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NURSING HOMES IN ISRAEL

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Introduction

There were approximately 13,500 patients in nursing homes in Israel at the beginning of 1999. Of these, approximately 9,000 patients receive government subsidization while the remaining 4,500 are in private nursing homes and pay the full cost of their care.¹ In 1999, the Ministry of Health budget for subsidization of geriatric hospitalization amounted to \$200 million, while direct support to the government nursing home system came to \$79 million.

The nursing home system in Israel is a government monopoly in almost every aspect of its operation: the setting of prices, licensing, number of beds, referral of patients from general hospitals, etc. Although private nursing homes do exist, they too are bound by the constraints imposed by the government monopoly.

The excess cost to the public of this monopoly is estimated in this study at \$200 million, per year. Furthermore, government policy in this sector leads to the violation of individual privacy and the rights of the family. At the same time it creates a complicated bureaucratic system for determining eligibility for financial assistance and results in waiting periods of up to two years for hospitalization.

A survey of the geriatric sector in the U.S. reveals a trend toward the reduction of government involvement and the growth of private geriatric insurance. This has developed from the realization that the government cannot efficiently supply this service.

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In the conclusion, recommendations will be made calling for an end to government involvement in this sector and the encouragement of private sector solutions. These include the privatization of government nursing homes, increased utilization of private insurance companies with specialization in the geriatric sector, encouragement of the purchase of geriatric insurance through tax incentives and finally, the restriction of the Ministry of Health's authority to regulate the medical system.

SURVEY

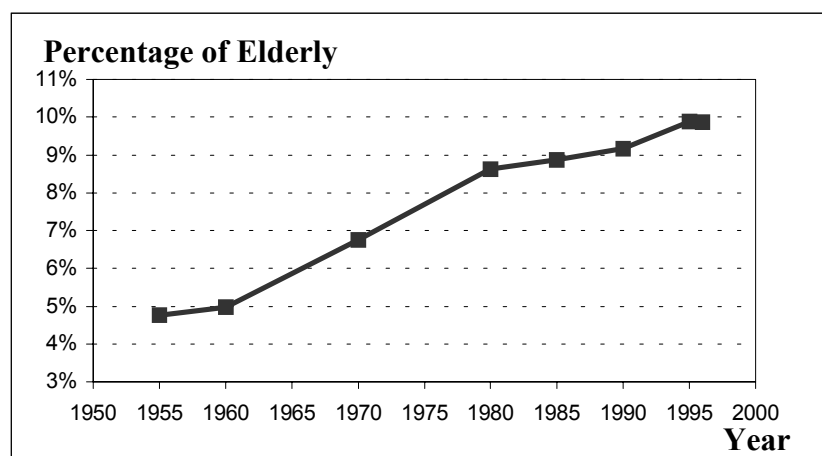
This survey is divided into four sections: the first discusses the continuous increase in the elderly population in Israel; the second outlines the structure of the geriatric sector; the third describes the government monopoly; and the fourth discusses the present system and its implications.

The Elderly in Israel

At the turn of the century, the percentage of the elderly (aged 65 and over) among the general population was a relatively high 16 percent. This was a result of the immigration of the elderly who wished to be buried in the Holy Land.²

The waves of immigration to Israel during the period prior to the establishment of the State consisted mainly of young people and as a result the percentage of the elderly among the Jewish population dropped to 3.8 percent. With the establishment of the State and the arrival of increasing numbers of elderly immigrants, this figure rose to 4.8 percent by 1955.³ This upward trend has continued up to the present day. The following graph depicts this trend for the years 1955-1996:

Figure 1
Percentage of the Elderly in the General Population, 1955-1996



Source: Based on Central Bureau of Statistics, *Statistical Abstract for Israel* 49 (Jerusalem: Central Bureau of Statistics, 1998), pp. 2-46. [Hebrew]

An additional explanation for this trend is the increase in life expectancy. Beginning in the 1970s, death rates among the elderly began to drop in most developed countries, including Israel, as a result of medical and technological advances.⁴ This decline led to a significant increase in life expectancy. Table 1 shows the trend in life expectancy which has increased by 10 years since 1948. As a result, the age of nursing home patients has also increased over the years and is now in the range of 75 and over. The proportion of elderly patients over the age of 80 has also been increasing continuously.⁵ The significance of these statistics is that the cost of elderly nursing care can be expected to increase in the future at a faster rate than the rise in their proportion of the population.

Table 1

Life Expectancy at Birth (Jews) from 1948 to 1995

Year	Life Expectancy at Birth	
	Men	Women
1948	64.9	67.6
1965	70.5	78.2
1970	69.8	73.3
1975	70.9	74.5
1980	72.5	76.2
1985	73.9	77.3
1990	75.3	78.9
1995	75.9	79.8

Source: 1965-1995: Jenny Brodesky, Yitzhak Shnorrr and Shmuel Be'er, eds., *The Elderly in Israel – Statistical Abstract 1998* (Jerusalem: Brookdale Institute and Eshel Association, July 1998), p. 63. [Hebrew] 1948: Central Bureau of Statistics, *Statistical Abstract for Israel 49* (Jerusalem: Central Bureau of Statistics, 1998), pp. 3-31. [Hebrew]

The increase in the percentage of the elderly in the population continued during the latter half of the 1990s when it reached 10 percent (approximately 500,000 people). Immigration from the former Soviet Union and Ethiopia, which was characterized by a relatively high percentage of the elderly, further contributed to this trend. Table 2 presents the percentage of the elderly among immigrants from the former Soviet Union.

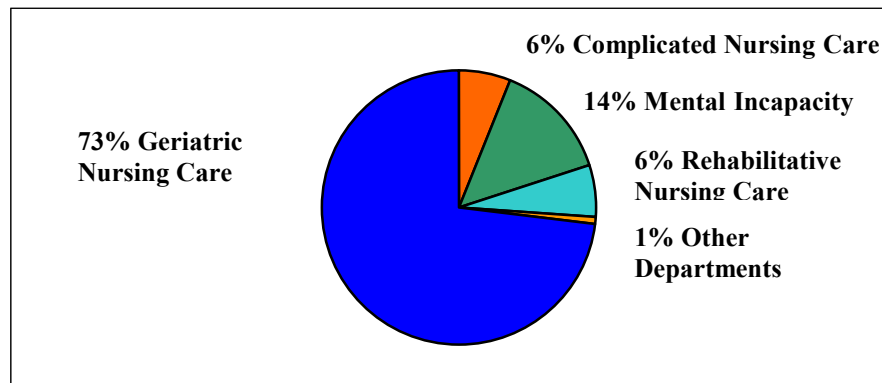
Table 2
Cumulative Percentage of the Elderly Among Russian Immigrants Arriving During the 1990s

Year	1990	1995	1996
Total immigrants (thousands)	184.3	549.8	594.5
Immigrants over the age of 65 (thousands)	22.6	88.1	96.3
Percentage of elderly (65+) among total immigrants	12.3%	16.0%	16.2%

Source: Jenny Brodesky, Yitzhak Shnorrr and Shmuel Be'er, eds., *The Elderly in Israel – Statistical Abstract 1998* (Jerusalem: Brookdale Institute and Eshel Association, July 1998), p. 17. [Hebrew]

Geriatric diseases are a direct result of aging. In Israel, approximately three quarters of geriatric hospitalizations are attributed to the need for medical and nursing care while only one quarter are a result of geriatric diseases. Elderly individuals requiring long-term medical attention are the responsibility of the Ministry of Health and can be divided into five categories according to their medical situation. Figure 2 shows the distribution of beds according to type of care:

Figure 2
Distribution of Long Term Patients in Nursing Homes, 1997



Source: Ministry of Health, *Hospitals and Outpatient Clinics in Israel, part 1: Trends in Hospitalization* (Jerusalem: Ministry of Health, Information and Computer Services, 1998), p. 93. [Hebrew]

Structure of the Sector

The nursing home system is a good example of a sector that was once in private hands but gradually came under government control. Today, the government controls licensing, pricing of hospitalization, referral of patients to the various nursing homes and determination of eligibility for hospitalization.

