients were elderly community residents considered to be at risk of institutionalization according to criteria based on disability or services needs. The programs were evaluated by studies which used experimental designs to varying degrees.

Of particular interest is the "channelling demonstration project" which was carried out at ten sites across the United States and represented a very highly planned and extensive evaluation effort. Channelling examined two different interventions. The first intervention, the "basic case management model", tested the premise that difficulties in obtaining appropriate community care are due mainly to lack of information and coordination between the various service providers. It provided heightened case management for arranging services under the existing system with only some slight additional funding. The second intervention, known as "the financial control model", substantially expanded public financing of formal services (Carcagno and Kemper 1988).

Results

These studies have provided no decisive conclusions. Most of the programs did reduce nursing home use, but only by small and statistically insignificant degrees (Kemper et al. 1987; Weissert et al. 1988). Subsequent analysis has pointed to a number of explanations: It seems that the institutionalization rates of the popula-

tions examined were low to begin with (Applebaum et al. 1980; Hicks et al. 1981; Weissert 1981). The mean number of nursing home days recorded annually even for the control groups was less than thirty in both of the channelling studies and the Georgia Alternative Health Services evaluation (AHS 1982; Woodridge and Shore 1988). Randomized experiments which looked only at nursing home use, funded by Medicare revealed baseline rates of 7 days and under (Kemper et al. 1987).

A major problem for programs geared to preventing institutionalization are the difficulties in correctly defining the population of elderly with the greatest prior chance of entering an institution from among populations with similar health and functional characteristics. While most elderly who enter institutions are disabled, functional status is in itself insufficient to predict nursing home utilization. We now know that numerous other social, cultural, economic and personal factors are involved, although the "state of the art" in this area is still not capable of accurately predicting nursing home utilization. Highly refined and extensive screening designed to achieve greater accuracy could be extremely costly because of the low prevalence of need (Greene 1987; Weissert 1985). Improved targeting through the adoption of criteria such as the availability of family support raises equity concerns.

Those programs which were most effective in targeting – indicated by higher control group nursing home utilization – were also most effective in reducing institutionalization (Weissert et al. 1988). A prime example of the critical role played by targeting is provided by the one major demonstration project which did succeed in reducing institutionalization by one third: The South Carolina CLTC demonstration (Blackman et al. 1983). This program enrolled clients who had already applied to institutions and passed a pre-admission screen. Similarly, the Community Care Scheme implemented in County Kent, England found that the provision of community services to elderly already referred to institutions or similarly characterized reduced the rate of placement by about 50%, even though the maximal cost of community services which could be provided was set at two-thirds of the cost of institutional care (Challis & Davies 1985).

Cost Considerations

Since most of the research was focused on the impact of alternative modes of care on the public service system, it usually related to public expenditures alone – either narrowly defined as the services offered by the program, or more broadly

defined to include other public expenditures not directly contingent on the implementation of the program (for example, medical services which are provided to all elderly community residents). Examination of the costs borne by the clients' family and friends in providing informal support (e.g. services bought, income forfeited, emotional stress and physical effort) would have provided a far wider perspective, but this approach was not typically adopted.

Most programs that compared the average cost per client of community care with that of institutional care demonstrated that the cost of caring for an elderly client in the community is lower, and usually very much so, than the institutional cost, for a large proportion of the elderly studied (Wager 1972; Department of Human Services Office on Aging 1978; Avon County Council 1980; Challis & Davies 1985; Bachelard & Tinturier 1988). A program in Utah found that the average cost of community services per elderly client was one-third the average cost of institutional care (Management Resources Associates 1979). However, contrasting results were obtained by a Massachusetts study of the projected cost of providing ideal community services to elderly requiring nursing care who were waiting to enter institutions (Sager 1979). It was found that the average cost of ideal care in the community would be higher than the current cost of institutional care. Several European studies also observed people maintained in the community at costs greater than the expense of residential care (Wright 1986).

Several factors may explain the difference in results. First, there is no doubt that there are elderly clients for whom community care is more expensive than institutionalization, and others for whom it is cheaper. Results will therefore depend on the composition of the population examined, and the type and extent of services required to maintain them in the community. The Massachusetts study (Sager 1979) dealt with very disabled elderly who had been placed on waiting lists to enter institutions directly after an episode requiring acute medical care. It may therefore be assumed that they were more disabled and required more expensive care than the typical populations investigated in other studies. Moreover, this study looked at ideal care plans, rather than the minimum required to enable them to stay in the community.

The extent to which community services are available in the region in which the program is implemented also has an impact on costs. When there are no available community services, even the elderly whose situation is not critical may apply for institutional placement – although for them the community alternative may be

cheaper. In contrast, where alternative community services are already provided, only those elderly whose situation is quite severe – and who require very extensive services – will tend to apply to enter institutions. In this case the cost of institutional care may be lower than that of community care for a larger proportion of the study population.

Finally, the difference in the results obtained by the various studies may be due to the comprehensiveness of the community services offered by the program. One should differentiate between the extent of minimal services required to prevent institutionalization and the extent required to answer all of the needs of the clients in an optimal way. In the Massachusetts study (Sager 1979) the cost of community care was calculated on the basis of ideal care plans which may have entailed more aid than that required to leave these elderly in the community. However, other projects sometimes limited the extent of services to be supplied in various ways (Davies & Challis 1986).

The community service demonstration projects usually failed to lower long-term care expenditures because the small reductions in placement costs were offset by the cost of expanding community services to an even larger group of clients. Most of the data, especially from the randomized experiments, has even pointed to increased costs (Kemper et al. 1987; Weissert et al. 1988). Again, the one major exception was the South Carolina CLTC program which, by substantially reducing nursing home use, succeeded in providing expanded community care at the same overall expenditure level.

Impact on Client and Caregiver Well-Being

Consistently, the research has reported an improvement in the quality of life for the elderly and family caregivers participating in these community service programs relative to that of the disabled elderly, residing in the community without such help. Studies have found increased levels of life satisfaction, increased confidence that help will be available, increased social interaction, and reduced levels of unmet needs among the elderly clients. Data regarding the impact on health status measures such as longevity, disability and self-reported health status are somewhat mixed. They are often positive, although to a lesser degree (Kemper et al. 1987; Weissert et al. 1988). Regarding caregivers, improved morale and relief of stress are consistent findings (Frankfather et al. 1981; Challis & Davies 1985; Kemper 1988).

There are few studies which systematically compare the effects of institutional versus community care on client and family well-being. Community care was found to be more effective in preventing functional deterioration (Katz et al. 1972; Mitchell 1978).

Community Services Required

Previous research has not discovered any one specific service which by itself could enable clients to remain in the community, or without which it would be impossible to provide adequate community care; rather it was found that a wide range of services geared to meet all types of needs was indicated. The central services required are personal care for help with ADL (activities of daily living), home management, and supervision for those incapable of staying alone. In addition, most of the studies also found the need for medical-nursing care in the home, and some studies indicated a need for services which meet social needs as well (Bell 1973; Kraus et al. 1976; Sager 1979).

Family members usually play a major role in providing care for the elderly who reside in the community. However, formal services are needed to supplement the care they are capable of providing. Often services need to be supplied outside of usual work hours, i.e. in the evening, at night, and on weekends. Family members need to be relieved of the burden of care – either for several hours of the day on a regular basis, or for a couple of weeks to a month during the year (Gibson 1984; Snyder & Keele 1985; Kosberg 1985).

The provision of services to impaired elderly in their homes is not the only way to prevent institutionalization. Alternative forms of care may also include various types of intermediate frameworks, such as sheltered housing, foster families and day care (Kraus et al. 1976; Barney 1977; Sherwood & Morris 1982; Braun & Rose 1987). Sheltered housing, which is a framework designed for elderly who require more secure and structured living arrangements than would be possible to organize for them at their homes, was found by some of the studies to be one of the main alternatives to institutional care (Kraus et al. 1976; Sherwood & Morris 1977; Doty 1984). Foster home care may also be a viable alternative for a segment of the nursing home population. It provides what those most likely to enter nursing homes need – 24 hour supervision and daily personal care (Oktay & Volland 1987).

In conclusion, research conducted primarily in the United States to date points to viewing community services as a vital component of a comprehensive service delivery system. While many of the most disabled, mentally impaired and socially isolated elderly will still require or prefer institutional placement, a significant proportion of the elderly may be able to receive more effective and appropriate care through home-delivered or community-based services, at cheaper costs per person. Community services are thus a vital supplement to institutional services, but not a substitute. Expansion of community services may result in higher overall costs depending on the size of the population served and the services required.

B. Study Objectives

In 1983–84 when the data were gathered, 12,729 elderly persons in Israel (3.6% of the elderly population) were in long-term care institutions (Bergman et al. 1986). The bulk of the long-term care expenditures was invested in institutional care and only 16% of the funds were spent on community services.

This study's purpose was to explore to what extent, and at what cost, the need for institutional care by the elderly population could be reduced through the provision of community services. Empirical data were required in order to develop a long-term care system compatible with the unique needs of the population and the existing service delivery system.

The study's main objectives were:

1) To estimate the proportion of disabled elderly currently awaiting institutionalization from the public sector for whom adequate community care would be possible, or even preferable by gathering data from the main sources involved in caring for the elderly: The elderly themselves, their primary informal caregivers, and the practitioner (nurse or social worker) responsible for providing them with formal services. In addition, professional expert teams who were not personally acquainted with the clients were asked to assess each case on the basis of two sets of assumptions: One postulated conditions of an ideal service delivery system, while the other restricted them to services and procedures of the service delivery system existing at the time.

2) To learn which community and home-delivered services, and in what amounts, would be required to provide adequate community care for the study's population. Our study went beyond requesting general evaluations to eliciting highly specific and detailed treatment plans which would facilitate accurate cost analyses of community services required for current and future disabled populations.

3) To look at client attitudes and professional opinions regarding the extent that intermediate frameworks – day care and sheltered housing – would be preferable to either institutionalization or home-delivered services. Due to the detailed level of analysis it was possible to make cost comparisons of alternative modes of care.

4) To examine the service needs of disabled elderly who were receiving home care from the public sector but had not applied for placement, in order to gain insight into the dynamics which lead some disabled elderly to seek institutionalization while many others do not.

5) Finally, to examine the amount and type of help from family, friends and neighbors recommended for clients in the opinions of all sources, in order to learn what would be the most preferable mix of formal and informal services.

II. Methodology

The study's population included all elderly clients who were on waiting lists to enter public long-term care institutions in three major Israeli cities: Jerusalem, Tel Aviv, and Beer Sheva (n=589). The lists were obtained from the two ministries responsible for institutionalization of the aged: The Ministry of Labor and Social Affairs – which is responsible for semi-independent and frail clients – and the Ministry of Health – which is responsible for mentally frail and nursing clients (see Appendix A for general overview of service delivery system and Appendix B for data regarding study population). The population studied was therefore diverse in its needs and characteristics. Since elderly of every functional level were included, we assumed that the problems presented by this population represented the range of problems leading to institutionalization in Israel.

In addition, a random sample of approximately 600 elderly was drawn from the population of over 2,400 elderly clients receiving personal care or homemaking services from the public sector (namely, from the Ministry of Labor and Social Affairs, the Ministry of Health, and the General Sick Fund, the health maintenance organization which served about 95% of the elderly in Israel) in the same three cities. This second group was investigated in order to appraise the community service needs of a second population of elderly considered to be at high risk of institutionalization; however, most of this report (chapters II-VII), focuses solely on the population of elderly who had already applied for public institutionalization.

Three interviews were conducted for each client in both groups. First the practitioner responsible for managing the case – a professional nurse or social worker – was interviewed. Later, the clients themselves and their primary, informal caregiver were also interviewed. When the clients could not be interviewed due to severe physical or mental impairment, their primary informal caregiver was interviewed again as a proxy.

The elderly, the practitioners and each elderly person's primary informal caregivers were all interviewed by means of a structured questionnaires that covered items selected to tap a broad range of possible physical, social and environmental problems. The interviews also incorporated questions about the type and scope of services received by the clients and the reasons that led them to seek institutionalization. All three sources were asked whether or not the client could remain in the

community with the aid of additional services, and if so, which services would be required to ensure adequate care.

During the second stage of the study, each case was evaluated by an independent multidisciplinary team of experts. There were four teams, each composed of a senior nurse and social worker with extensive experience in working with the elderly within the public service network. In order to enhance consistency in the assessments of the different teams, the four teams' members (1) participated in a group discussion and (2) received the information collected from the three interviews for each of the clients, on uniformly structured form. They were not told which formal services the client already received, or whether or not the client was on a waiting list for institutionalization. The information provided related to the client's functional, social and housing problems and the amount and type of informal support he or she was receiving.

On the basis of this information the teams were requested to record on standardized forms their assessment of the needs of each client and to formulate a care plan adapted to varying conditions. Furthermore, they were also asked to assess whether the client, assuming the care suggested by each of the various plans was provided, could be adequately cared for in the community, if this would be desirable for the client and the client's family, if it would be advisable to also recommend day care or sheltered housing, and, if so, what home-delivered services these special frameworks would replace.