At the end of the nineteenth century, private institutions were established for elderly patients requiring constant medical supervision. These institutions were funded by charitable contributions from overseas and were managed by the Jewish community. Elderly patients unable to pay for hospitalization received financial assistance through private contributions.⁶

Financial support from Jews in the Diaspora continued even after the establishment of the State principally through the Joint Distribution Committee and the Jewish Agency, both of which served as liaisons between the Diaspora and Israel.⁷ In 1949, for example, contributions from abroad were used to establish the "Organization of Institutions for the Care of Needy Immigrants," whose function was to establish services for the elderly, including nursing homes.

In 1940, the British passed the Public Health Act, which constituted the first step in the monopolization of all medical institutions, including nursing homes. This Act, which was amended several times over the years, regulated the licensing of entrepreneurs wishing to open nursing homes, established criteria for nursing homes such as the number of beds and rooms and determined the number of beds per thousand residents in each region of the country. This legislation was in keeping with the well-known paternalistic approach of the British authorities. It was also subsequently adopted by Jewish authorities. These authorities believed in controlling as many aspects of life in the State as possible, including geriatric hospitalization.

The concentration of the geriatric sector in government hands gained momentum in the wake of discussions held between the Joint Distribution Committee and the government during the years 1972-1975. At the conclusion of these discussions, the responsibility for many of the nursing homes, which had been built using private contributions, was transferred to the Ministry of Health. This transfer was in line with the prevailing attitude that while the Joint Distribution Committee had assisted the government during a period of emergency prior to the establishment of the State, it should now transfer assets to the government. The nationalization of nursing homes constituted a significant step in the development of the government monopoly in this sector.

Government control of the geriatric sector reached its peak with the "National Health Insurance Act" of 1994. Officially, this law included geriatric hospitalization in the basket of health services which the government was obligated to supply to all citizens. In other words, geriatric hospitalization was to be made available to the elderly in the same manner as regular hospitalization. In fact, this section of the law was not put into practice due to a shortage of funds. The status quo was thus maintained and elderly individuals were still forced to undergo a long and exhausting process before being accepted into nursing homes. This is characteristic of much of the populist legislation which was passed without taking into consideration the financial implications or the government's ability to put these laws into effect.⁸

In September 1997, the Netanyahu government finally acknowledged the inefficiency of government nursing homes and requested that the Minister of Health nominate a committee to draw up a plan for privatization. Although it was intended that privatization begin in 1998, it had not yet been implemented at the time this paper was written.⁹ In December 1999, the Ministry of Health announced that it intended to change the fee structure and method of payment, purportedly to improve the quality of service in nursing homes.¹⁰

The Structure of the Nursing Home System

There are three categories of nursing homes in Israel whose patients fall under the jurisdiction of the Ministry of Health. In these three sectors, the level of care is considered to be satisfactory and meets the criteria of the Ministry:

1. Government nursing homes, which are owned by the government and are budgeted directly by the Ministry of Health.
2. Public nursing homes, which are non-profit organizations owned by various institutions such as the Maccabi Sick Fund, the United Sick Fund, municipalities, etc. Most of their patients are referred to them by the Ministry of Health.
3. Private nursing homes, whose patients are for the most part referred to them by the Ministry of Health under various arrangements to be discussed below.

Table 3 shows the distribution of beds among the various types of nursing homes:

Table 3

**Distribution of Beds in Nursing Homes
According to Type of Nursing Home in 1996**

Category of Nursing Home	Number of Beds	Percentage of Total	Occupancy Rate
Government	1,228	10.3	102%
Public	5,436	45.7	92.11%
Private	5,236	44.0	91.8%
Total	11,900	100	-

Source: Calculations of the author using data published in *The Elderly in Israel – Statistical Abstract 1998*, edited by Jenny Brodeski, Yitzhak Shnorrr, Shmuel Be'er, Jerusalem, July 1998, p. 198. [Hebrew]; Occupancy rate in 1997: Ministry of Health, *Hospitals and Outpatient Clinics in Israel, part 1: Trends in Hospitalization* (Jerusalem: Ministry of Health, Information and Computer Services, 1998) p. 402. [Hebrew]

The table shows that 90 percent of all beds are divided equally between public and private nursing homes while only 10 percent are in government nursing homes. It is important not to be misled by these statistics since the government controls the public and private nursing homes as well. The government determines prices, the criteria for hospitalization and the transfer

of funding and refers patients to the various nursing homes. The occupancy rates are almost identical in all three sectors, since in addition to those patients referred to the private nursing homes by the Ministry of Health, additional patients are admitted independently. This will be discussed in detail below.

The Fourth Category: “The Black Market”

Beyond the three categories discussed above, “black market” private nursing homes also exist. The prices in these nursing homes are 50 percent lower than the rates set by the Ministry of Health. These nursing homes came into being as a result of the fact that the majority of the elderly cannot afford the full price of geriatric hospitalization and that some of them are unable, mentally or physically, to go through the long bureaucratic process required to receive Ministry of Health subsidies. According to estimates of the State Comptroller, there were some 2,000 elderly patients in “black market” nursing homes in 1998.¹¹ In other words, approximately one out of every seven nursing home patients is “illegally” housed and cared for.

Officially, these nursing homes operate illegally since they do not have a license from the Ministry of Health. However, the Ministry of Health informally inspects these nursing homes in order to ensure a basic level of hygiene and care for the patients. The Ministry of Health has not closed down these nursing homes because it cannot at present answer the medical needs of every elderly person requiring hospitalization.

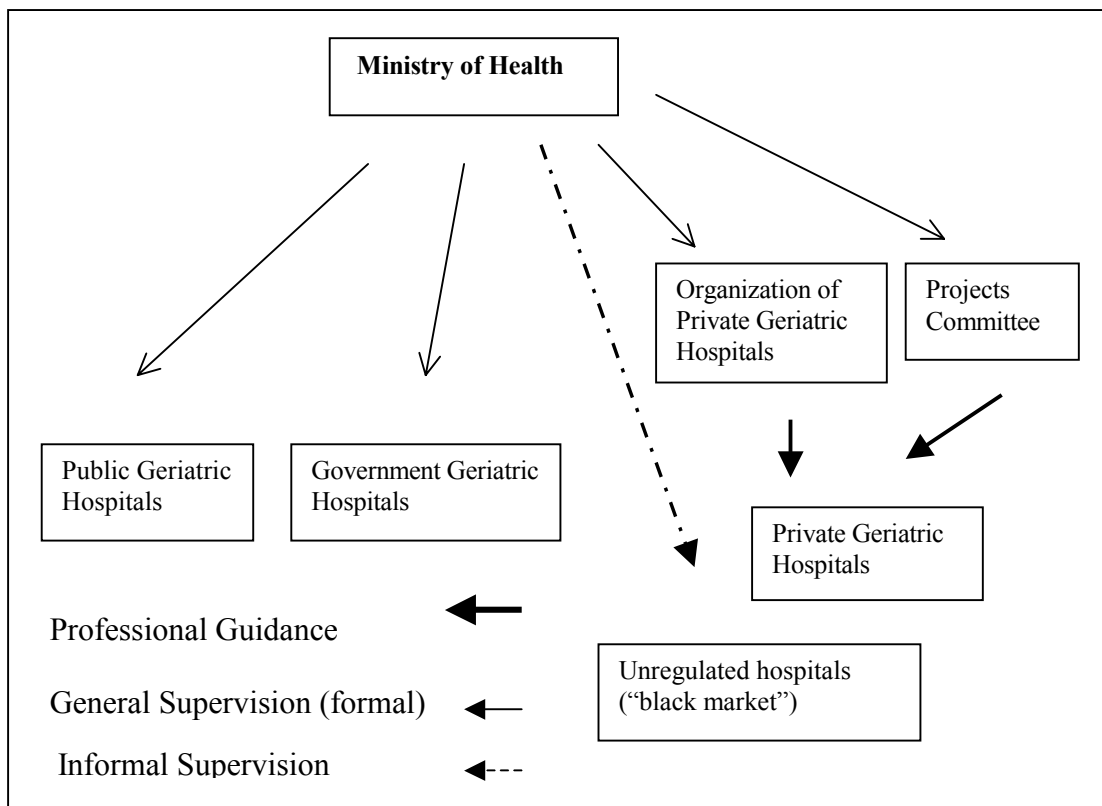
In 1992, the Organization of Private Nursing Homes for the Chronically Ill in Israel, representing private nursing homes, presented a report to Ora Namir, then the chairman of the Knesset Committee for Labor and Welfare. The report warned of the “black market” phenomenon and listed 43 private nursing homes that were operating without licenses.¹² No action has so far been taken as a result of this report and the “black market” nursing homes are still in operation.

Government Control and the Bureaucratic Structure of the Sector

The sector’s bureaucratic structure involves a number of government bodies. This section will survey government regulation of the sector and its bureaucratic structure.

Figure 3 illustrates the regulatory structure of the nursing home sector. The figure shows that the central institution in this sector is the Ministry of Health, which directly regulates all nursing homes in Israel including those in the private sector in accordance with the Public Health Act of 1940. The Ministry of Health’s authority includes the granting of licenses, the setting of prices for hospitalization, sanitary and medical inspection, regulation of personnel, regulation of the internal division of nursing homes, etc. As already stated, the Ministry of Health also regulates “black market” nursing homes, although this is confined to sanitary and medical inspection.

Figure 3
Regulation and Decision Making in the Geriatric Sector in Israel



Source: Based on Shraga Haber, senior advisor at the Ministry of Health and chairman of the Inter-Institutional Committee, interview with the author, January 2, 1999; Uzi Keren, chairman of the Projects Committee, interview with the author, February 25, 1999; and Yakov Nevo, senior advisor at the Ministry of Health specializing in the geriatric budget, interview with the author, August 26, 1999.

As illustrated in Figure 3, private nursing homes are regulated by both the Ministry of Health and the Organization of Private Nursing Homes, which was established in 1971. This voluntary organization works to improve service and care in private institutions and offers professional assistance and advice.¹³

Private nursing homes have recently been complaining that they are subject to much stricter regulation than government nursing homes. For example, on November 20, 1997, inspectors from the Ministry of Health found that occupancy in the private nursing homes exceeded the legal limit (each nursing home is permitted to exceed the limit by up to 5 percent). In response, Natan Oren, the chairman of the Organization of Private Nursing Homes, prepared a report in March 1998, which detailed the same violations of occupancy limits among public nursing homes. According to Natan Oren, Professor Mark Klarfield, the director of the Geriatric Branch of the Ministry of Health, responded to the report by simply saying that all nursing

homes receive the same treatment from the Ministry and that there is no discrimination between the different types of nursing homes.¹⁴

An additional body regulating nursing homes is the Projects Committee. This committee, which is part of the Ministry of Health, discusses applications from private entrepreneurs wishing to open or expand nursing homes. An entrepreneur wishing to open a nursing home must go through a bureaucratic process which includes the filling out of forms specifying the structure of the nursing home, its internal division, location, and a variety of other details. These forms must be approved by several bodies: the District Health Office, the District Engineer and the Projects Committee. Once approved by the Committee, the applicant receives a permit which obligates him to begin construction within 18 months. The length of the process varies – entrepreneurs who manage to meet the stringent regulations of the Ministry of Health can obtain a permit within a few months; those who do not are required to present a new plan which meets the requirements of the Ministry. In fact, only about half of the applicants ever receive a permit.¹⁵

Financial Analysis of the Sector

The budget of the Ministry of Health totaled \$3.4 billion in 1999. Of this amount, \$288 million is allocated to “chronic illness,” which includes \$200 million for the subsidization of nursing homes and \$79 million for the direct support of government nursing homes and administration costs.

Approximately 13,500 elderly patients are hospitalized in nursing homes around the country, of which 9,000 are subsidized by the government.¹⁶ The remaining 4,500 patients are in private nursing homes and finance the full cost of hospitalization, which is presently about \$1,750 per month. These figures do not include elderly patients in “black market” nursing homes.

As part of government policy, the Ministry of Health subsidizes the elderly requiring geriatric hospitalization. This subsidization is called the hospitalization “code” and is essentially a form granting eligibility for government assistance.

In order to receive the “code,” the candidate must go through several examinations to determine his state of health, financial situation, social status, and other personal details. Government support generally covers most of the hospitalization expenses while the rest is paid by the elderly patient and his family.

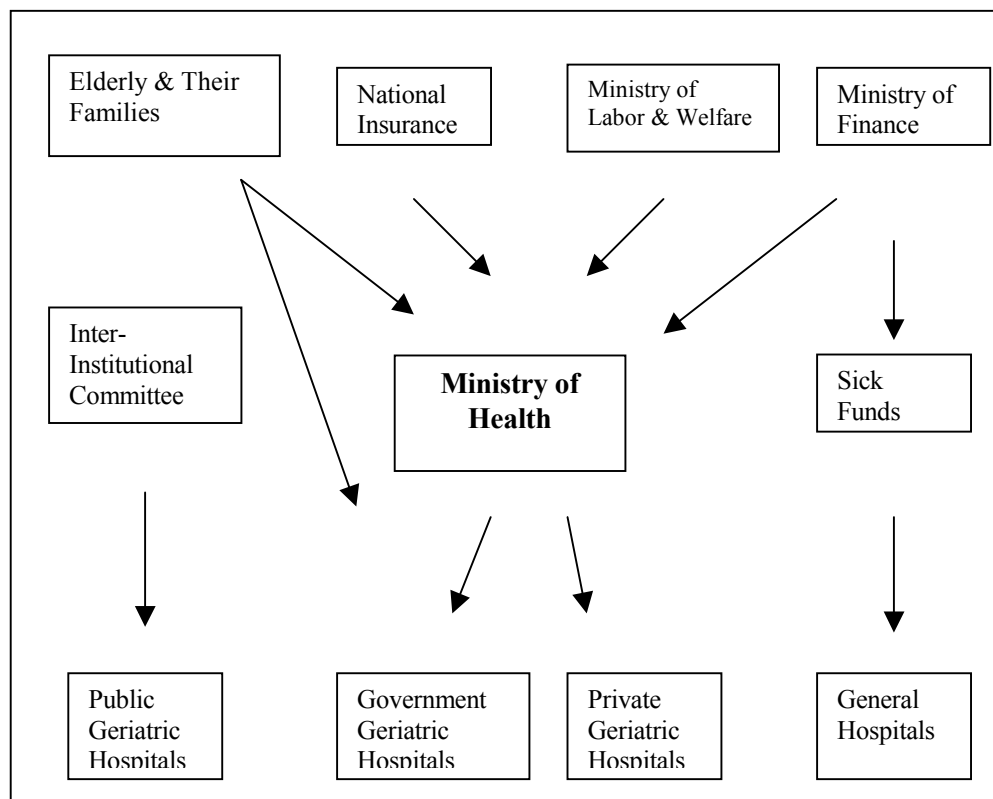
The Ministry of Health’s rate of subsidy for a day’s hospitalization in government nursing homes is \$103, for public (non-profit) nursing homes it is \$84; and for private nursing homes it is \$42. The differences in the price of hospitalization are primarily a result of the unnecessary manpower in government nursing homes.¹⁷ Paradoxically, the Ministry of Health prefers to refer patients first to government nursing homes, followed by public nursing homes and finally private nursing homes.¹⁸ In response to parliamentary inquiries submitted in March and April, 1997, by MKs Haim Dayan and Amnon Rubinstein, regarding the price differences and the excess use of public funds, then Deputy Minister of Health Shlomo Benizri explained

that the Ministry “seeks a balance between the public and private sectors.”¹⁹ The different rates and their financial implications will be discussed in more detail below.