The experts designed two main care plans for each client: (a) an ideal care plan which assumed no limitation on the extent or type of formal services provided; and (b) a restricted care plan in which only services currently provided by the public service sector could be recommended, and only to the extent stipulated by existing regulations. (The services and their maximal allocation per client appear in Appendix C.) For example, under restricted care plan conditions, personal care for a nursing patient could not exceed eighteen hours a week and non-professional supervision could not be recommended at all. However, limitations conceivably due to budgetary shortages, lack of sufficient personnel, or financial eligibility criteria were not taken into account. Care plans of both types also included recommendations for help from the informal support network. However, the type and amounts could not exceed what was already provided on the assumption that without actually discussing with family members their capability and willingness to provide

more or different aid, it would not be possible to determine exactly how much, or what kind of, additional aid to expect from them.[1]

The reliability of the teams' assessments was examined by requesting all of the teams to evaluate the same twenty clients. We looked at the average number of hours of aid recommended for each client by each team, and at the average number of hours of aid expected from the family for each client, so as to see if the teams evaluated similarly the total amount of aid required and the division of responsibility between the formal and informal networks. Results indicated a great deal of consistency. In both areas, the average number of hours of aid recommended by the teams fell within a range of 10% above and below their general average. Cronbach coefficients (alpha) were also calculated regarding inter-team judgmental reliability, and they proved to be very high (over 0.90), indicating agreement in the ranking of the clients regarding their aid requirements. Since it is not feasible to investigate the appropriateness of the recommended services to the needs of the clients in a controlled experiment, the consensus of the experts provides support for the validity of their recommendations.

---

1 The experts also formulated a second type of ideal care plan which was not limited in the amount or types of aid they could delegate to family members. We thus sought to learn about the most desirable division of labor between formal and informal parties assuming communication with the families. However, findings revealed that in most cases these two ideal care plans were identical because the experts assessed that the families were already providing as much care as they could. We will therefore present data about the first type of plan only.

III. Characteristics of the Elderly on Waiting Lists for Institutionalization and the Extent of their Need for Help

The population surveyed included a large proportion of old-old clients, women, and unmarried clients (Table 1). We found that clients at all functional levels suffer from impairments and problems in numerous areas. The public service system

Table 1: Characteristics of Elderly On the Waiting List for Institutionalization (Percentages)

	Semi–Independent	Frail	Mentally Frail	Nursing
Age: % over 75	73	81	72	74
Sex: % female	67	69	80	66
Marital status: % unmarried*	81	81	69	65
Functional disability (% disabled)				
Mobility (within the home)	–	13	6	70
Bathing	21	61	82	97
Dressing	5	42	66	94
Eating	–	6	26	58
Urinary incontinence	4	10	36	80
Orientation problems	11	18	87	52
Unable to perform at least one household task**	95	98	100	100
Housing conditions				
Lack of basic equipment (at least one)***	45	35	15	12
Lack of shower	32	24	7	6
Dampness	49	35	41	26
Informal support network				
Lives alone	65	56	21	26
Has no informal support	22	6	3	1
Family report they cannot continue to provide help to the same degree, or at all	54	48	55	63

* Includes widowed and divorced and never married.
** Cleaning, cooking, shopping, laundry.
*** Refrigerator, cooking burners, heating stove, facility for heating water.

classifies elderly who apply for institutionalization in terms of four categories: Semi-independent, frail, mentally frail and nursing. This sequence reflects differences in the severity of the client's functional disability.

With the exception of bathing, most of the elderly in the study classified as semi-independent do not require help with personal care. However, 95% are unable to perform at least one of the instrumental activities of daily living, (primarily tasks of household management). Such impairments are liable to affect their ability to remain in the community since 65% live alone and 22% have no informal support. Significant proportions of the elderly in this group also lack basic household equipment (45%) or live in apartments which are damp (49%). In sum, the semi-independent elderly who requested institutionalization tend to lack social and economic resources.

The frail elderly are typically more disabled than the semi-independent: 61% require help in bathing and 42% in dressing. Many need help in order to leave their homes (47%) and virtually all of the frail clients (98%) are unable to perform at least one household task.

As expected, orientation problems are the salient characteristic of the mentally frail clients (87%). As a consequence, a considerable proportion of the mentally frail require help with personal care: 82% need help in washing, and two-thirds need help with dressing. A significant proportion are also incontinent: 36%. Most mentally frail clients require constant supervision.

The nursing clients are characterized by serious functional limitations: 70% are bedbound or require help in moving within their homes. The great majority are incapable of bathing or dressing without assistance (97% and 94%, respectively), and a large proportion need help in eating (58%). Eighty percent suffer from urinary incontinence and 52% have orientation problems.

Regarding approximately half of the elderly at all functional levels, their families reported that they could not continue to provide help to the same degree, or even to provide help at all. For the nursing patients, as many as 63% reported they could not continue as before.

The experts were asked to assess the total extent of help required by the elderly in a number of areas, notably mobility, personal care, and home management. Their

assessments were based on the time required to perform each activity and took into account numerous relevant factors – such as urinary or fecal incontinence which increases the need for help with bathing, dressing and laundry, or sub-adequate housing conditions which makes the execution of these tasks more difficult. The extent of the need for help is a more sensitive indicator of overall disability level than the list of specific disabilities from which the client suffers since it also takes into account the effect of varying combinations of problems, such as the occurrence of both incontinence and orientation problems. Thus it also distinguishes more accurately between different groups.

The semi-independent elderly need an average of 1.3 hours of help each week in personal care and 8.4 hours of help each week in home management. The frail require an average of 4.6 hours of help each week in personal care and 12.4 hours of help in home management. The mentally frail and nursing clients require an average of 14.6 hours of help in personal care and 16.8 hours of help in home management.

IV. The Prevention of Institutionalization through Alternative Community Care Services

A. The Ability to Remain in the Community under the Experts' Ideal Care Plans

The proportion of elderly assessed as able to remain in the community with the aid of additional services was used as our measure of the extent to which community services could replace institutional care. And, in fact, the experts assessed that a very large proportion of the clients now awaiting institutionalization could remain in the community, provided they were to receive optimal community-based services (Table 2). The proportion of these clients is highest among the semi-independent (94%) and the frail (82%), but even among the nursing and mentally frail clients at least two-thirds could remain in the community (67% and 72%, respectively).

Table 2: The Proportion of Elderly Awaiting Institutionalization Capable of Remaining in the Community under Ideal Care Plan Conditions

	Semi–Independent	Frail	Mentally Frail	Nursing
Total (N)	**(174)**	**(95)**	**(54)**	**(180)**
%	**100**	**100**	**100**	**100**
Could remain in the community (%)	94	82	72	67
Of these – % for whom:				
Community care desirable for client and family (or no family)	76	79	77	88
Community care desirable for client but not for family	10	9	18	7
Community care undesirable for client	7	4	–	1
Unknown	7	8	5	4

It should be noted that these data refer to the possibility of providing alternative care for clients waiting at home to enter institutions. The possibility of providing alternative care for those clients who enter institutions directly from hospitals is assumed to be lower. However, this group is under-represented on the waiting lists because these clients usually wait for institutionalization for a shorter period than those who apply while residing in the community. Therefore, it is not possible to conclude that these substitution rates are applicable for the entire population requesting institutional placement. Final conclusions await further demonstration in the field.

For those cases in which the experts assessed that the client could remain in the community, they were asked if this would also be desirable – for the client, and for the client's family, if he has one. In most cases, community care was considered the more desirable alternative for both the client and his or her family (Table 2). When remaining in the community was deemed feasible but not desirable for one of the parties, it was usually the family for whom the community alternative was not considered desirable. This was generally due to the considerable burden or stress that such care would entail for the family, though such care would provide a satisfactory answer to the elderly's needs. This underlines the necessity of taking family needs and interests into account when considering community-based care for individual clients. There were very few cases in which the experts assessed that for the elderly client remaining in the community was feasible but not desirable.

B. Comparison of the Assessments of Experts, Practitioners, Clients and Primary Informal Caregivers

The experts and professionals independently came to the same assessment for 66% of the cases: Regarding 56% of the cases they agreed that the client could remain in the community, and regarding 10% of the cases they both thought that he could not. In terms of the four categories of the elderly, the experts and the practitioners independently concluded that 81% of the semi-independent, 57% of the frail, 43% of the mentally frail and 35% of the nursing clients on waiting lists could remain in the community if they were provided with additional services. This consensus regarding a large number of specific cases is a further indication of the validity of the separate assessments of the experts and the professionals.

Table 3: The Proportion of Elderly Awaiting Institutionalization Assessed as Capable of Remaining in the Community according to the Experts' Ideal Care Plans, the Practitioners, the Elderly and the Primary Informal Caregivers

	Semi-Independent	Frail	Mentally Frail	Nursing
Total (N)	**(174)**	**(95)**	**(72)**	**(67)**
%	**100**	**100**	**100**	**100**
Could remain in the community (%)				
According to experts (ideal care plan)	94	82	72	67
According to practitioners	86	69	53	50
According to elderly	55	43	–*	–*
According to primary informal caregivers	42	37	41	43

* Elderly's opinions are not presented since many could not be interviewed due to functional or mental incapacity.

As functional disability increases, the rate of agreement drops: Experts and professionals agreed with each other regarding 82% of the semi-independent, 64% of the frail, 60% of the mentally frail, and only 54% of the nursing clients. It seems that when the client is more disabled, the assessment regarding his ability to remain in the community is more open to divergent opinions.

The experts concluded that a greater number of clients could be cared for in the community than did the practitioners. When the experts and practitioners disagreed regarding a case, it was usually because the experts favored leaving the client in the community while the practitioners objected. Although experts and practitioners alike were asked to base their decisions on a hypothetical ideal service delivery system which would pose no problems in the attainment of services, it may be that the practitioners were influenced by their first-hand knowledge of the difficulties their clients faced daily in coping with life in the community and their dependence on the often cumbersome, inadequate and fragmented public service system.

Fewer elderly and their caregivers thought that the community care option was viable than did the experts or practitioners (Table 3).[1] This may have been due to inadequate knowledge regarding the type and extent of community services which could possibly be provided by a public service system. Furthermore, all of the elderly in the sample had already decided to apply for institutional placement at the time of the interview, and this may have influenced the willingness of the elderly and their caregivers to seriously consider an alternative solution.

While a preference for either care alternative may also be an expression of idiosyncratic personal desires of clients and families, the preference of elderly clients and caregivers for institutional care – despite professional evaluations that it is not be necessary – may also reflect the heavy price which the family may frequently pay when the client remains in the community. This certainly need to be taken into account when choosing among care alternatives.

Nevertheless, for those cases in which all parties concurred with their assessments – and this is true for a significant proportion of the elderly in the sample – the possibility that institutional admission may be prevented seems quite likely. This consensus by experts, practitioners, elderly and caregivers may be seen as evidence of the reliability of the information used by the experts to evaluate the clients' situations and of the validity of the assessments by the experts and practitioners.

C. The Ability to Remain in the Community under the Experts' Restricted Care Plans

The experts assessed that even if the provision of services would be restricted to the limitations imposed by the existing public service system, a significant proportion of the elderly in all functional groups could still remain in the community: 87% of the semi-independent, 69% of the frail, 50% of the mentally frail and 37% of the nursing clients (Table 4). Nonetheless, for all functional levels the rate is lower than under ideal care plan conditions (Table 2), and the discrepancy

---

1 This data refers only to semi-independent and frail clients because many of the mentally frail and nursing clients were unable to respond to the question.

between the proportions assessed as able to receive community care under the two types of care plans grows larger as the level of functional disability rises. This finding apparently reflects the needs of the more severely disabled clients for more hours of aid than regulations permit and for certain kinds of services which are not currently available.

Table 4: The Proportion of Elderly Awaiting Institutionalization Capable of Remaining in the Community under Restricted Care Plan Conditions

	Semi–Independent	Frail	Mentally Frail	Nursing
Total (N)	**(174)**	**(95)**	**(54)**	**(180)**
%	**100**	**100**	**100**	**100**
Could remain in the community (%)	87	69	50	37
Of these – % for whom:				
Community care desirable for client and family (or: no family)	76	84	78	76
Community care desirable for client but not for family	10	10	19	14
Community care undesirable for client	7	1	–	2
Unknown	7	5	4	8

As under ideal care plan conditions, in most cases in which the experts determined that the client could remain in the community, they assessed that this would be desirable for both the client and his family. This finding was consistent for all functional groups. When remaining in the community was deemed possible but not desirable, this was usually because that alternative conflicted with the family's interests. Cases in which the solution was assessed as possible, but not desirable, for the client were few.

V. Community Services Required to Prevent Institutionalization and their Cost

A. Services Required Under Experts' Ideal Care Plans

The ability of the elderly to remain in the community is contingent on various arrangements of formal and informal services. A wide range of services was recommended by the experts, some of them ongoing and long-term, like personal care, homemaker services and professional nursing care, and others one-time only, such as the acquisition of basic household equipment (Table 5). Most of the ongoing services recommended by the experts are already in existence – although not to a sufficient extent in terms of either the proportion of elderly clients who receive the service or the amount of the service provided to each recipient.