Primary responsibility for the care and subsidization of elderly patients requiring long term institutional care is shared by the Ministry of Health and the Ministry of Labor and Welfare, according to the patient’s state of health. This historical division of responsibility lacks both medical and financial sense. Attempts have been made to consolidate elderly care under one ministry but with no success. The changes were opposed by politicians not wishing to concede any of their authority. For example, on November 27, 1990, the government decided to consolidate the responsibility for the elderly in the Ministry of Health, only to cancel that decision three months later.²⁰ The reason for the cancellation: opposition came from senior bureaucrats in the Ministry of Labor and Welfare who did not wish to reduce the number of workers under their authority.²¹

The division of authority between the various ministries is not always clear to the elderly patient and his family who are faced with a complex bureaucratic system.

Figure 4
Transfer of Funds in the Geriatric Sector



Source: Based on Shraga Haber, senior advisor at the Ministry of Health and chairman of the Inter-Institutional Committee, interview with the author, January 2, 1999; Uzi Keren, chairman of the Projects Committee, interview with the author, February 25, 1999; and Yakov Nevo, senior advisor at the Ministry of Health specializing in the geriatric budget, interview with the author, August 26, 1999.

Figure 4 shows that the Ministry of Health receives funds for geriatric hospitalization from four sources:

1. The Finance Ministry – from the annual budget in the amount of \$287 million per year.
2. Ministry of Labor – purchase of hospitalization services for elderly patients defined as “frail” and “independent” in the amount of \$11 million per year.
3. National Insurance Institute – transfers \$11 million per year.
4. The elderly patients and their families pay their portion of hospitalization costs in the amount of \$53.5 million per year.

The Ministry of Health transfers funds to the government, public and private nursing homes according to the number of patients eligible for subsidization (those with a “code”) in each category. A separate branch of the Ministry of Health, the “Inter-Institutional Committee,” finances 50 percent of the cost of building public nursing homes using charitable contributions. In addition, the Ministry of Labor compensates the Sick Funds for the hospitalization of elderly patients in the general hospitals. This point will be discussed below in more detail.

The Ordeal of Hospitalization

In order to understand government policy and its implications, the case of the average elderly individual requiring long-term care will be examined through the following generic scenario. The elderly individual’s state of health is not critical, but he does require daily medical attention. Throughout his life, he has paid some of the world’s highest rates of direct and indirect taxation as well as national insurance payments and Sick Fund premiums. It is important to note that these payments are not segregated – that is, no part of these funds are deposited in a special fund which is earmarked for nursing home care. Most taxpayers are unaware of the fact that the taxes they have paid over their lifetime do not ensure them nursing home care in their old age.

Under the present system, the elderly individual described above, and his family, will have to pay for geriatric hospitalization according to their present financial situation without any consideration given either to the contributions he and his family have made through taxation during his lifetime or to the actual price of hospitalization. The Ministry of Health, through the Geriatric Branch, pays the difference between ability to pay and the cost of hospitalization.

The candidate for hospitalization begins the ordeal with his application for a hospitalization “code” from the Ministry of Health. In order to assign a “code,” the Ministry checks the financial status of the candidate and his family. These inquiries often violate the individual’s right to privacy. The candidate must present documents on his financial situation, savings, residence and ownership of residential units, etc. If he has savings, he must use them to finance his hospitalization. If, for example, the candidate owns an apartment, he must rent it out and transfer the funds to the Ministry of Health. Furthermore, the candidate must transfer between 65-80 percent of his National Insurance pension to the Ministry. Again, it is important to emphasize that the individual’s and his family’s past contributions through taxation play no part in determining their collective present-day obligations.

According to the Amendment to the Family Act (Support) 1959, if the family refuses to pay for hospitalization, legal action can be initiated against them by the Legal Counselor of the District Health office. The Legal Counselor has the option of transferring the case to the District Attorney's office for prosecution.²²

The foregoing is not meant as a criticism of a system that requires patients to participate in the financing of hospitalization. It should be understood, however, the process violates the privacy of the patient and his family. The government collects taxes from individuals throughout their lifetime, but the return on these payments comes only after an oftentimes excruciatingly extended time period and oftentimes does not reflect the fact that the individual might have been a hard-working taxpayer all of his life. Then, at the time when he wishes to benefit from his taxes, the state calculates his contribution in the same manner as someone who never paid taxes.

In addition, the waiting period for a "code" can be up to two years from the time of application and many patients pass away before the end of the process. The Ministry of Health does not presently have any information on elderly candidates who have died while waiting for a "code."²³ The State Comptroller wrote the following regarding this phenomenon:

The Ministry of Health has no up-to-date information on candidates waiting for geriatric hospitalization. They do not know how many of those waiting have passed away, how many have been privately hospitalized and under what conditions the candidates are living under during their wait.²⁴

During a discussion in the Knesset on June 5, 1990, Member of Knesset Nava Arad (Labor) estimated that 25 percent of candidates for geriatric hospitalization die during the waiting period.²⁵ Even if this is an overestimate, it is clear that a significant percentage of elderly candidates do not survive the prolonged waiting period for a "code." The State Comptroller commented as follows in the 1998 Report:

In December 1997, there were 2,772 elderly candidates waiting for geriatric hospitalization, half of whom had completed the bureaucratic process preceding hospitalization. The waiting period for long-term hospitalization is a long one and many candidates endure great suffering and deprivation during this period.²⁶

In many cases, the elderly individual's medical situation worsens during this waiting period and he may require immediate hospitalization. In this case, the individual enters a general hospital and is typically placed in an internal medicine ward. The result is that these departments are over-utilized (especially during unusually hot or cold periods of the year) and many patients, not necessarily elderly ones, are forced to sleep in the hallways or dining rooms under less than sanitary conditions. Furthermore, as will be shown below, the cost of hospitalization of a geriatric patient in an internal medicine ward costs 7.5 times the cost of hospitalization in a private nursing home.

As early as the 1950s, Member of Knesset Ben Zion Harel (General Zionists) warned of this phenomenon in a speech to the Knesset, in which he declared:

...This geriatric patient often occupies a very expensive bed in a general hospital. In my opinion, this problem could be solved by transferring these chronic patients to special nursing homes where costs are much lower.²⁷

If the candidate decides that he is not willing to wait the long period required to receive a “code,” he has several options: (1) to live at home with medical supervision (i.e., private nurse) or without; (2) to enter a nursing home privately and to pay the full cost of hospitalization (minimum \$1,750 per month); or, (3) to enter one of the unregulated “black market” nursing homes at a cost of \$875 per month.

If the candidate is fortunate enough to survive the waiting period, he will receive the long-awaited for “code” within a year to a year and a half. At that point, he can in theory choose either a public or private nursing home, but the Ministry of Health gives preference to government nursing homes. There is no such formal policy, but the patient is given the impression that conditions are better at government nursing homes.²⁸

Figure 4 (on p. 10) supplies the explanation for this policy: the Ministry of Health directly budgets the government nursing homes. The funding of these nursing homes is not dependent on the number of patients; in other words, their budget is the same whether their occupancy rate is 80 or 100 percent. Therefore, the Ministry of Health prefers to fill these beds first and only then to refer patients to private nursing homes.²⁹

ANALYSIS

This section analyzes the harm caused by government policy in the geriatric sector. It is both direct and indirect and affects both the elderly patients and the taxpayers whose money is being used irresponsibly.

Cost to the Economy

The inefficient management of the nursing home system in Israel results in a significant waste of resources. In order to quantify this cost, this study will use an economic model which assumes that the prices in an efficient nursing home system would be equal to those presently charged in private nursing homes. In other words, according to economic theory, geriatric hospital care should optimally be supplied by private nursing homes.

One reservation should be mentioned here: in Israel, the cost of a day’s hospitalization in all sectors, including the private sector, is set by the government. In other words, this analysis is comparing different levels of prices which are all determined by the government. This is not an optimal comparison between government prices and those in the free market. Nonetheless, the analysis shows the excess cost to the public in the administration of nursing homes in Israel insofar as the private nursing homes manage to show a profit of between 5 and 10 percent on a per diem rate of \$42.³⁰

Further, the private sector nursing home owners maintain steadfastly that they could absorb the elderly presently waiting for admittance and, over the long term, absorb all the elderly requiring

hospitalization. Natan Oren, the chairman of the Organization of Chronic Care Nursing homes in Israel, claimed in an interview in *Ha'aretz* newspaper in May 1998 that the private sector has the potential to absorb all elderly individuals requiring hospitalization.³¹ In a newspaper advertisement directed at the Minister of Health, Yehoshua Matza and the Minister of Finance, Dan Meridor, it was stated that 400 beds in the private sector are presently unoccupied and ready to immediately accept patients.³² The entrepreneurs maintain that they are willing to invest in additional beds in order to accommodate the rest of the elderly patients.³³ Indeed, given their profitability to date, notwithstanding competition from the state-sponsored nursing homes, their claims are supported by economic theory.

The next stage of this study's analysis will involve the calculation of the excess costs borne by the health system beyond the cost of hospitalization in the private sector. These amounts constitute the financial cost to the economy of the government's involvement in the geriatric sector.

1. *Cost differences between the various sectors.* The Ministry of Health purchases hospital services from every type of nursing home: government, public and private. Each category of nursing home can be compared to a vendor supplying an identical service at different prices. The highest price is charged by the government nursing homes (\$103 per day), followed by the public nursing homes (\$84 per day) and finally, the private nursing homes (\$42 per day). The price charged by the private sector is set by the government which subsidizes it, yet it is still the lowest among all the different types of nursing homes. Despite having the lowest price, these private hospitals provide a level of services to the elderly which meets all the standards of the Ministry of Health. It is worth noting that there are nursing homes in Israel which provide a variety of high quality services to their patients. Their prices range up to \$120 and more per day. Our comparison is between nursing homes supplying identical services which meet the basic criteria of the Ministry of Health.

2. *Cost of hospitalization in the internal medicine ward of general hospitals.* As mentioned above, some elderly patients are unnecessarily hospitalized in the internal medicine wards of general hospitals. As a result, the health system is paying 7.5 times the cost of geriatric hospitalization for these patients. The average cost of a day of hospitalization in an internal medicine ward is \$318 per day as opposed to \$42 per day in a private nursing home.³⁴

3. *Number of subsidized beds in each sector.* According to data in the Ministry of Health's budget proposal for 1999, the number of subsidized beds in the public sector is 4,375. In the government sector, the total number of beds for chronically ill patients is 2,578,³⁵ of which 1,228 are intended for elderly patients with a "code."³⁶

According to sources within the geriatric sector, between 30 and 60 percent of elderly patients in the internal medicine wards of general hospitals could be moved to geriatric institutions.³⁷ The calculation herein will be based on the conservative estimate of 35 percent. Thus, out of a total of 2,988 elderly patients in internal medicine wards, it will be assumed that 1,046 could be in private nursing homes.³⁸

The excess costs resulting from government policy in the geriatric sector are summarized in Table 4. It shows the large gap between the high cost of hospitalization in government and public nursing homes as well as internal medicine wards, in comparison to private nursing homes. The

difference is calculated by multiplying the excess cost per bed by the number of subsidized beds in each sector:

Table 4
Excess Cost in Nursing Home System

Category	Number of Subsidized Beds	Cost of Subsidized Bed Per Day	Cost of Bed Per Day in Private Sector	Excess Cost Per Bed Per Day	Excess Cost of Subsidized Beds Per Day	Excess Costs of Subsidized Beds Per Year
	A	B	C	B-C	D=A*(B-C)	E=365*D
Public	4,375	\$84	\$42	\$42	\$183,750	\$67 million
Government	1,288	\$103	\$42	\$61	\$74,908	\$27.3 million
Internal medicine wards	1,046	\$318	\$42	\$276	\$288,696	\$105.3 million
Total excess costs in the sector					\$547,354	\$199.6 million

Source: Author's calculations using data in: Ministry of Health, *State Budget: Proposal for 1999* (Jerusalem: Ministry of Health, October 1998), pp. 12-13. [Hebrew]

The calculation shows that the annual excess expenditure of government funds in the nursing home system is approximately \$200 million. This expenditure is a result of the government monopoly and the government's effort to artificially regulate the sector. The reasons for the large price differential between the various types of nursing homes will be analyzed below.

The Complex and Inefficient Structure of the Government Nursing Home System

The main reason for the price differential in the price of hospitalization arises from the structure of the government system, which is characterized by a lack of incentive to improve efficiency. This characteristic is of course shared by other government systems, many of which have been surveyed in numerous studies published by the Institute for Advanced Strategic and Political Studies. Government nursing homes are equipped with expensive medical instruments and equipment, such as X-ray machines and laboratories, when in fact only basic equipment is required for the care of elderly patients. The patients in nursing homes, on a day-to-day basis, are in a state of health that does not require expensive medical care. In cases where patients require such care, they can be sent to a general hospital.

Furthermore, since nursing home workers are government employees, it is almost impossible to fire them or transfer them in order to cut costs and improve efficiency. As a result, unnecessary

departments exist in nursing homes, which complicate the structure of the nursing homes and increase the cost of maintenance.³⁹

1. *Inflated Public Administration.* According to the State Comptroller's 1984 Report, the Ministry of Health established requirements for the number of employees in the various types of nursing homes as follows: government nursing homes – 0.9 workers per bed (including administrative staff); public nursing homes – 0.73 per bed; and private nursing homes – 0.5 workers per bed. If one takes into consideration only the nursing staff in these nursing homes (i.e. the staff which cares directly for the patient), then the regulations call for 0.5 workers per bed in government and public nursing homes in comparison to 0.4 in private nursing homes.⁴⁰ These regulations still remain in effect today.⁴¹

These numbers demonstrate two points. One, the Ministry of Health established different manpower requirements for two identical nursing home systems. The Ministry realizes that the lower manpower requirements of private nursing homes are sufficient to provide suitable medical care. If this were not the case, presumably the Ministry would not purchase hospital services from them. Two, the government nursing homes are overstaffed, principally with administrative and general workers who increase the cost of hospitalization. The fact that not all private nursing home applicants are granted building permits and operating licenses is prima facie evidence that the Ministry of Health insists on basic standards for granting licenses to private nursing homes. Those who finally receive licenses have met the standards of the Ministry and have passed their inspections.⁴² Thus, one is hard pressed to argue that the lesser costs of operating a private nursing home are the result of lesser or substandard care.

2. *Labor costs.* The public sector in Israel is characterized by excessive labor costs. This is an additional factor contributing to the high costs of government nursing homes. While the average pre-tax wage was \$1,500 as of April 1999, the average wage in government nursing homes stood at \$2,425.

It is important to mention that the high labor costs are not a result of the number of doctors employed in government nursing homes. In fact, only 5 percent of employees in government nursing homes are doctors while some 34 percent are defined as administrative and maintenance staff.⁴³

3. *Indirect or "hidden" cost of operating government nursing homes.* The pension costs of government nursing home workers is an additional cost that does not directly affect the cost of a day's hospitalization since they are paid by the Ministry of Finance. Despite this, pension costs directly affect the burden borne by the Israeli taxpayer.