Personal care and homemaking services were by far the most highly demanded ongoing services. The proportion of elderly who require personal care, and the extent of the service required, is to a large extent a function of their level of functional disability. According to the experts' ideal care plans, 92% of the mentally frail and nursing clients require this service (for an average of 21 hours per week for those in need of this service); 77% of the frail clients require this service (for an average of 10 hours a week for clients in need of this service), and even a significant proportion of the elderly considered to be semi-independent (37%) require personal care – mainly help with bathing, accompaniment when they leave their homes, and taking care of errands.

Implementing the experts' recommendations would require extensive expansion in both the amount of aid provided to individuals, and the proportion of clients receiving the aid. While approximately 90% of the nursing clients require personal care, only 40% were receiving this service at the time of the study. Seventy-seven percent of the frail require this aid while only 23% receive it. Providing the elderly in the study with the recommended services would involve increases of 375% in the personal care services provided to the semi-independent on waiting lists, of 276% in those provided to the frail, and of 252% in those provided to the nursing and mentally frail clients.

We found that a large proportion – about 75% – of the elderly at all functional levels require homemaking services (household cleaning and management), and

Table 5: The Extent of the Need for Formal Services among Elderly Awaiting Institutionalization who are Capable of Remaining in the Community under Ideal Care Plan Conditions

	Semi-Independent (N=150)		Frail (N=75)		Mentally Frail and Nursing (N=159)	
	% of Elderly	Average need*	% of Elderly	Average need*	% of Elderly	Average need*
Ongoing services						
Personal care	37	6.9	77	9.8	92	21.2
Homemaking	73	3.1	75	3.4	79	3.4
Home-delivered meals	38	7.0	51	7.0	34	7.0
Laundry services	33	1.1	22	1.3	50	1.9
Social club	61	4.0	32	4.0	12	4.7
Club for mentally frail	(1)	3.0	9	5.6	19	4.6
Friendly visiting	12	4.4	8	5.5	10	5.5
Professional supervision	4	3.3	9	4.6	12	12.7
Non-professional supervision	11	46.8	22	48.2	44	46.4
New housing	15		7		4	
One-time services						
Emergency beeper	33		32		13	
Respite care	10		7		32	
Basic household equipment	70		62		40	
Stove for home heating	44		45		31	
Water heating facility	36		27		20	
Home repairs	45		40		21	
Home adaptation	51		59		45	
Burglar protection	46		53		36	

* Expressed in terms of average number of hours or units of service allocated weekly for those in need of the specific service.

that the mean extent of the service required – about 3.3 hours of aid per week for clients in need – is also similar for all functional levels. Most of the elderly classified as semi-independent and frail were found to be unable to perform all of the essential tasks of household management. Since a majority of them live alone, the high demand for this service among the semi-independent and frail was to be anticipated. However, it was interesting to note that this service was also recom-

mended for most of the mentally frail and nursing clients even though the large majority of them live with their families.

A significant gap was found between the extent of homemaker services required and those currently provided, mainly in terms of the proportion of elderly requiring it, rather than the number of hours required. Nineteen percent of the independent received this service, while the experts assessed that 73% required it. The situation of the other functional groups was similar.

Home-delivered meals need to be expanded substantially since they were recommended for one-third of the semi-independent, mentally frail and nursing clients, and for half of the frail, while less than 15% of the elderly in all functional groups were receiving this service. Laundry services were recommended for approximately one-third of the semi-independent, one-fourth of the frail, and fully half of the mentally frail and nursing clients, but they were almost non-existent at the time of the study.

To meet social needs, visits to a social club were recommended for 60% of the semi-independent and 30% of the frail. Visits at clubs for the mentally frail were recommended for 40% of the mentally frail in the sample. These clubs have a two-fold purpose: To provide suitable occupational activities for the mentally frail in order to prevent further deterioration in their situation, and to free families for a few hours from the heavy burden of their care.

Rehabilitative and therapeutic services were also recommended for a significant proportion of the clients – even though only a small group of elderly was receiving these services. Physiotherapy was recommended for 20% of the frail and approximately 40% of the mentally frail and nursing clients. Most of the more severely impaired elderly require frequent nursing services: 60% of the frail and 70% of the nursing clients require an average of three visits a week by a nurse. However, at the time of the study only 12% of the independent, 9% of the frail and 18% of the nursing clients received this service. Casework treatment was recommended for 93% of the clients, medical follow-up for 86% of the clients and general follow-up of service provision for 86% of the clients. It was also recommended that 36% of the clients be referred for psychogeriatric evaluation or treatment.

A large proportion of the elderly, especially among the nursing clients, require formal supervision for at least part of the day or night in addition to other specific services. The number of hours of aid devoted solely to supervision was calculated

separately from the time demanded to provide other specific services. In all, formal services of supervision (by professional and non-professional staff) were recommended for 15% of the semi-independent, 31% of the frail and 56% of the mentally frail and nursing clients.

In most cases it was recommended that the supervision be performed by a non-professional worker. Supervision by a para-professional was advised for only 12% of the mentally frail and nursing clients. The average number of hours of non-professional supervision recommended for clients in need was about 47 hours a week. This extensive need for supervision services – even for those who do not live alone – is in stark contrast to the present situation in which these services are not available at all from the public sector. The experts also recommended that a significant proportion of the nursing and mentally frail clients (37%) receive respite services, an arrangement whereby the elderly stays in an institution for a short time in order to give the caretaking family some rest.

A very high proportion of the elderly also requires various services or equipment to improve their housing conditions including household heaters, washing machines, facilities for heating water, household improvements, and burglar protection devices. The nursing clients have fewer needs in this area, probably because many of them live with their children in newer housing. "Beepers", e.g. devices which enable one to call for help in case of a medical or other emergency, were recommended for about a third of the semi-independent and frail, and for about 13% of the mentally frail and nursing clients.

In sum, we found that in order for clients who had applied for institutionalization to remain in the community, they would require a wide range of services. The central components of the long-term care treatment packages were usually personal care and homemaking, but additional types of aid were also frequently required, some ongoing, and others in the form of one-time acquisitions or installations.

The needs of the elderly were not suitably met by the current services, and the projected rates of growth were considerable. Indeed, at the time of the interview, 68% of the frail clients were not receiving personal care, and 40% were not receiving any home care services from public agencies at all; one quarter of the nursing clients were not receiving personal care and 21% were not receiving any community services. Some of the services were not available at all, thus requiring basic planning and development efforts prior to any actual provision. Of most impor-

tance in this category are formal supervision and housing improvements which were recommended for large proportions of the elderly.

As expected, service needs and their cost rise with increasing client dependency. The average cost per client of providing the services included in the experts' ideal care plans was $161 per month for the semi-independent, $354 per month for the frail, and $675 per month for nursing and mentally frail clients.[1] For all groups, extensive expansion of the services currently provided would be required: 403% for the semi-independent, 532% for the frail and 396% for the nursing and mentally frail clients. Supervision represents an important component – about 30% – in the cost of the services required for each of the functional groups.

The elderly and their informal caregivers were also asked to specify the services needed in order to maintain them in the community. The range of services requested by the clients was much narrower than that recommended by the experts or the practitioners. They asked mainly, and almost solely, for personal care and homemaking services; a small proportion mentioned supervision as well. This smaller range of services may reflect the limited information that clients and their families possess about available and potential services, or may express their preference to receive help in these ways.

Table 6: Current and Recommended Services for Elderly Awaiting Institutionalization who are Capable of Remaining in the Community under Ideal Care Plan Conditions

	Semi-Independent	Frail	Mentally Frail and Nursing
	(N=150)	(N=75)	(N=150)
Current services: average cost per client ($ per month)	32	56	136
Recommended services: average cost per client ($ per month)	161	354	675
Required rate of expansion (%)	403	532	396

1 For more details on cost calculations, see chapter V, B and C.

B. Method of Calculating Relative Costs of Community and Institutional Care

It is necessary to compare the cost of providing the necessary community services with the cost of institutional care in order to determine the proportion of elderly for whom the community care alternative would be cheaper, and to what extent. As discussed in the introduction, there are several issues involved in comparing costs of community services with those of institutional care and the way they are handled greatly affects the results of the analysis.

A pivotal question is: Which components of the alternative care arrangements should be included in the cost calculations? In our study we decided to make the comparison from a public service system perspective i.e. to analyse the cost of each of the alternatives to the public service system and to evaluate the changes expected in public expenditures as a result of different decisions regarding service provision. It should be noted, however, that including private expenses in the cost calculations – especially the cost to family members of the care they provide – could significantly alter the results of the comparison, especially regarding those elderly who require a great many hours of assistance, and whose families fulfill a central role in providing the necessary care.

Since our focus was on the public service system, we calculated the cost of community-based services on the basis of the rates paid by the public service system to parties who provide the services. In the case of personal care, for example, this was the Matav Association which employs most of the personal care workers. Matav has determined that the minimal duration of a visit is one hour. Therefore, the cost of a visit recommended for less than one hour was calculated as the cost of a visit lasting a full hour. In addition, the personal care workers usually leave the client's home ten minutes before the allotted time is up in order to reach the next client's home. In order for them to give the full time recommended for care, it is necessary to compensate them for this traveling time so we added ten minutes to each visit when required.

We included in the cost of community-based services only the costs of the ongoing services recommended in the experts' ideal care plans. The cost calculation did not include the cost of medical services normally covered by the medical insurance

held by the elderly,[1] or services which are to be provided only once – such as home adaptations or basic equipment. Expenses incurred in developing the required services were also left out of the analysis.

The rate per person of institutional care was based on the standard fees paid by the government to public institutions, and the standard, but lower, fees paid by the government to privately-owned institutions, weighted according to the relative proportions of elderly residing in institutions of the two different sectors whose placement was funded by public authorities. Since our cost figures were intended to represent public expenses only, the average proportion of costs contributed by the elderly and their families was subtracted from this weighted fee. As in the case of community services, cost calculations did not include investment funds for building new institutions, or developing infrastructure.

Since, in our calculation of the cost of community services, medical services provided in the framework of medical insurance were not included, we subtracted the cost of these services from the cost of institutionalization for mentally frail and nursing clients because these elderly receive primary health care within the institution. Specifically, we subtracted costs for the following items: Medications, tests and medical equipment, primary physician and expert physician services. Semi-independent and frail clients continue to receive medical services at community clinics in the framework of their health insurance even when they are residents of an institution, so the cost for them is identical under both care alternatives.

Another issue which arises in comparing the costs of institutional and community services involves variations in the kind and quality of the services provided in each of the different arrangements. Certain services may exist both at institutions and in the community, but may not be provided at the same general level of quality in both frameworks, or targeted to as many clients, or to the same group of clients. An important example of this is physiotherapy. The experts recommended physiotherapy for approximately half of the nursing and mentally frail clients. This service should also be provided in long-term care institutions for the elderly, but in

---

1 In Israel, about 95% of the elderly are members of the General Sick Fund which provides them with medical coverage which includes primary medical care, acute care hospitalization, and ancillary care such as physiotherapy. Elderly who are not otherwise members in a health maintenance organization and have low incomes, also receive medical coverage through the General Sick Fund as part of their social security entitlements.

fact a far smaller proportion of institutional residents generally receive this treatment. Furthermore, the community services were planned by the expert teams to precisely meet the needs of each individual client. Thus, it should be remembered that the cost of community care presented covers the whole spectrum of services outlined by the ideal care plans which probably represents a far fuller answer to the needs of the clients than the care actually provided in institutions at present.

C. The Relative Cost of Ideal Care Plans Versus the Cost of Institutionalization

In this chapter we compare the cost of public institutional care to the community care recommendations of the experts' ideal care plans. Table 7 shows that the average cost of community-based care is lower than that of institutional care for the semi-independent and frail, and only slightly higher for the mentally frail and nursing.

We also examined the proportions of elderly in each functional level for whom community care would be cheaper, and found that they constituted 82% of the semi-independent, 67% of the frail and 63% of the mentally frail and nursing clients assessed by the experts as able to remain in the community. For approximately half of the semi-independent and the frail, and almost one fourth of the mentally frail and nursing, community care was estimated to be less than half the cost of institutional care. These findings clearly indicate that caring for elderly in the community – even if all possible services are offered – would still be resource-efficient, relative to the cost of institutional care.

It is interesting to note that even among the mentally frail and nursing clients, who often require a large amount of help, there is a significant proportion of elderly who could remain in the community at a cost less than the cost of institutional care. This is possible primarily because of the extensive involvement of their families in providing care. If responsibility for providing all of the services required by these clients were to fall on the public service system, the public cost of providing adequate community care would be far higher than the public cost of institutional care.