Government nursing home workers are government employees in all respects. Their pensions are funded by the government, as opposed to premiums paid by the worker, and are calculated at 2 percent per year of seniority.⁴⁴ In other words, in the present system, today's labor costs do not increase as a result of pension costs; however, the future obligations of the government are continually growing as a result of future pension payments. In contrast, private sector workers and employers must pay pension premiums on a regular basis, since their pension is basically a long-term savings plan.⁴⁵ It is difficult to estimate the cost of pensions for the employees in the

public sector since the calculations made by the Ministry of Finance are for all government employees.⁴⁶ Thus, pension costs represent an additional indirect or “hidden” cost of operating government nursing homes.

Recently, demands have been made for a reform in the public sector which would replace the present budgetary pension system with a funded pension system. No new agreement has been reached as of yet due to the opposition of government workers and Histadrut leaders.⁴⁷ Thus, the high labor costs of government nursing homes discussed above are an underestimate since they do not take into account the cost of pensions to the taxpayer.

Government Violation of Individual Privacy

The present system results in a serious violation of the privacy of the individual and the family unit. Although this occurs as a result of efforts to ascertain the patient’s ability to pay, it is nonetheless a flagrant violation of privacy, especially as it relates to one’s personal property.

The present system forces the family to support an elderly relative. This law ignores the principle that financial transactions between individuals, including those between family members, should be made out of free choice. Only in socialist dictatorships does the government prevent the development of markets on the one hand, and force people to buy a product on the other. It is reasonable to assume that in a free system, in which hospitalization was reasonably priced, people would choose to support their relatives in most cases. The problem of the present system is that people are forced to do so.

Corruption in the System

The method of operation in the geriatric sector is totally distorted and creates artificial surplus demand and unnecessarily long waiting periods. This is an ideal situation for politicians and the well-connected to arrange shortcuts for their relatives and friends requiring geriatric hospitalization. The politicization of the system has resulted in the misuse of power to such an extent that in certain cases, well-connected elderly individuals have received a “code” for hospitalization without any wait at all. The line for other less well-connected elderly individuals is of course made longer as a result.⁴⁸

Other examples of corruption at the Ministry of Health came to light during the research for this policy paper. There were several cases in which the Ministry filed complaints against private or “black market” nursing homes as a result of medical or sanitary problems. The owners of the nursing homes, who were well-connected politically, had the complaints cancelled. For example, a nursing home in Bnei Brak did not meet the standards of the Ministry of Health and as a result those patients who were subsidized by the Ministry were removed. The owner of the nursing home used his personal and political connections to have his license restored even though his nursing home had been found unsuitable for the geriatric hospitalization.⁴⁹

In summary, the government’s policy in the geriatric sector has created numerous distortions. The financial loss to the economy as a result of government involvement is estimated at \$200 million per year. In addition, the government system suffers from inflated costs, overstaffing

and unjustifiably high wages. The distortions also include corruption and violation of the basic right of privacy. The final result is that many of the elderly do not receive the care they require even though they have paid taxes, national insurance premiums and Sick Fund premiums throughout their lifetime.

INTERNATIONAL COMPARISON

This section will examine the policy toward geriatric hospitalization in the U.S. and will compare it to that in Israel.

U.S.A.

The over-65 population in the U.S. comprises approximately 12.5 percent of the general population which translates into more than 33 million individuals. Of these, over 7.3 million require some type of long-term care. The elderly are principally cared for in community “senior citizen” homes where they receive personal, medical and social services.⁵⁰ The remaining 1.6 million (i.e. 4.8 percent of the total elderly population), are hospitalized in some 17,000 nursing homes throughout the country.⁵¹

Ownership of nursing homes in the U.S. is divided as follows: 70 percent private ownership, 29 percent non-profit organizations and 1 percent government.⁵²

Financing of Hospitalization in the U.S.

The average cost of hospitalization per elderly patient is \$40,000 per year. The majority of this cost is almost evenly divided between the patients and the government. The remainder is financed by private geriatric insurance and various schemes sponsored by individual states.⁵³ In contrast, only a small percentage of hospitalization costs in Israel are covered by the patient while the government finances the lion’s share.

As a result of the high cost of hospitalization, most of the annual budget for elderly care (approximately 70 percent) is used for geriatric hospitalization, while the rest goes to community “senior citizen” homes.⁵⁴

Table 5 shows the various sources of financing for geriatric hospitalization. As already stated, the majority of costs are covered by the patients and the Federal government.⁵⁵ Note the small percentage covered by private insurance, a point which will be discussed below.

Table 5

Sources of Financing for Geriatric Hospitalization in the U.S. (1995 data)

Source of Financing	Amount of Finance (billions of dollars)
Federal financing programs	33.3
Local financing programs (in various states)	0.6
Patients	30
Private insurance	0.4
Total	64.3

Source: Richard Price, *CRS: Report for Congress: Long Term Care for the Elderly: Themes of Financing Reform* (Washington D.C.: Library of Congress, January 15, 1999), p. 2.

Geriatric Insurance in the U.S.

1. *Private Insurance.* Private insurance companies began offering geriatric insurance in the late 1970s. Most states require that insurance companies offer this type of insurance. Some employers offer this benefit as part of employee medical insurance.

Private geriatric insurance can be very expensive, especially if it is purchased late in life. The average annual premium in 1996 was: \$364 for a 50-year old, \$980 for a 65-year old and \$3,907 for a 79-year old.

These policies cover geriatric hospitalization costs of up to \$100 per day and nursing care in an old age home of up to \$50 per day. The hospitalization period covered is four years on average and the wait for hospitalization is 20 days. This is in contrast to the waiting period in Israel of up to two years.

Private geriatric insurance is quickly gaining popularity. According to the Health Insurance Association of America, five million nursing care insurance policies were sold in 1996 and during the period 1987-1996, private insurance policies increased by an average of 22 percent per year.⁵⁶

2. *Government Insurance (Federal).* There are two government hospitalization programs which finance about half of geriatric hospitalization costs. These programs finance geriatric hospitalization for individuals who do not have the means to fully pay for their care.

Medicaid: This is a government health plan meant to cover the cost of hospitalization for individuals unable to pay and individuals whose resources have been exhausted by the cost of hospitalization. Most government finance is channeled through this program.

Medicare: This is a government health plan for the elderly and the handicapped requiring acute health care.⁵⁷

The Disadvantages of Medicaid Insurance

The main problem in the geriatric sector in the U.S. is the conflict between the encouragement of private insurance and the desire to assist the elderly who cannot afford care. For those with average or less than average incomes, it is not worthwhile to purchase private geriatric insurance since they will be eligible for government assistance through Medicaid.

Furthermore, high-income individuals view private insurance as an unnecessary expense since they may not require geriatric hospitalization.⁵⁸ In addition, a certain amount of fraud also exists, whereby individuals claim they possess fewer assets than they actually do in order to receive Medicaid. As a result, legislation was passed in 1996 prohibiting the transfer of assets in order to attain eligibility for geriatric hospitalization assistance.⁵⁹ This legislation was motivated by the phenomenon of individuals transferring their assets to relatives in order to claim eligibility for government assistance.

Trends in the U.S.

The U.S. is presently witnessing a public debate on the issue of geriatric hospitalization. Until a decade ago, it was widely felt that financing should come from the government. Today, it is widely held that the private sector, by means of geriatric insurance, is more suitable for this task.⁶⁰

Those supporting government involvement point out that any individual may need geriatric hospitalization during his lifetime. Therefore, financing for all individuals should come from the government through plans such as Medicare or Medicaid. The high cost of hospitalization should be covered by tax increases. The increased tax burden should fall equally on all citizens, including those who will not require geriatric hospitalization.

The basic assumption underlying this approach is that the public sector can provide services cheaper and more efficiently. This policy paper has argued, based upon the Israeli experience, the opposite to be true. A government institution does not have the incentive for efficiency and improvement of service which exists for a private company. Furthermore, employees of government nursing homes earn much higher wages than those in private nursing homes. In the U.S., as in Israel, the basic ideology is paternalistic and holds that the citizen cannot always take care of himself in which case the government must do so. In this way, government intervention without private decision making is justified.