For example, the cost of caring for a nursing client who requires about four hours a day of personal care, about four hours a day of homemaking (i.e., cleaning,

Table 7: Comparison of Community Care and Institutional Care Costs for Elderly Awaiting Institutionalization who are Capable of Remaining in the Community under Ideal Care Plan Conditions

	Semi–Independent	Frail	Mentally Frail and Nursing
Average public cost of community care (# per month)	161	354	675
Weighted average cost of public institutional care (# per month)	200	373	636
Proportion of clients for whom community care costs less than institutional care (%)	82	67	63
Proportion of clients for whom community care costs less than half of institutional care (%)	51	45	23

cooking and laundry), and constant supervision, i.e. an additional 16 hours a day of non-professional supervision, was estimated at $1,740 per month. However, if this same person lives with his or her family and they perform much of the housework and also watch over him or her at night and during the afternoon hours, then the cost of care in the community drops to $727 per month, a cost which is close to the cost of institutionalization. Fortunately, most of the nursing clients do not require this much assistance, so the cost of leaving them in the community would be even lower.

Another way to assess the economic advantages of the care alternatives is to look at the expected savings to the entire long-term care service system which would result from providing community care to some or all of the elderly awaiting institutionalization. In other words, we would be comparing: (1) the expense demanded of the public system if no community services are added and all of those on waiting lists enter institutions, with: (2) the expense demanded of the public sector if different groups of elderly presently on waiting lists would receive the additional services recommended and would therefore not require institutional care.

The extent of savings to be expected as a result of providing community care depends to a great extent on which elderly, from among those able to remain, it is decided to leave in the community. This decision is essentially a question of policy and rests not only on factors affecting costs – such as the extent and type of services required by the client, the availability of services in a given region, and the cost of developing additional institutions or services – but also value considerations such as the personal interests of the elderly and their families.

The following analysis of expected savings to the long-term care system is based on two alternative policy decisions: First, that all of the elderly assessed as able to be left in the community will remain there, and second, that only those elderly assessed as able to remain in the community for whom the cost of community care is less or equal to that of institutional care will remain in the community. Determining a ceiling regarding the cost of services provided in the community is a common strategy in programs for the prevention of institutionalization (Challis & Davies 1980).

Table 8 presents the total cost demanded from the Israeli public service system in order to meet all of the needs of the elderly currently on waiting lists for public institutionalization by applying either of these two alternative policies. Even if all of the elderly able to remain in the community were kept there, the system would still benefit from a total savings of 8% in the cost of care for these clients. The greatest savings would occur in the care for the semi-independent – about 22% – while the smallest savings would occur in the care for the mentally frail and nursing clients – about 6%. Of course, if only those elderly for whom community care was less expensive were to be left in the community, the expected savings rise significantly, to a total of 23% of the cost of care.

Nevertheless, a reservation is in order. Experience from similar demonstration projects conducted abroad has shown that it is not possible to increase service provision solely to those elderly who would otherwise enter institutions, and a larger population of impaired elderly generally become consumers of the additional community services as well. Thus, the savings in public expenditures which result from the implementation of a community care program as an alternative to institutionalization may vary greatly as a function of the population to whom the new services are targeted and delivered.

Table 8: Comparison of Public Expenditure Required to Provide Care[1] for Elderly Awaiting Institutionalization, According to Different Policy Options (in thousands of dollars per year)

	Semi-Independent	Frail	Mentally Frail	Nursing
a. Cost of institutional care for all clients	438	453	2,032	2,924
b. Public expenditure required if all elderly who could remain in the community receive community care	342	412	1,918	2,672
Amount of savings (a minus b)	96	40	115	252
Rate of savings (a minus b)	22%	9%	6%	8%
c. Public expenditure required if only elderly for whom the cost of community care is lower than that of institutional care receive community care	264	329	1,663	2,257
Amount of savings (a minus c)	174	124	370	667
Rate of savings (a minus c)	40%	27%	18%	23%

1 According to experts' ideal care plans.

D. Services Required under Experts' Restricted Care Plans

The experts were also requested to design care plans tailored to the existing limitations of the public service system concerning the type and extent of services available. Personal care and homemaking services were limited to the amount stipulated in regulations and the experts could not recommend services which were not available in most parts of the country – notably laundry services, special clubs for the mentally frail, non-professional supervision, and moves to new housing (Appendix C). However, limitations due to budgetary constraints, lack of sufficient personnel, or financial eligibility criteria were not taken into account.

The differences in the amount of formal services recommended according to the two different types of care plans reflect the limitations imposed in these restricted plans. For all functional groups, the extent of personal care recommended was far

less under the restricted care plans. According to the ideal care plans, personal care was recommended to mentally frail and nursing clients for an average of approximately 21 hours per week for clients in need of this service, whereas in the restricted care plans only about 13 hours per week, on the average, were recommended. With regard to homemaking services, there was no significant difference in the average number of hours of help recommended under the two plans since the number of hours recommended according to the ideal plans did not usually exceed the ceilings set by the public service system.

It should be noted that in drawing this comparison of the services recommended in the two types of plans, we are not looking at the same group of elderly, since some of those who could remain in the community with ideal care plans, could not do so if they were provided only with restricted care plans. It is likely that these are the elderly whose need for services is most extensive, either because they are more functionally impaired, or because their informal support network is more contracted.

Our data revealed that in many cases the amount of services actually delivered to the elderly was not only less than what they needed, but also far less than what regulations would have permitted as depicted in the restricted care plans. The gap between the extent of services recommended in the restricted care plans, and the provision of services in reality is particularly striking regarding personal care services for the semi-independent and the frail: Current services need to be expanded by 350% and 221% respectively, for the two groups. Among nursing clients the required expansion in personal care services is 92%. For all functional groups, most of the gap is due to the fact that a large proportion of elderly who required the service were not receiving it.

Also, with regard to homemaker assistance, services need to be expanded by 548% for the semi-independent, 299% for the frail and 204% for the mentally frail and nursing elderly in order to meet restricted care plan conditions. Here, too, the gap is due to the fact that many who needed this service were not receiving it at all. Only 20% of the semi-independent and 22% of the frail received this service, while the proportions who required it were 75% and 73%, respectively.

This gap between services recommended in the restricted care plans and those actually provided reflect additional limitations in the public service system, such as budgetary limitations, eligibility requirements, and problems in service delivery.

E. The Relative Cost of Restricted Care Plans versus the Cost of Institutionalization

For all groups, the average cost of providing the services of the restricted care plans is about half, or less than half, the cost of institutional care. Moreover, Table 9 shows that almost all of the elderly in all functional groups assessed as able to remain in the community with restricted care plan services, would require services which cost less than the cost of institutionalization, and that 71% of the semi-independent, 44% of the frail, and approximately half of the mentally frail and nursing clients assessed as able to remain in the community with the restricted care plans would require community services which cost less than half the cost of institutional care.

It is important to remember that economic factors are not the sole consideration in deciding whether to leave the client in the community or not economic considerations are not. Other factors should be taken into account, such as the burden on the family, client preference and needs, and the amount of time in which it is possible to leave the client in the community under these conditions.

Table 9: Comparison of Community Care and Institutional Care Costs for Elderly Awaiting Institutionalization who are Capable of Remaining in the Community under Restricted Care Plan Conditions

	Semi–Independent	Frail	Mentally Frail and Nursing
Average public cost of community care ($ per month)	84	201	298
Weighted average cost of public institutional care ($ per month)	200	373	636
Proportion of clients for whom community care costs less than institutional care (%)	95	92	98
Proportion of clients for whom community care costs less than half of institutional care (%)	71	44	52

F. Comparison of Experts and Practitioners' Recommendations of Services Required

In this chapter we will compare the extent of services recommended by the expert teams' in their ideal care plans with that recommended by the practitioners in the field.[1] The comparison is only for those elderly on waiting lists for institutionalization who were assessed as able to remain in the community with the aid of additional services in the opinion of both sources, since only for this group did we obtain full information from both sources on the services required.

In the area of personal care, no significant difference was found between the opinion of the experts and the opinion of the practitioners regarding the proportion of elderly who require this service. Furthermore, the average number of hours required for the semi-independent and frail clients who need this service is similar according to both sources. Only with regard to the mentally frail and nursing clients did the practitioners recommended more hours of care per person than did the experts.

The experts recommended providing homemaker services to a far higher proportion of the population than did the practitioners. They recommended this service for more than 70% of each functional group, while the practitioners recommended it for only 42% of the semi-independent, and 48% of the frail, mentally frail and nursing clients. It may be that the practitioners recommended homemaking services for a smaller proportion of the population because under current policy this service may not be provided to clients who live with members of their family and the practitioners in the field may have inadvertently been influenced by this guideline. Alternatively, the practitioners may in fact support this policy so that the gap in recommendations reflects a disagreement on substance between the two groups.

However, to those clients that the practitioners recommended providing this service, they recommended, on the average, far more hours of aid – twice as much as recommended by the experts for the frail, and three times as much for the nursing

---

1 While the recommendations of all four expert teams were fairly consistent, we found considerable variance among the practitioners of each of the three cities. The findings presented here are averages.

clients. The practitioners also recommended providing a significantly lower proportion of the elderly with home-delivered meals or laundry services than did the experts. For example, 35% of the semi-independent require home-delivered meals in the opinion of the experts, while only 23% of them require this service in the opinion of the practitioners. The difference between the recommendations of the experts and those of the practitioners is even greater regarding laundry services: In the opinion of the experts, 31% of the semi-independent require this service, while only 8% do in the opinion of the practitioners. These gaps were also found for the frail, mentally frail and nursing clients. It is possible that those practitioners who recommended a larger number of hours of homemaking services were including laundry and meal preparation in that service, while the experts recommended these services separately.

If we compare the total cost of the services recommended by the experts with that of the services recommended by the practitioners, we see that with regard to the semi-independent, the average cost of services recommended by both sources is almost identical: $160 and $164, respectively. However, with regard to the frail, the cost of services recommended by the experts averages $353 compared to $244 for those recommended by the practitioners. For the mentally frail and nursing clients, the balance is reversed: The average cost of services recommended by the experts is $554, while those recommended by the practitioners comes to $630.

VI. Sample of Home Care Recipients: Selected Characteristics and Services Required

We also studied elderly who were currently receiving personal care or homemaking services from the public sector but had not applied to enter institutions, on the assumption that they nevertheless represented an important population at risk for institutionalization. In comparison with the population of applicants to institutions, the elderly in this sample were generally found to be younger, and there were fewer unmarried clients (Table 10).

Table 10: Characteristics of Elderly Receiving Home Care Services from the Public Sector who have not Applied for Institutionalization (Percentages)

	Semi–Independent	Frail	Mentally Frail	Nursing
Age: % over 75	53	64	57	62
Sex: % female	66	75	59	68
Marital status: % unmarried	78	69	40	57
Functional disabilities (% disabled)				
Mobility (within home)	4	19	12	56
Bathing	24	61	69	98
Dressing	8	39	50	92
Eating	2	12	16	56
Urinary incontinence	4	15	48	65
Orientation problems	4	13	95	40
Unable to perform at least one household task*	94	97	93	100
Housing condition				
Lack of basic equipment (at least one)**	25	29	14	26
Lack of shower	6	9	6	8
Dampness	34	37	28	38
Informal support network				
Lives alone	64	49	24	22
Has no informal support	23	16	12	3
Family reports they cannot continue to provide help to the same degree or at all	29	31	42	39

* Cleaning, cooking, shopping, laundry.

** Refrigerator, cooking burners, heating stove, facility for heating water.

The extent of impairment of the two groups is fairly similar, although it is interesting to note that among the members of all functional groups there are more elderly suffering from orientation problems among the waiting-list population than among the non-waiting-list population. More of the semi-independent and frail who were on waiting-lists suffered from housing problems than did this non-waiting-list sample, but housing problems and lack of basic equipment were reported for this group as well.

The extent of aid required in personal care and homemaker services recommended for clients in this population requiring those services was found to be similar to that of the waiting-list population: An average of 6.6 hours of personal care and 3.3 hours of homemaker services among the semi-independent, an average of 10.6 hours of personal care and 3.6 hours of homemaker services for the frail, and an average of 17.9 hours of personal care and 3.9 hours of homemaker services for the mentally frail and nursing clients.

The gap between services recommended under the ideal care plans and those actually provided was not as great for this group as for the population of institutional applicants, but it was still substantial. As in the case of the waiting list population, the experts recommended that this sample of elderly also be provided with a wide range of home-delivered services in order to adequately meet their long-term care needs. According to our data at the time of the study, there was not a single service which was provided to everyone requiring it. Those services which were provided were given in amounts inadequate to meet some clients' full needs, and some were altogether unavailable. We estimated that providing these clients with the full spectrum of services they required according to the ideal care plans would involve an increase of 109% in the services currently provided to the semi-independent, of 170% in the services for the frail and of 232% in the services for the mentally frail and nursing clients.

Provision of personal care to the extent recommended in the ideal care plans would involve expansion of the service by rates of 41% for the semi-independent, 85% for the frail, and 74% for the mentally frail and nursing clients, indicating smaller gaps between provided and required services than were observed among the waiting-list population. In even sharper contrast to the waiting list population, most of the semi-independent and frail of this group were receiving homemaking services to the extent they required, and only among the nursing clients significant expansion was required – at a rate of 39% – mainly in order to increase the

number of recipients. However, the extent of unmet needs observed with regard to other services was often sizeable, and similar to those observed among the waiting list applicants.

The average amount of services provided to the non-applicants is higher since the inclusion of these clients in this sample was contingent on their receiving personal care or homemaking services from the public sector, while only some of the waiting list applicants receive these services – either because they are not eligible for them, or because the practitioners responsible for providing community services sometimes preferred to allocate the scarce services available to those still trying to cope at home.

With regard to the recommendations of the restricted care plans, the extent of both personal care and homemaking services currently provided is very close to the amount recommended, indicating that these elderly are apparently receiving the full amount of these types of aid permitted under existing regulations. This is very different from the situation among the waiting-list population who are receiving far less services than public sector regulations would allow. However, the restricted care plans also included other types of services which were provided to the non-applicants to a lesser degree, for example, home delivered meals, senior citizen clubs, and clubs for the mentally frail, so that full service provision to this population would still demand some expansion – at overall rates of 28% for the semi-independent, 64% for the frail and 83% for the mentally frail and nursing clients. While part of this under-coverage is no doubt due to budgetary constraints or organizational difficulties in service-delivery, in the case of certain services – particularly home-delivered meals, senior citizen clubs, and clubs for the mentally frail – under-coverage may be due to rejection of the service by the elderly.

In sum, our data regarding supplied and required services to this sample of elderly already receiving personal care and homemaking services revealed that considerable service expansion would be demanded to ensure adequate care for this group as well. If we remember that the population of waiting list applicants comprises only a small part of the impaired elderly based in the community, and that there are many other impaired elderly residing in the community who have been either receiving long-term care services to an extent similar to this sample, or not receiving any services at all from the public sector – then it is clear that an extremely substantial expansion of the public service system would be demanded in order to appropriately meet long-term care needs of the country's elderly population.

VII. Informal Assistance

Formal services generally cover only some of the needs for assistance of impaired elderly; a significant part of the help may also be provided by the members of the family, or, usually to a far lesser extent, by other informal agents, such as neighbors and friends. Since the family contribution should also be taken into account in designing care plans, the experts were asked to include in their recommendations what should be the part played by the informal support network in the provision of help – in terms of the amount of help, the types of help, and how responsibility for executing different tasks should be divided among the various members of the informal support network.

In deciding how to delegate responsibility for the various types of help needed among the formal parties and informal helpers, the experts took into consideration the amount of help presently provided by the family and their assessment of the strengths of the family. They could recommend that the families provide less help than they had been providing – and place responsibility for those tasks on the formal services – in order to ease the strain on the families and thus, hopefully, strengthen their ability to continue to provide care. However, they were not allowed to recommend an increase in the amount of help currently provided by the families, even if they assessed that the family might be capable of it. This is because the experts lacked information from family members regarding their willingness to provide more aid, and regarding which specific additional tasks they would be able to perform.[1]

In formulating the care plans, the experts related to all of the problems of each client and to all of the help provided through informal support. Clearly, when a client lives with other members of the family, some of his or her needs for help –

---

1 Originally, the experts also formulated a second type of ideal care plan which included the recommended division of responsibility between formal and informal parties, assuming communication with the family was possible. This second variant allowed the experts to indicate the type or amount of family aid they assessed as most appropriate on the basis of the information presented to them. However, since findings revealed that in most cases both variants of the ideal care plans were identical because the experts assessed that the families were already providing as much care as they could. Our report therefore presents data about the first variant only.

especially regarding house cleaning, laundry, shopping, cooking, and some supervision – are provided in the framework of normal household activity. Nevertheless, the needs of impaired elderly may also require help which exceeds what would be done on a regular basis in the household – such as constant supervision, laundry for a person who is incontinent, etc. In our presentation of the recommended division of help between the formal system and the informal network, we have not differentiated between household tasks and activities which are routinely performed by members of the family, and activities of the same nature which are undertaken especially on his or her behalf. It is therefore likely that in the case of elderly who do not live alone, our figures regarding the amount of help to be shouldered by members of the family who live with the client are biased upwards.

The experts recommendations for informal support for those elderly on waiting lists whom they assessed could remain in the community are shown in Table 10. When informal support was not recommended, it was usually because there was no source of informal support available, or the sole source of support was the client's spouse who was also sick and/or physically impaired. When informal support was recommended for this group, it was usually placed on family members who do not live with the client and only rarely on friends or neighbors. This corresponds to professional attitudes that responsibility for providing informal support rests solely on the family. Since nursing clients who have no or little informal support are often simply incapable of residing in the community, they tend to enter institutions quickly and are therefore under-represented among the waiting list population. In contrast, the proportion of elderly without any informal support is highest among the semi-independent.

When the client lives with his or her spouse, or with other family members, they were usually seen as the source of care provision, and usually most of the informal support was provided by them. For example, informal help was recommended for 93% of the frail and nursing clients who live with family members, and for more than 80% of them it was further determined that it would be given by the family members who live with them. An exception to this was found among semi-independent elderly who live with their spouse alone: Only for 33% was informal help recommended, and only in 12% of the cases was it placed on the spouse. This finding may be explained by the fact that in many cases the spouse is also impaired and both members of the couple have applied to enter an institution because they lack informal support.

The average amount of help required by each functional group also rises with increasing disability (Table 11). For those living in every type of household arrangement, the average number of hours of care that was recommended increased in accordance with the severity of the functional state: The extent of informal support required on the average for a semi-independent elderly person who lives with family members is about ten hours per week, for a frail client in the same arrangement about 16 hours per week, and for a nursing client – about 19 hours. There seem to be two reasons for this: First of all, when the client is more disabled, and therefore requires more help, there is a greater need to mobilize all possible sources of help. Secondly, the experts tended to place more responsibility on family members when they lived together with the client – and such household arrangements are more common with each increasing disability level. However, it should be remembered that many of the tasks required by the clients are performed as part of routine household management, and they comprise part of the care delegated to the families in these cases.

Table 11: The Extent of Informal Support Recommended for Elderly Awaiting Institutionalization who are Capable of Remaining in the Community under Ideal Care Plan Conditions, by Type of Living Arrangement

	Semi–Independent	Frail	Mentally Frail and Nursing
Live alone			
Total number of elderly (N)	99	44	48
% requiring informal support	47	68	54
Average number of hours recommended	6.1	7.4	10.4
Live with spouse			
Total number of elderly (N)	24	15	45
% requiring informal support	33	66	82
Average number of hours recommended	8.2	25.1	18.6
Live with others			
Total number of elderly (N)	26	16	66
% requiring informal support	88	93	93
Average number of hours recommended	10.1	16.3	19.3

The restricted care plans imposed limits on the extent and type of services that could be recommended. Thus, in order to fulfill all of the clients' care needs, it seems that the experts would have had to demand more help from the informal support network than had been necessary under ideal care plan conditions. This, however, did not seem to have occurred, as no significant differences were found between the amount of care delegated to family members under the two plans. It seems that in most cases the experts thought that it would not be possible to expect more help from the family than they had in the framework of the ideal plans, so that when the client required more help, they preferred to recommend that he enter an institution or remain with unmet needs. In addition, it may be that under conditions of the restricted care plans the families are mainly expected to take responsibility for supervision, rather than other instrumental tasks.

The amount of informal support recommended for the non-waiting-list sample was greater than that recommended for most of the waiting-list population. This reflects the fact that more informal help is already given to these elderly today and the fact that the experts assessed that the families are indeed able of carrying that burden. The difference between the non-waiting-list and the waiting-list population is most striking among the semi-independent and frail who live with their spouses and among the mentally frail and nursing elderly in all of the household arrangements. These findings support other data from our study which have indicated that the informal support networks of those who have not applied to enter an institution are stronger and firmer than those of the population who are on waiting lists.

VIII. Intermediate Frameworks

In addition to services which are supplied at the client's home, "intermediate frameworks" have been developed which represent yet another way to meet long-term care needs of the elderly population while still avoiding institutionalization. The term "intermediate frameworks" reflects their position on the spectrum between care provided exclusively in the home and care provided within a closed institution. Clients receiving these services continue to reside in the community, but receive more protection and supervision than provided by home care services. The most common of these intermediate frameworks are day care, foster families, and sheltered housing.

Several of the studies which examined alternatives to institutionalization found that a sizeable proportion of the elderly who were candidates to enter institutions could only remain in the community by receiving care through frameworks such as sheltered housing, day care or foster families (Kraus 1976; Sherwood and Morris 1982). They therefore concluded that the development of frameworks such as these is essential to efforts to prevent institutionalization.

In this study, we also looked at the extent of the need for two of these frameworks which exist in Israel today – sheltered housing for independent and semi-independent elderly, and day care for frail, mentally frail and nursing clients. We endeavored to examine the proportion of elderly in our study who could benefit from these intermediate care settings and their appropriateness as alternatives to institutionalization.

After the experts had determined that a client could remain in the community, and had completed the design of a care plan which included recommendations for home-delivered services, they were asked for which of the semi-independent elderly they would also recommend sheltered housing. Similarly, they were asked for which of the frail, mentally frail and nursing clients they would recommend day care, and if so, for how many times a week and for how many hours a week. Whenever one of these services was recommended, the experts were requested to indicate which of the home-delivered services that had previously been recommended would now be provided through the alternative framework. The experts were also asked to indicate which of the clients, for whom it was originally determined that they could not remain in the community with care based exclusively

on home-delivered services, could now be left in the community if they were to participate in these more structured frameworks.

A. Day Care

Day care centers are frameworks into which impaired elderly clients may enter several times a week, usually during the morning hours. They are intended to meet the social and activity needs of the frail, mentally frail, and occasionally, nursing clients, and to provide them with services which could also be provided in the home: Personal care (especially bathing), medical and nursing care, and in some centers, para-medical care, such as physiotherapy and occupational therapy. In addition, day care programs provide constant supervision, so that during those hours that the client is at the center, family members are relieved of their normal caretaking duties and freed for other concerns.

The specific day care framework recommended by the experts participating in our study was an ideal setting which enabled clients to visit for a full eight-hour day for up to six days a week, and which provided all of the numerous services mentioned above. However, it must be kept in mind that current programs in Israel generally operate for only part of the day and do not provide such an extensive range of services. Clients usually attend the centers for up to six hours during the morning, and the services provided are help in bathing, meals, and participation in organized activities. Only infrequently is there rehabilitative treatment, such as physiotherapy or occupational therapy, or professional nursing care. Moreover, at present nursing clients are not usually accepted to day care programs in Israel. We asked the experts to recommend day care for nursing clients as well, but it is important to realize that in making their recommendations, our experts were referring to the ideal framework outlined above, which – we emphasize – may often deviate from the programs which actually exist. Their recommendations would thus not, in the meantime, be applicable when all of the essential services are not available.

Within the context of the ideal care plans, day care was recommended for 25% of the frail, 15% of the mentally frail and 16% of the nursing clients who had applied to enter institutions. We obtained a similar, though not identical, picture for the non-applicants. Three visits weekly were recommended for most of the frail elderly for whom this service was recommended, but six visits weekly were recommended

for more than half of the mentally frail and nursing clients for whom the experts recommended this service. These data indicate serious under-provision of this service since at the time of the study, only a small proportion of the elderly examined were attending day care programs: About 6% of the frail and 12% of the mentally frail and nursing.

The experts indicated that for most of the elderly for whom day care was recommended, it would serve as a substitute for home-delivered services of personal care, particularly aid in bathing. In addition, day care was expected to replace to some degree supervision, social, para-medical and nursing services in a significant number of cases. Day care frameworks are also intended to ease the strain on the families by eliminating the need for some of the help they would otherwise provide.

It is important to examine to what extent day care can provide a substitute for institutional care. To this end, we looked at the population in terms of three separate groups: (1) elderly assessed as unable to remain in the community with home-delivered services; (2) elderly assessed as able to remain in the community with home-delivered services, but for whom this option would not be desirable for them or for the members of their families; and (3) elderly assessed as able to remain in the community with the aid of the home-delivered services, and for whom this option would be desirable.

We found that only a very small proportion of the elderly assessed as unable to remain in the community with the aid of the services recommended in the ideal care plans were assessed as able to remain in the community with the addition of day care: 6% of the frail in this category and 2% of the mentally frail and nursing clients. However, day care was recommended as a substitute for institutional care for a higher proportion of those elderly assessed as able to remain in the community but for whom this would not be desirable: About 30% of the frail and mentally frail, and about 20% of the nursing clients in this second category could benefit from day care. Among the clients assessed as able to remain in the community, and for whom this would be a desirable care option, day care was recommended for about 30% of the frail, 14% of the mentally frail and 20% of the nursing clients.

In the framework of the restricted care plans, day care was recommended by the experts for a similar proportion of the elderly in each functional group as under the ideal care plans, (for 25% of the frail, 15% of the mentally frail, and 10% of the nursing clients), and as a substitute for the same home-delivered services.