In contrast, those supporting private geriatric insurance claim that the goal should be the reduction of the tax burden. Geriatric hospitalization is a personal problem which should be solved within the framework of the family. It is simply another component in family financial planning, much the same as saving for higher education or retirement. Financing of hospitalization should be the function of private insurance companies. Even those in favor of expanding the role of the private sector do not suggest that Medicaid should be cancelled. In their opinion, however, this program should only be a safety net for the needy.⁶¹

The Light at the End of the Tunnel

On August 21, 1996, Congress passed legislation to encourage the private sector to finance geriatric hospitalization. Tax incentives were created to encourage employers and individuals to buy geriatric insurance. The basic idea was that geriatric insurance premiums would be deducted from salaries and be exempt from taxes.⁶²

An employer who decides to add geriatric insurance to the medical insurance of his employees can deduct the payment from the worker's pre-tax wage. Furthermore, geriatric insurance premiums are tax deductible for the employer. On the other hand, the method of tax incentives tends to increase the overall problems of the tax system by making it that much more complicated.

The U.S. is faced with several challenges as a result of its increasing elderly population. According to forecasts, the number of elderly who will require some sort of nursing care will be 10-14 million by the year 2020 and 14-24 million by the year 2060 (in comparison to 7.3 million in 1994).⁶³ A comprehensive reform will be required since tax incentives will not be a sufficient solution in view of the other problems mentioned earlier.

In both the U.S. and Israel, the government is heavily involved in the geriatric sector. However, in the U.S., as opposed to Israel, the issue is on the agenda of policymakers. Members of Congress from both parties have initiated legislative proposals, some of which conflict, in an effort to solve the problem of geriatric hospitalization. Those interested in strengthening the private sector emphasize that government finance of geriatric hospitalization paradoxically benefits the young rather than the old, since it is they who enjoy their parents' assets, which were not sold in order to finance hospitalization. Those interested in strengthening the government sector seek to widen the eligibility for Medicaid. In addition, the public is becoming increasingly conscious of the problem and is purchasing more geriatric insurance policies.

This study has shown that the nursing home system in Israel is characterized by a high level of government intervention. There is government involvement in the U.S. as well but to a much lesser extent. The popularity of geriatric insurance policies in the U.S. is growing steadily; in contrast, it is almost unknown in Israel. Furthermore, the participation of elderly patients in the cost of hospitalization is much higher in the U.S. than in Israel.

Nonetheless, it should be noted that government policy in both countries does not overly encourage self-reliance. In both countries, programs which were meant to help only the needy (Medicaid in the U.S. and the "code" in Israel) are assisting a much wider population.

RECOMMENDATIONS

This policy paper has discussed the various aspects of government involvement in the nursing home system, from the granting of eligibility to the opening of nursing homes and the determination of prices. The harm caused by this policy is significant both in a financial sense and as a result of the violation of basic individual rights. Government involvement in the geriatric sector is characteristic of its desire to control areas which should be the personal responsibility of each individual.

The reduction of government involvement in the nursing home sector is essential first and foremost in order to allow the elderly to grow old with dignity. To this end, a proposal for reform in the nursing home sector is presented below. It should be noted that this proposal primarily consists of guidelines for reform. Carrying out of the reform will require the government to deal with questions such as the following: How long will the privatization of nursing homes take? How long will subsidization continue during the privatization process and how long will the subsidization of needy patients continue following privatization? The main difficulties in the reform process will occur during the transition period which will last 5-10 years. However, in the long run, a change in policy is absolutely essential, as argued in this research paper. Following are the main policy recommendations:

1. *Cancellation of the government monopoly.* As stated above, this monopoly was legitimized in the National Health Insurance Act, which determined that sole responsibility for geriatric hospitalization would be in the hands of the government. As a first step, this exclusivity clause should be rescinded.
2. *Elimination of "codes."* The system of "codes" should be eliminated. It interferes with the free market's supply and demand mechanism and therefore prevents the development of a real free market environment in the nursing home system. The system of "codes" is essentially one of government subsidization, which results in a lack of long-term planning and self-reliance on the part of the individual. The cancellation of the system will force people to take a hard look at their future and to take responsibility for their lives. This will also eliminate the long wait for hospitalization and the violation of family privacy.
3. *Privatization of government nursing homes.* The government nursing homes should be privatized. This will result in much higher operating efficiency and will force the nursing homes to engage market competition, thereby reducing the price structure in effect in today's statist system. Not only will supply in the private sector grow (as is characteristic of a competitive situation), but public nursing homes, which are owned by organizations such as the Sick Funds, the Histadrut, etc., will also be forced to increase efficiency and reduce prices since they will no longer receive patients with "codes."

Privatization should be carried out over a period of three years in order to allow for the preparation and award of tenders. Entrepreneurs will have to meet financial, medical and health requirements in addition to any other relevant criteria of the Ministry of Health. There will be no regulation of prices in order to allow competition. The government will continue to assist elderly patients in specific cases of financial need during a five-year transition period. This assistance will be given directly to the elderly patient rather than subsidizing the system as a whole. Following the transition period, subsidization will be cancelled completely.

4. *Adoption of private insurance for geriatric hospitalization.* Private geriatric insurance should be encouraged in order to replace the government in this sector. They should offer special policies for geriatric hospitalization. In this manner, the range of options will increase since there will be policies which guarantee a minimal level of hospitalization and those which offer a higher level of care. In order to encourage the switch to private insurance, the system adopted in the U.S., which has proved successful, should also be adopted in Israel. As mentioned above, this involves granting

tax incentives for the payment of geriatric insurance premiums. In other words, premiums will be recognized as tax deductible expenses.⁶⁴ This recommendation is only meant to serve as a guideline. The tax incentives will have to be calculated so as to be appropriate for both the younger age groups, who pay lower insurance premiums, and older age groups, who pay higher premiums.

5. *Regulation of sanitary and medical conditions.* Since human life is at stake, the Ministry of Health should continue to inspect the medical and sanitary conditions in nursing homes. In this case, the Ministry will no longer be a “player” in the nursing home system; the end of the politicization of nursing home administration will allow it to operate solely in its area of expertise. Furthermore, it can be assumed that insurance companies will form business alliances with nursing homes that maintain reasonable levels of hygiene and medical care which will encourage the maintenance of high standards in the nursing homes.

6. *Solutions for already hospitalized patients and those awaiting hospitalization.* The process of reform should also take into account the elderly who are presently hospitalized in nursing homes and those awaiting hospitalization. These individuals have been paying National Insurance, Sick Fund premiums and various taxes throughout their lifetime. The initiation of private insurance is liable to result in high insurance premiums for this group. Therefore, subsidization of needy individuals during the transition period, as mentioned in paragraph 3, will provide a solution for this age group. In extreme cases of need where the elderly patient cannot afford hospitalization, it may be necessary to consider the continuation of subsidies; however, only certain individuals, rather than the whole sector, will receive subsidies.

7. *Reduction of the tax burden in Israel.* In order to solve the problem of individuals over the age of 50, who do not presently require geriatric hospitalization but will pay excessively high insurance premiums, the government should increase individual financial freedom. It can be assumed that most of this population would be able to finance geriatric insurance if the tax burden was reduced and if they could invest the money paid in National Insurance as they saw fit. One of the principal reasons that the elderly are not able to finance hospitalization is the high tax burden in Israel. Reducing the tax burden will not only increase disposable income but will allow individuals to save for their old age. (This principle does not apply to the elderly who require hospitalization today and did not benefit from a reduced tax burden in their lifetime. As mentioned above, specific solutions will have to be found for them during the transition period.) Furthermore, higher disposable income will increase contributions to charitable organizations, which could assist the elderly as they did before the establishment of the State.

This reform will not only save the taxpayer money but will allow the elderly to grow old in dignity.