The recommendations of the experts, in the ideal and restricted care plans, taught us that day care programs are not perceived by the professionals as alternative frameworks to institutionalization when the client is unable to remain in the community with care based on home-delivered services. However, in many borderline cases in which the client could stay in the community but it would not be desirable for him or his family, attendance at a day care framework may tip the balance in favor of community care. For many of the clients assessed as able to remain in the community with home-delivered services, day care can provide a fuller and more appropriate answer to their needs and the needs of their family members than care based only on services provided at home.

While day care cannot substitute for institutionalization more than home-delivered services, it can greatly aid in leaving those elderly in the community for whom this is possible. The contribution of day care in the care of the mentally frail is particularly striking since providing care for them at home is so difficult. In addition, day care frameworks may prevent institutionalization by easing the burden placed on the family: This was cited by the experts as a purpose of the day care in 38% of the cases in which it was recommended. Day care programs release family members from responsibility for care during several hours of the day or the week, and may thus prevent a build-up of burden and stress which, when left unchecked, may eventually cause the family to feel unable to continue to offer any help at all to the elderly person.

We also compared the cost of care plans which include day care with the cost of care plans which do not include day care and with the cost of public institutional placement. In most cases, we found no great difference between the cost of community care plans with or without day care, although the cost of institutional care was generally higher.[1]

---

1 For findings which compare the average cost per client of community care with day care, to community care without day care and to institutional care, under ideal and restricted care plans conditions, see Appendix D. Full details of the cost analysis appear in our report in Hebrew (Habib et al. 1988).

B. Sheltered Housing

For semi-independent elderly the experts could also recommend sheltered housing – in addition to, or as a substitute for, services to be delivered in the home. Sheltered housing frameworks are mainly intended for elderly who are able to take care of themselves independently. Their purpose is to meet housing needs while providing the client with a greater feeling of security than he or she would have while living alone. At sheltered housing frameworks, there is usually a "house mother" who ensures that the buildings and apartments are properly maintained and serves as a source of support to whom residents can turn at any time. The elderly reside alongside each other, and there is usually a social club, so that residents may also benefit from greater opportunities for social interaction.

The ideal care plans. Sheltered housing was recommended for 43% of the semi-independent who had applied to enter institutions and for 34% of the non-applicants. The higher proportion of recommendations among the applicant population mainly reflects the greater prevalence of housing problems among that group and the larger proportion of elderly living alone. Among the elderly for whom sheltered housing was recommended, a very high proportion suffer from severe housing problems – about 90%, and a significant proportion live alone – 43%.

For three-quarters of the elderly for whom sheltered housing was recommended, the experts indicated that it was recommended as a substitute for new housing, home repairs, or other apartment adaptations. In addition, it was expected to substitute for supervision and social services for about one half of the elderly for whom it was recommended.

We previously reported that, under the ideal care plans, only a very small proportion of the semi-independent could not remain in the community (7%, n = 12). We subsequently found that residence at a sheltered housing framework would enable only one of these clients to remain in the community. However, it is highly significant to note that for more than half of those elderly who could remain in the community but for whom it would not be desirable with only home-delivered services, sheltered housing was recommended as a way to provide adequate alternative care. The service was also recommended for 35% of the elderly who would have been able to receive appropriate care solely from home-delivered services.

Thus, similar to the case with day care, sheltered housing frameworks were by and large not found to provide a viable alternative for institutionalization for those

cases in which maximal home-delivered services were assessed as insufficient to provide appropriate care. However, they may make a very significant contribution in the care of those elderly who could possibly remain in the community, but for whom reliance solely on home-delivered services would not provide a totally suitable answer to their needs or the needs of their families.

Restricted care plans. Sheltered housing was recommended for an almost identical proportion of elderly under the restricted care plans as under the ideal care plans (42% for the applicants, and 35% for the non-applicants), and it was recommended as a substitute for the same services.[1]

---

1 Due to the methodological complexities, we did not attempt a comparison of the cost of care plans which include sheltered housing to the cost of care plans without sheltered housing.

IX. Discussion and Conclusions

Our study indicates that large proportions of the elderly on waiting lists for public institutionalization could remain in the community if they were to receive additional community services. Multi-disciplinary teams of professional experts, practitioners responsible for case-management, elderly who had applied for institutionalization and their primary informal caregivers all independently came to this same assessment. Although for some clients institutionalization is probably the only feasible way to provide adequate long-term care, for many others at all functional levels other alternative care options are possible and often more desirable.

Under the assumption that clients would be provided with any possible service required to meet their needs or the needs of their families, the experts assessed that 94% of the semi-independent, 82% of the frail, and even 72% of the mentally frail and 67% of the nursing clients could remain in the community. These findings support the results of research undertaken in the United States and the United Kingdom which found that institutionalization may be prevented through the development of community care programs (Bell 1973; Kraus et al. 1976; Davies and Challis 1980; Sherwood and Morris 1982).

In our questioning of respondents, we differentiated between whether the client would be **able** to remain in the community and whether that would also be **desirable** for him or her, as well as for the family. Ultimately, social services aim to achieve enhanced client well-being and so it was highly significant to learn that community services would be preferred by about half of the independent and frail clients who had applied for institutionalization. Furthermore, caring for these clients through community-based services will ameliorate the shortage of institutional beds and shorten the waiting period for those clients that cannot be adequately provided for in an alternative way.

The experts and practitioners assessed that more of the elderly could remain in the community than did the clients or their families. It may be that as lay people, the latter groups are less familiar with the potential services that could be provided and this seems to be reflected in the narrow range of services recommended by the clients and their families. In fact, Kraus et al. (1976) found that lack of information about the public service system was one of the factors associated with applications for institutionalization.

However, the disparity between the opinions of the professional staff and those of the clients and their families may also have been due in some measure to the desire of some clients to enter an institution rather than remain in the community for a variety of personal reasons associated with group or institutional living. Furthermore our interviews were held when the elderly respondents had already made a decision to enter an institution and had even taken steps in this direction. Moreover, community residence for these elderly was often contingent on massive support from the family and the preference of some caregivers for institutional care may have expressed their reluctance to continue to shoulder this burden. The professionals' awareness of these potential conflicts of interest between the client and the family are reflected in the small, but still substantial, group of elderly for whom they assessed that community care would be desirable for the client, but not for the family.

Our data is based on hypothetical assessments. The fact that they were collected from all of the relevant informants, who all confirmed each other's evaluations, provides strong evidence for the validity of the assessments. But final conclusions regarding the feasibility of alternative community care in Israel await demonstration in the field.

It should be noted that we anticipate that overall substitution rates achieved from actual implementation of a community care program will be somewhat lower than the rates recorded here. It is also unclear to what extent the population of clients on waiting lists represents the population of those who actually enter institutions. A follow-up survey conducted 16–19 months after the original interviews revealed that some of the clients had left the waiting lists without having entered an institution. We do not know how many of these clients found adequate alternative care in the community, or how many were simply discouraged by the long wait. In any case, the number of institutional applicants who could remain in the community far exceeds that of those who left the waiting lists.

Moreover, our data refer to the possibility of providing alternative care for clients currently waiting to enter institutions from their community residence, and does not report on the possibility of providing alternative care for those clients who enter institutions directly from acute care hospitals. It must be assumed that in general this latter group suffers from more severe problems – hence the expediency with which their placement is generally executed – and that there is thus also less likelihood of providing them with adequate community care.

The current lack of community services seems to be a major factor contributing to applications by the elderly to institutions. At the time of the interviews, a large proportion of the elderly on waiting lists were not receiving any public long-term care services whatsoever, and a highly substantial expansion of services provided by the public sector would be required in order for these clients to have all of their needs met through community care – increases of about 400% in the cost of care currently provided to the semi-independent and to mentally frail and nursing clients, and about 530% in the services for the frail. Although extensive expansion of existing community-based services would be required in order to provide adequate care for this target group as a whole, for a large proportion of the clients the public cost of even ideal community care for each of them individually would still be lower than the cost of public institutionalization.

The experts also assessed the possibility of leaving clients in the community with only those services currently available and in amounts not surpassing those stipulated by agency regulations. We found that even with these restricted care plans, large proportions of the elderly, particularly the semi-independent and the frail, would still be able to remain in the community, but the service expansion demanded from the public sector would be far less. Much of the cost savings of community care stem from the involvement of the families in providing aid. When disabled elderly have no informal support, the cost of caring for them in the community rises steeply. The generally stronger support networks of the elderly we studied who were equally disabled but had not applied for institutionalization strongly hints at the crucial role of family support in helping disabled elderly to remain at home.

The lower average cost per client of community care does not allow us to conclusively determine that lowered public expenditures for long-term care may be anticipated from the development of community care programs. This is because much of the experience of demonstration projects undertaken abroad has shown that it is difficult to limit the provision of enriched services solely to those elderly who would have entered institutions, and a larger population of impaired elderly generally also receive expanded services (Weissert 1985; Weissert 1986; Greene 1987). While an additional population thus benefits from better care, the public sector can record no savings relative to anticipated institutional expenses for the elderly. In contrast, when community services were effectively targeted to elderly at risk of institutionalization, then they were shown to be cost-effective (Skellie et al. 1982; Davies & Challis 1986).

The savings in public expenditures which result from the implementation of a community care program as an alternative to institutionalization will vary greatly as a function of the population to whom the new services are targeted (Doty 1984).

Moreover, we believe public policy should consider wider societal values about public responsibility for populations in need (Brody 1986; Weissert 1986). Even elderly who would not, in fact, apply for institutionalization may suffer from severe unmet needs. While expanded community care may not reduce overall public expenditures, it could be effective in complementing institutionalization to together provide a spectrum of care for a larger population of elderly at different levels of disability, with varying needs.

The inclusion of day care in the experts' care plans did not lessen the need for institutionalization when home-delivered services were determined insufficient. However, day care would apparently allow those elderly who could remain in the community, but for whom it would be undesirable with only home-delivered services, to do so. Moreover, under existing conditions, in which community services are inadequately supplied, day care may make a highly vital contribution to the basket of home-delivered services. For frail elderly, day care would even lower the average cost of community care; for other groups relative costs were difficult to analyse. Sheltered housing was recommended for nearly half of the semi-independent clients who had applied for institutionalization, usually in response to housing needs, but, like day care, it was rarely considered able to prevent institutionalization when other home-delivered services would not suffice.

It has been gratifying to witness that even before this final report sees publication, numerous findings of the study have already made important contributions to Israel's long-term care planning. The documentation of existing gaps between existing and required services, including institutional care for some part of the population, substantiated the need to develop long-term care services in both the community and institutional sector. Data on the population of disabled elderly and estimates of the need for services served as the basis for national and municipal five-year plans and as input for the planning of the 1988 Community Long-term Care Law of the National Insurance Institute which gives legal entitlement for home care to disabled elderly in the community.[1]

---

1 For a detailed description of the law, see Cohen 1988; Morginstin and Shamai 1988.

Bibliography

Abt Associates (Birnbaum, H.; Goomer, G.; Prater, F.; and Burke, R.). 1984. *Nursing Home Without Walls, Evaluation of the New York State Long Term Home Health Program.* Cambridge, Mass.

Alternative Health Services Project Staff and Wittaker Medicus (AHS). 1982. "Alternative Health Services (AHS) Demonstration Project". Final Project Report. Washington D.C.

Applebaum, R.; Seidl, F.W.; and Austin, C.D. 1980. "The Wisconsin Community Care Organization: Preliminary Findings from the Milwaukee Experiment". *The Gerontologist* 20(3):350–355.

Avon County Council. 1980. "Admissions to Homes for the Elderly". County of Avon Social Service Department, Bristol. (Mimeograph).

Bachelard, B.; and Tinturier. 1988. "Long-term Institutional Care or Home Care? What is the Best Solution for the Canton of Vaud?" *Health Policy* 10:57–63.

Barney, J.L. 1977. "The Progressive Choice of Long-Term Care". *The Gerontologist* 17(4):309–314.

Bell, W.G. 1973. *Community Care for the Elderly: An Alternative to Institutionalization.* Program in Social Policy and the Aging Department of Urban and Regional Planning, Florida State University, Tallahassee, Florida.

Bergman, S.; Factor, H.; and Kaplan, I. 1986. *Census of Long-Term Care Institutions in Israel, 1983: Population, Functional Level and Financing.* S–26–86. JDC-Brookdale Institute, Jerusalem. (Hebrew).

Blackman, D.; Brown, T.; and Learner, M. 1983. *South Carolina Community The First Year Cohort After 18 Months.* Spartansburg, South Carolina.

Braun, K.L.; and Rose, C.L. 1987. "Geriatric Patient Outcomes and Costs in Three Settings: Nursing Home, Foster Family and Own Home". *Journal of the American Geriatrics Society* 35(5):387–397.

Brodsky, E.; Cohen, M.; Habib, J.; and Heron, T. 1986. *Case Management in Services for the Aged.* D–134–86. JDC-Brookdale Institute, Jerusalem.

Brody, E.M. 1986. "Institutional versus Community Health Care of the Elderly: The Delicate Balance of Social Policy". *Home Health Care Services Quarterly* 7(3/4):113–129.

Carcagno, G.; and Kemper, P. 1988. "The Evaluation of the National Long-Term Care Demonstration. Ch. 1: An Overview of the Channeling Demonstration and Its Evaluation". *Health Services Research* 23(1):1–22.

Challis, D.; and Davies, B. 1985. *Long-term Care for the Elderly: The Community Care Scheme.* Personal Social Services Research Unit, University of Kent at Canterbury.

Cohen, S. 1988. "The Long-Term Care Insurance Law: Background, Principles and Organization Toward Implementation". In: *Social Security, Journal of Welfare and Social Security Studies.* Special Edition: Toward the Implementation of the Long-Term Care Insurance Law in Israel. pp. 4–22. The National Insurance Institute, Jerusalem.

Congressional Budget Office. 1977. *Long-Term Care for the Elderly and Disabled.* Washington, D.C.

Davies, B.; and Challis, D. 1986. *Matching Resources to Needs in Community Care.* Gower Publishing Company Ltd., Hunts, England.

Davies, B.; and Challis, D.J. 1980. "A New Approach to Community Care for the Elderly". *British Journal of Social Work* 10:1–18.

Department of Human Services, Office on Aging. 1978. *The In-Home Option – An Evaluation of Non-Institutional Services for Older Arkansas.*

Doty, P. 1984. *Can Home and Community-Based Services Provide Lower Cost Alternative Nursing Homes?* Office of Policy Analysis, Health Care Financing Administration. Washington D.C.

Factor, H.; Habib, J.; and Be'er, S. 1988. "Evaluating the Need for Long-Term Care Services and their Cost". *Social Security, Journal of Welfare and Social Security Studies.* Special Edition. Toward the Implementation of the Long-Term Care Insurance Law in Israel. The National Insurance Institute, Jerusalem. pp. 134–154.

Frankfather, D.L.; Smith, M.J.; and Caro, F.G. 1981. *Family Care of the Elderly.* Lexington Books, D.C. Heath, Lexington, Mass.

General Accounting Office. 1979. *Entering A Nursing Home – Costly Implications for Medicaid and the Elderly.* Report No. PAD–80–12, Washington D.C.

Gibson, M.J. 1984. Family Support Patterns, Policies and Programs. In: *Innovative Aging Programs Abroad: Implications for the United States.* Nusberg, C. (ed.). pp. 159–196, Greenwood Press, Westport, Conn.

Greene, L.V. 1987. "Nursing Home Admission Risk and the Cost-Effectiveness of Community-Based Long-Term Care: A Framework for Analysis". *Health Services Research* 22(5):656–669.

Habib, J.; Factor, H.; Naon, D.; Brodsky, E.; and Dolev, T. 1988. *Disabled Elderly in the Community: Developing Adequate Community-based Services – their Implications for Institutional Placement. Phase Two: Evaluation by Multidisciplinary Teams.* D–160–88. JDC-Brookdale Institute, Jerusalem. (Hebrew)

Hicks, B.; Raisz, H.; Segal, J.; and Doherty, N. 1981. "The Triage Experiment in Coordinated Care for the Elderly". *American Journal of Public Health* 71(9):991–1003.

Katz, S.; Ford, A.B.; Downs, T.D.; Adam, M.; and Rusby, D.I. 1972. *Effects of Continued Care: A Study of Chronic Illness in the Home.* DHEW Publication No. (HSM)73–3010, National Center for Health Service Research and Development, Washington, D.C.

Kemper, P. 1988. "The Evaluation of the National Long-Term Care Demonstration. Ch. 10: Overview of the Findings". *Social Services Research* 23(1):161–174.

Kemper, P.; Appelbaum, R.; and Harrigan, M. 1987. "Community Care Demonstrations: What Have We Learned?". *Health Care Financing Review* 8(4):87–100.

Knowlton, J.; Clauser, S.; and Fatula, J. 1982. "Nursing Home Pre-admission Screening: A Review of State Programs". *Health Care Financing Review* 3:3, pp. 82–83.

Kraus, A.S.; Spassof, R.A.; and Beattie, E.J. 1976. "Elderly Applicants to Long-Term Care Institutions: II The Applicants Process Placement and Care Needs". *Journal of the American Geriatrics Society* 24(4):165–172.

Management Resources Associates. 1979. *Final Evaluation Report of Alternative Program for the Elderly.* Salt Lake City, Utah.

McAuley, W.J.; and Blieszner, R. 1985. "Selection of Long-Term Care Arrangements by Older Community Residents". *The Gerontologist* 25(2):188–193.

Mitchell, J.B. 1978. "Patient Outcomes in Alternative Long-Term Care Settings". *Medical Care* 16(6):439–452.

Morginstin, B.; and Shamai, N. 1988. "Issues in Planning Long-Term Insurance Law in Israel Social Security System". In: *Social Security , Journal of Welfare and Social Security Studies.* Special Edition: Toward the Implementation of the Long-Term Care Insurance Law in Israel. pp. 31–48. The National Insurance Institute, Jerusalem.

Oktay, J.S.; and Volland, R.J. 1987. "Foster Home Care for the Elderly as an Alternative to Nursing Home Care: An Experimental Evaluation". *American Journal of Public Health* 77(12):1505–1510.

Sager, A. 1979. *Learning the Home Care Needs of the Elderly.* Levinson Policy Institute, The Florence Heller Graduate School for Advanced Study in Social Welfare, Brandeis University, Waltham, Mass.

Sherwood, S.; and Morris, J.N. 1982. *Alternative Paths to Long-Term Care.* Department of Social Gerontological Research, Hebrew Rehabilitation Center for the Aged, Boston, Mass.

Skellie, F.A.; Mobley, M.; and Coan, R.E. 1982. "Cost-Effectiveness of Community-based Long-Term Care: Current Findings of Georgia's Alternative Health Services Project". *American Journal of Public Health* 72:353–358.

State of Oregon. 1981. Flexible Inter-governmental Grant (fig). Wains/Continuum of Care for the Elderly. Final Report Executive Summary. Department of Human Resources.

Wager, R.A. 1972. *Care of the Elderly.* IMTA.

Weissert, W.G. 1986. "Hard Choices: Targeting Long-Term Care to the 'at Risk Aged' ". *Journal of Health Politics, Policy and Law* 11(3):463–481.

Weissert, W.G. 1985. "Seven Reasons Why it is so Difficult to Make Community-based Long-Term Care Cost-effective". *Health Services Research* 20(4):423–433.

Weissert, W.G. 1981. "Towards a Continuum of Care for the Elderly: A Note of Caution". *Public Policy* 29(3):331–339.

Weissert, W.G.; Cready, C.M.; and Pawelak, J.T. 1988. "The Past and Future of Home– and Community-based Long-Term Care". *The Milbank Quarterly* 66(2):309–388.

Williams, M.E.; and Williams, T.F. 1982. "Clinical Conference: Assessment of the Elderly for Long-Term Care". *Journal of the American Gerontological Society* 30(1):71–75.

Woodridge, J.; and Shore, J. "The Evaluation of the National Long-Term Care Demonstration: Ch. 7: The Effect of Channeling on the Use of Nursing Homes, Hospitals, and Other Medical Services". *Health Services Research* 23(1):119–128.

Wright, K.G. 1986. *Economic Aspects of Strategies for the Health Care of the Elderly.* Report prepared for the World Health Organization, University of York, UK.

Appendix A: General Overview of Services for the Elderly in Israel at the Time of the Study (1983–1984)

Responsibility for services for the aged has been shared by numerous government, public and voluntary agencies. The main government agencies involved in the care for the elderly are the Ministry of Health, the Ministry of Labor and Social Affairs, and the National Insurance Institute. The principal public organizations which are responsible for the development of services for the aged are the General Sick Fund (Israel's major provider of health care) and ESHEL (the Association for the Planning and Development of Services for the Aged in Israel).

The various agencies operate within a clearly-defined but complex division of financial responsibility, based on the type of service and the level of disability of the client classified along the continuum of dependency in IADL (semi-independent) to moderate dependency in ADL (frail) to severe dependency or cognitive impairment.

The Ministry of Labor and Social Affairs is responsible for institutionalization and personal-care services for the semi-independent and frail elderly, the provision of all homemaking maintenance services to all the disabled, special needs for transportation (for example, as required for medical care), and the operation of day-care and sheltered housing frameworks. The Ministry operates through a network of local social welfare offices that provide care on a discretionary basis within closed budget constraints, and are administered by the local authorities. In most areas there are social workers who specialize in the care of the elderly.

The Ministry of Health is responsible for the institutionalization and provision of personal care for the nursing and mentally frail elderly,[1] the operation of mental-health clinics, and the development of preventive services in the family-health clinics. The care is provided through a network of regional public offices.

---

1 Since data for this study were gathered, the National Insurance Institute has begun implementation of the Community Long-Term Care Insurance Law which provides home care and day care services to severely disabled elderly on an entitlement basis.

Medical care is the formal responsibility of the Ministry of Health, but most of the medical care received by the elderly is, in fact, provided by the Sick Funds. At present Israel has no compulsory health-insurance program which covers the entire population. Health insurance for most of the population is arranged through voluntary Sick Funds. These Sick Funds are organized on an insurance basis and finance the full range of health services (hospitalization, rehabilitation and primary care). The largest is the General Sick Fund founded by the Histadrut, Israel's largest labor union. It insures 75% of the population and 95% of the elderly population. The General Sick Fund is organized primarily on the basis of a national network of 1,200 neighborhood clinics, which integrate medical, nursing and paramedical staff. In addition, there are regional continuing-care units which are specifically responsible for supervising and facilitating the care of the chronically ill and dependent elderly within the clinics. The Sick Funds also can provide personal care to those who are fully insured, and institutionalization of the elderly with complex nursing needs.

Appendix B: Study Population and Data Collection

1. Definition of the Population

The study population included:

a) All elderly (women aged 60 and over, men aged 65 and over) who were on the waiting lists for long-term institutional care of the Ministry of Health or the Ministry of Social Affairs – in Jerusalem, in Beer Sheva, and in Tel Aviv. In Israel over 70% of the elderly who enter institutions apply to public agencies, and these two Ministries share responsibility for placement. (Some of these clients were also receiving home care services while they awaited placement).

b) Elderly from the same cities receiving personal care or homemaking services which are funded by the Ministry of Health, Ministry of Labor and Social Affairs or the General Sick Fund of the Federation of Workers, and who were not listed on the waiting lists for long-term institutional care.

Table B–1: The Number of Elderly Awaiting Institutionalization or Receiving Personal Care or Homemaking Services in Jerusalem, Tel Aviv, and Beer Sheva*

	Jerusalem	Tel Aviv	Beer Sheva
On waiting list of Ministry of Health	133	72	44
On waiting list of Ministry of Labor and Social Affairs	175	130	35
Recipients of personal care – Ministry of Health	220	145	97
Recipients of personal care – Ministry of Labor and Social Affairs	130	48	15
Recipients of homemaking services – Ministry of Labor and Social Affairs	413	655	267
Recipients of personal care – General Sick Fund	343	146	71

* Clients who were both awaiting institutionalization and receiving home care, or were receiving home care from more than one source, were assigned to the applicable category which appears first in the Table.

2. Size of the Population in Jerusalem, Tel Aviv and Beer Sheva.

Among the service recipients, only Jewish elderly residing within the city limits of Jerusalem, Tel Aviv and Beer Sheva were investigated. Table B–1 indicates the number of elderly in each group.

The waiting-list population was investigated, and a sample was drawn of those receiving community services (but not on the waiting lists for institutionalization).

3. Instruments

The study instruments were designed to collect data on the needs of the elderly. This included their health-functional status, socio-economic characteristics, the extent of formal and informal aid they were receiving. Data was also collected on the problems faced by the elderly, the families, and the professionals responsible for care at the service agencies in the provision of services. In addition, they sought to gather information on reasons for applying for institutionalization and on the possibilities of leaving the client in the community. For these purposes, three questionnaires were built:

1) ***Practitioner File Questionnaire*** – intended for the person responsible for providing care to the client on behalf of the formal services. Some of the data gathered with this questionnaire were already found in the personal files of the elderly at the agencies, while the rest of the information required was filled in by the practitioner (social workers at the Welfare offices, nurses and social workers at the Health Offices, nurses at the Continuing Care Units and nurses at the General Health Fund clinics).

2) ***Elderly Questionnaire*** – intended for administration directly to the client at home. When it was not possible to interview the client for mental or health reasons, the ***Caregiver Proxy for the Elderly Questionnaire*** was administered to the primary informal caregiver which enabled us to receive much of the important data collected by the Elderly Questionnaire. When the client had already entered a long-term care institution by the time of the interview, he was asked only a small number of questions from the Elderly Questionnaire.

3) ***The Primary Caregiver Questionnaire*** – intended for that person identified by the client as helping him or her to the greatest extent in his daily life

(aside from a person paid by the formal services or paid by the client). When the client could not answer questions, and so failed to tell us who his primary helper was, the caregiver was identified by the practitioner responsible for care.