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NOTES

¹ Shraga Haber, senior advisor at the Ministry of Health and chairman of the Inter-Institutional Committee, interview with the author, January 2, 1999.

² Ariela Levenstein and Esther Iecovich, *The Elderly, the Family and the Institutional Setting – Issues and Methods for Intervention* (Tel Aviv: Ramot, 1995), p. 16. [Hebrew]

³ *Ibid.*, p. 21.

⁴ Central Bureau of Statistics, *Health, 50th Anniversary Publications 7* (Jerusalem: Central Bureau of Statistics, November 1998), p. 34. [Hebrew]

⁵ Haber, interview, November 11, 1999.

⁶ Levenstein and Iecovich, *The Elderly*, p. 16.

⁷ The Joint Distribution Committee is an American-Jewish charitable organization established in 1914 to assist European Jews during World War I. Today the organization helps needy Jews.

⁸ Gerald Steinberg, “Obstacles to Change in the Health System,” in *The Health System in Israel – Towards the 21st Century* (Jerusalem: Jerusalem Center for Public Affairs, 1997) pp. 12-13. In this article, Professor Steinberg of Bar-Ilan University writes that socialist ideology prevents reform of public institutions in general and the health system in particular. Professor Steinberg points out that it is this ideology which motivated the National Health Insurance Act.

⁹ Government Decision no. 2641, September 8, 1997. [Hebrew]

¹⁰ *Ha'aretz*, December 13, 1999.

¹¹ State Comptroller, *State Comptroller's Report 48* (Jerusalem: State Comptroller, 1998), p. 170. [Hebrew]

¹² Tiram-Barak, special report prepared for the Organization of Private Nursing Homes in Israel, December 1, 1992. [Hebrew]

¹³ Levenstein and Iecovich, *The Elderly*, p. 35.

¹⁴ Natan Oren, chairman of the Organization of Nursing Homes, interview with the author, June 28, 1999.

¹⁵ Uzi Keren, chairman of the Projects Committee, interview with the author, February 25, 1999.

¹⁶ Thus, the total annual governmental expenditure per government nursing home patient is \$31,000.

¹⁷ Yakov Nevo, senior advisor at the Ministry of Health specializing in the geriatric budget, interview with the author, August 26, 1999.

¹⁸ Haber, interview, January 2, 1999.

¹⁹ Parliamentary Inquiry 909, 14th Knesset, March 5, 1997; Parliamentary Inquiry 1141, 14th Knesset, April 9, 1997, Knesset Information Retrieval System. [Hebrew]

- ²⁰ Government Decision No. 569, November 27, 1990; Government Decision No. 1036, February 24, 1991.
- ²¹ Benno Havut, former director of the Geriatrics Branch at the Ministry of Health, interview with the author, August 4, 1999.
- ²² Talia Edery, legal advisor at the Health Ministry specializing in geriatrics, telephone interview with the author, July 18, 1999.
- ²³ Mark Klarfield, director of Geriatrics Branch at the Ministry of Health, telephone interview with the author, March 23, 1999.
- ²⁴ State Comptroller, *State Comptroller's Report* 48 (Jerusalem: State Comptroller, 1998), p. 173. [Hebrew]
- ²⁵ 12th Knesset, 2nd sess., *Minutes of the Knesset*, volume 117, June 5, 1990, p. 3769. [Hebrew]
- ²⁶ State Comptroller, *State Comptroller's Report* 48, p. 170.
- ²⁷ 2nd Knesset, *Minutes of the Knesset*, May 11, 1953. [Hebrew]
- ²⁸ Haber, interview, January 2, 1999.
- ²⁹ Nevo, interview, August 26, 1999.
- ³⁰ Oren, fax to the author, November 10, 1999. [Hebrew]
- ³¹ *Ha'aretz*, May 11, 1998.
- ³² *Ha'aretz*, February 26, 1997.
- ³³ Oren, interview, June 28, 1999.
- ³⁴ Ministry of Health, *State Budget: Proposal for 1999* (Jerusalem: Ministry of Health, 1998) p. 124. [Hebrew]
- ³⁵ *Ibid.*, p. 12.
- ³⁶ Jenny Brodesky, Yitzhak Shnorrr and Shmuel Be'er, eds., *The Elderly in Israel – Statistical Abstract 1998* (Jerusalem: Brookdale Institute and Eshel Association, July 1998), p. 198. [Hebrew]
- ³⁷ Various sources in the Geriatrics Branch, the private sector and the public sector give estimates in this range. For example, Haber, interview, November 11, 1999, and Oren, interview, June 28, 1999.
- ³⁸ Naama Rotem, Central Bureau of Statistics, letter to the author, March 23, 1999. [Hebrew]
- ³⁹ Gal Hershkowitz, economist at the Finance Ministry specializing in the Ministry of Health budget, interview with the author, July 18, 1999.
- ⁴⁰ State Comptroller, *State Comptroller's Report* 34 (Jerusalem: State Comptroller, 1984), p. 215. [Hebrew]; Nevo, interview, August 4, 1999.

⁴¹ Nevo, telephone interview with the author, August 4, 1999.

⁴² Keren, interview.

⁴³ Author's calculation based on Ministry of Health, *State Budget: Proposal for 1999*, p. 159.

⁴⁴ Finance Ministry, *State Budget: Proposal for 1999* (Jerusalem: Finance Ministry, October 1998), pp. 20-37. [Hebrew]

⁴⁵ *Ibid.*, p. 97.

⁴⁶ Yossi Cohen, assistant director for wages at the Finance Ministry, telephone interview with the author, November 10, 1999.

⁴⁷ Hamotal Ben David, economist specializing in wages and wage agreements at the Finance Ministry, telephone interview with author, August 4, 1999.

⁴⁸ The information has been verified by three separate individuals. Names withheld upon request.

⁴⁹ *Ibid.* As this study deals in policy and not specific wrongdoings, the name of the nursing home has been omitted.

⁵⁰ Richard Price, *Long Term Care for the Elderly: Themes of Financing Reform* (Washington D.C.: Congressional Research Service, Library of Congress, January 15, 1999), p. 2.

⁵¹ Congressional Quarterly, Inc., *Caring for the Elderly*, C Q Researcher (Washington D.C.: Congressional Quarterly, Inc., 1998), p. 149.

⁵² Richard Price, Congressional Research Service specialist in geriatrics, telephone interview with the author, November 15, 1999.

⁵³ Price, *Long Term Care for the Elderly*, pp. 2-3.

⁵⁴ Congressional Quarterly, Inc., *Caring for the Elderly*, p. 162.

⁵⁵ If one assumes that the entire annual state and federal budget for geriatric hospitalization of \$33.9 billion applies only to nursing home care, the government's annual per patient budget in the U.S. is \$21,187.50. In Israel, by contrast, the government's annual per patient expenditure is \$31,000 (see footnote 16 above). In other words, the taxpayer's burden in Israel is \$9,817.50 per patient per year more than in the U.S. Thus, Israeli taxpayers pay 46% more in tax dollars to care for their elderly while receiving what appears to be less (i.e., longer waiting periods, overcrowding, etc.).

⁵⁶ Price, *Long Term Care for the Elderly*, p. 11.

⁵⁷ *Ibid.*, pp. 3-4.

⁵⁸ Congressional Quarterly, Inc., *Caring for the Elderly*, p. 162.

⁵⁹ *Ibid.*, p. 155.

⁶⁰ Price, *Long Term Care for the Elderly*, p. 5.

⁶¹ *Ibid.*, pp. 6-13.

⁶² *Ibid.*, conclusion.

⁶³ *Ibid.*, p. 2.

⁶⁴ As noted, this industry is not yet developed in Israel. There are a few companies offering this type of policy. For example, for a policy which pays \$250 a month in case of hospitalization, the premium for a 50-year old man is \$63.70, for a 60-year old man \$102 and for a 70-year old man \$310.

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