4. Data Collection

The sequence of data collection was as follows: In the first stage we administered the "Practitioner File Questionnaire" in order to obtain basic data regarding the situation of each client and his or her ability to be interviewed.

Next, the Elderly Questionnaires were administered to the clients, and on this basis we learned the identity of the primary informal caregiver who was then interviewed.

Appendix C: Restricted Care Plan Options: Type and Extent of Services to be Provided

Informal caregivers

1. Family members residing in the same household (hours of aid per week)
2. Family members residing outside of elderly's household (hours of aid per week)
3. Friends or neighbors (hours of aid per week)

Formal services

Personal care and aid in home management

4. Personal care aide (hours of aid per week)
5. Homemaker services – home help (hours of aid per week)
6. Home-delivered meals (units per week)
7. Meals provided at club or center (units per week)
8. Mobile laundry services (number of times laundry collected and delivered per week)
9. Laundry services at club or center (number of times laundry collected and delivered per week)

Medical and para-medical services in the home

10. Physician home visits (number per week/month)
11. Nurse home visits (number per week/month)
12. Nursing supervision at night (hours per week/month)
13. Physiotherapy (hours per week/month)
14. Occupational therapy and speech therapy (hours per week/month)
15. Medical equipment for aid with mobility – tripod, wheelchair, etc. (units)
16. Other medical equipment – oxygen, zonda, dialysis equipment (units)

Housing services

17. Basic household equipment
18. Home adaptations – widening doorways, building ramps, etc.
19. Home repairs – painting, plumbing repairs, problems of dampness, burglary protection, grids on windows, locks, etc.
20. New housing

Social and other services

21. Friendly visiting/social home visits (hours per week)
22. Social club (visits per week)
23. Club for the mentally frail (visits and hours per week)
24. Club for the blind
25. Transportation to medical treatment or to a club or center (number of times per week)
26. Mobile library
27. Casework treatment (number of meetings per week)
28. Emergency beeper
29. Appointment of a legal guardian
30. Respite care (days)

Limitation of Service Provision under the Restricted Care Plans

A. Personal care:

- Frail clients: up to 6 hours per week

  Mentally frail and nursing clients: up to 18 hours per week, for up to three hours each time (for exceptional cases – up to four hours each time)

- Minimum duration of each visit: One hour
- Service not provided on Saturday
- Service not provided more than once a day

B. Homemaking services: Up to four hours per week for all groups

C. Home-delivered meals: Up to seven meals per week for all groups

Services Unavailable under the Restricted Care Plans

1. Mobile laundry
2. Nursing supervision at night (hour per week/month
3. New housing
4. Club for the mentally frail (hours)
5. Mobile library
6. Emergency beeper
7. Respite care (days)

Appendix D: Comparison of the Average Cost per Client of Community Care without Day Care, Community Care with Day Care, and Institutional Care, under Ideal and Restricted Care Plan Conditions

	Adequate Community Care Unlikely*		Adequate Community Care Likely But Undesirable*		Adequate Community Care Likely and Desirable*	
	Frail	Mentally Frail	Frail	Mentally Frail	Frail	Mentally Frail
Ideal care plans						
No. of elderly for whom day care recommended	2	1	12	4	147	19
Cost of care plans which include day care ($ per month)	390	1098	292	519	348	684
Cost of care plans without day care ($ per month)	–	–	382	473	361	691
Cost of institutional care ($ per month)	397	724	397	724	397	724
Restricted care plans						
No. of elderly for whom day care recommended	5	6	11	–	130	10
Cost of care plans which include day care ($ per month)	194	413	216	–	222	302
Cost of care plans without day care ($ per month)	–	–	203	–	211	212
Cost of institutional care ($ per month)	397	724	397	724	397	724

* The community care assessed as likely to be adequate and/or desirable includes only home-delivered services.

דפי דיון דפי דיון דפי דיון דפי דיון דפי דיון דפי דיון

מניעת מיסודם של קשישים מוגבלים
על-ידי הספקת שירותי טיפול ממושך במסגרת הקהילה

דניז נאון חיים פקטור ג'ני ברודסקי טלל דולב מרים כהן

המחקר הוזמן ומומן על-ידי אשל, האגודה לתכנון ולפיתוח שירותים למען הזקן בישראל.

ג'וינט ישראל
מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה

גבעת-ג'וינט ת.ד. 13087
ירושלים 91130

ד-92-185

תאריך	תאריך	תאריך

20280

סימן הפירסום

BR-D-185-92 c.2

Naon, Denise

שם המחבר

THE PREVENTION OF INSTITUTIONAL

שם הספר

PLACEMENT OF DISABLED ELDERLY...

שם השואל	תאריך	חתימה
קלי אבמן וג'ק	7.06.93	

מניעת מיסודם של קשישים מוגבלים
על־ידי הספקת שירותי טיפול ממושך במסגרת הקהילה

דניז נאון חיים פקטור ג'ני ברודסקי טלל דולב מרים כהן

המחקר הוזמן ומומן על־ידי אשל, האגודה לתכנון ולפיתוח שירותים למען הזקן בישראל.

אלול תשנ"ב ירושלים ספטמבר 1992

ג'וינט – מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה
ת.ד. 13087
ירושלים 91130, ישראל
טל. 618251 (02)
פקס 635851 (02)

תקציר

דו"ח זה מתאר מחקר מעמיק שכלל 600 קשישים הנמצאים ברשימות המתנה למיסוד בשלוש ערים גדולות בישראל (ירושלים, תל אביב ובאר שבע) ומדגם מייצג של 600 קשישים נוספים שנדגמו מתוך אוכלוסייה של 2,400 קשישים שקיבלו שירותי טיפול ביתי מהמגזר הציבורי באותן שלוש ערים. המחקר בדק את האפשרות למנוע מיסודם של קשישים מוגבלים באמצעות הספקת שירותים במסגרת הקהילה.

הנתונים על קשישים אלה התקבלו מהקשישים עצמם, מבן משפחתם או מאדם אחר המספק את מרב העזרה על בסיס יומיומי, ומהעובדת הסוציאלית או האחות שמנהלות את הטיפול בקשיש מטעם הגורם הציבורי האחראי למיסוד או לשירותי טיפול בית. המידע שנאסף הוצג בפני צוותים רב־מקצועיים של מומחים שהעריכו האם קשישים אלה יוכלו להישאר בקהילה, ואם כן, אלו שירותים קהילתיים יידרשו כדי לתת להם טיפול חולם ובאיזה היקף. הקשישים, המשפחות והמטפלים התבקשו אף הם לבצע הערכות אלה ונערכה השוואה בין תשובותיהן של כל הקבוצות.

על־פי המומחים, שיעור ניכר מהקשישים הממתינים למיסוד יוכלו להישאר במסגרת הקהילה אם יקבלו את כל השירותים הדרושים להם: 94% מהקשישים שהוגדרו עצמאיים, 82% מהתשושים, 72% מתשושי הנפש, ו־67% מאלה הזקוקים לטיפול סיעודי.

המומחים המליצו על מתן טיפול אישי ל־37% מהקשישים העצמאיים, ל־77% מהתשושים ול־92% מתשושי הנפש והסיעודיים, ושירותי עזרה ביתית ל־75% בקירוב מהקשישים בכל הקבוצות התפקודיות שהמתינו למיסוד. המומחים המליצו גם על מגוון רחב של שירותים נוספים המסופקים לבית. בסך־הכל, כדי לתת טיפול הולם על־פי תכנית הטיפול האידיאלית, תידרש הרחבתם של שירותים קהילתיים קיימים ב־403% לעצמאיים, 532% לתשושים ו־396% לתשושי הנפש ולסיעודיים. מצאנו שהעלות של הספקת טיפול הולם באמצעות שירותים קהילתיים נמוכה יותר מעלות המיסוד לכ־82% מהקשישים העצמאיים, ל־67% מהתשושים ול־63% מתשושי הנפש והסיעודיים שהוערכו כמסוגלים להישאר בקהילה. עם זאת, גם אם יורחבו השירותים הקהילתיים אין הדבר מבטיח את הקטנת ההוצאות הציבוריות, שכן גם קשישים שממילא לא היו פונים למיסוד ייהנו, קרוב לוודאי, משירותים אלה.

המומחים התבקשו גם לבנות תכניות טיפול המותאמות לתנאי הזכאות שהיו נהוגים במגזר הציבורי. ניתן היה להמליץ רק על שירותים קיימים, בהיקף הדומה להיקף המותנה בתקנות הקיימות, ובדרגת גמישות דומה. אפילו בתכניות טיפול שכללו מגבלות אלה, הוערך ש־87% מהעצמאים, 69% מהתשושים, 50% מתשושי הנפש ו־37% מהסיעודים יוכלו להישאר בקהילה. אולם, השירותים עליהם המליצו המומחים עולים בהרבה על אלה המסופקים הלכה למעשה.

הרחבה משמעותית בשירותים תידרש גם כדי להבטיח טיפול הולם למקבלי השירותים אשר לא פנו למיסוד, למרות שהפער בין השירותים הניתנים כיום, לבין אלה המומלצים, לא היה כה גדול לגבי קבוצה זו לעומת אוכלוסיית הממתינים. המומחים המליצו גם שהמשפחות יטלו אחריות על חלק ניכר מהעזרה הדרושה, במיוחד כאשר הם גרים במשק־הבית בו מתגורר הקשיש.

לפי תכנית הטיפול האידיאלית הומלץ טיפול יום ל־25% מהתשושים, ל־15% מתשושי הנפש ול־16% מהסיעודים הממתינים למיסוד. דיור מוגן הומלץ, לפי תכנית הטיפול האידיאלית, ל־43% מהעצמאים הממתינים למיסוד. אולם, שירותים אלה ימנעו את מיסודם של מעטים מאוד מאלה שהוערכו כבלתי

מסוגלים להישאר בקהילה, אפילו אם יקבלו את מרב השירותים המסופקים לבית. עם זאת, השפעתן של שתי המסגרות – דיור מוגן וטיפול בית – על מניעת מיסוד גדולה יותר כאשר לא ניתן לספק את כל השירותים הדרושים בבית, או כאשר השירותים אינם מסופקים בהיקף הרצוי.

אין להניח שהספקת שירותים קהילתיים אמנם תמנע מיסוד בהיקף שדווח כאן, שכן קשישים הסובלים מהבעיות החמורות ביותר מגיעים בדרך כלל מהר יותר למוסדות, וקרוב לוודאי שלא היו מיוצגים כהלכה ברשימות ההמתנה. בנוסף לכך, הנתונים שלנו מבוססים על הערכות היפותטיות. העובדה שהם נאספו מכל מקורות המידע הרלוונטיים, שאיששו הדדית אלה את אלה, מחזקת את תקפות ההערכות. אולם, כדי שאפשר יהיה להגיע למסקנות סופיות באשר לישימותו של טיפול קהילתי כחלופה למיסוד בישראל, עדיין יש לחכות לעדויות מן השטח.

תודות

חובה נעימה היא להודות לכל האנשים והארגונים שאיפשרו את ביצוע המחקר.

אנו מודים לחברי ועדת ההיגוי של המחקר: אורי לאור (יו"ר), מרים בר־גיורא, חמדה כהן, יונתן למברגר, דוד מור ז"ל, מרים שטרקשל ופרופ' יצחק מרגולץ ז"ל – שעקבו אחר המחקר במשך כל שלביו השונים ותרמו תרומה גדולה להצלחתו. תודות מיוחדות מגיעות לחמדה כהן ולאילה שפירא על תרומתן.

לעמיתינו חוליאנה פייקס ועמיר שמואלי, שהשתתפו בשלבים שונים של המחקר אנו חבים תודה מיוחדת.

שלב זה של המחקר לא היה מתאפשר ללא שיתוף הפעולה, הזמן הרב והמאמץ שהוקדשו על־ידי קבוצה של עובדות סוציאליות ואחיות – יהודית הורוביץ, ציפורה נאה, אסתר עודד, שושנה עוזר, שרה עזריאלי, אסתר פלבן, בירוטה שטרן – אשר בנוסף לביצוע הערכות ותכנון טיפול במסגרת המחקר סייעו גם בשיחות ובעצות, הן בשלב התכנון והן בשלב ניתוח הנתונים ופירושם. על כך אנו חייבים להן תודה מיוחדת.

אנו מודים לאביגיל דובני על עבודתה בריכוז עבודת השדה, לאורנה ליסאי אשר עזרה בעבודת איסוף הנתונים ועיבודם, ולמלכה יוסוט ואילנה קורצוייל שסייעו בעבודת התכנות. לבלהה אלון שהדפיסה את הדו"ח ולטרי בנינגה שעזרה בעריכתו.

מחקר זה נתאפשר בזכותם של העובדים במחלקות לשירותים חברתיים בעיריות, בלשכות הבריאות וביחידות להמשך טיפול של קופת־החולים הכללית בירושלים, בתל אביב ובבאר שבע, להם אנו חבים תודה מיוחדת.

המחקר הוזמן ומומן על־ידי אשל – האגודה לתכנון ולפיתוח שירותים למען הזקן בישראל.

תוכן העניינים

רשימת לוחות