The article presents several organizational and structural dilemmas after a decade of implementation of the Israeli Long-term Care Law. A description of the background, principles and goals of the law is followed by an analysis of the dilemmas that are associated with the policy of contracting out of services to nongovernmental organizations, the financing of the services and the relative merits of cash benefits vs. benefits in kind. Other issues discussed and evaluated are: home care workers, the strategic behavior of the service providers, the critical factor of monitoring and control in maintaining high standards of quality of services, the impact of the law on institutionalization of the elderly and the burden of care borne by primary informal caregivers.

Introduction
Israel’s Long-Term Care Insurance Law (LTCI) began to be implemented just over a decade ago. The enabling legislation was passed following a prolonged struggle between proponents of different viewpoints concerning the need for a law that assured at least some assistance to the growing number of frail elderly. We now have sufficient experience of the law to make it possible to reasonably assess its major effects, to draw some select lessons, and to identify continuing dilemmas.

The framework chosen for the presentation of lessons learned from the law is based on three main components, which are addressed in the respective sections of the paper: Inputs, Process, and Effects. The Inputs section includes:

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Background, principles, and goals of the law; contracting out of service delivery; home care workers; financing long-term care services; and the relative merits of cash benefits versus benefits in kind, an issue that has been a focus of public debate. The Process section includes: The home care industry that developed as a result of implementation of the law; the strategic behavior of provider organizations that had to adapt themselves to the changing demands of their task environments; dilemmas related to monitoring and control, which derive from the unique situation of organizations providing services outside of the organizational boundaries, i.e., at the home of the elderly client. The Effects section focuses on three main effects: The impact of the law on institutionalization of the elderly, the burden of care borne by primary informal caregivers, and service quality. The article ends with a discussion and conclusions section.

Background to the Law, Its Principles and Goals
Israel’s Long-Term Care Insurance Law was essentially enacted in response to the demographic changes that are typical of modern societies. Here we present some of the international and Israeli trends in these demographic changes. This is followed by an outline of the principles upon which the law was based and its goals.

1. International and Israeli Trends and Prospects in Population Aging
The Long-Term Care Insurance Law was enacted in response to population aging. The emergence of this phenomenon made it necessary to seriously explore alternative ways of providing needed services for the growing number of frail elderly.

Population aging, especially the growth in the proportion of the population aged 65 and over, is the dominant feature of the age structure of Israel and most of the Western industrialized nations. Thus, for the OECD countries, the proportion of the elderly population is expected to more than double from an average of 10% in 1950 to an average of more that 20% by 2050 (OECD, 1996). The considerable implications of this unprecedented shift in the balance between the young and the old for income security and health care policy have been broadly recognized for at least two decades.

The phenomenon of population aging has been accompanied by a secondary aging process, which refers to the rapid growth in the proportion of very elderly amongst the aged population – “the aging of the aged”. For example, the
proportion of the elderly population aged 80 and over is projected to increase from 19.5%, 20.8%, 19.7% and 25.5% in 1990 in Australia, Canada, Japan and Switzerland, respectively, to 27.4%, 31%, 31.7% and 28.1% in 2040 (OECD, 1996). Given the correlation between age and functional disability, the sizable increases in the proportion and number of very elderly will place ever-growing demands on long-term care services. While projections of the scope of future demand for long-term care are sensitive to assumptions about likely rates of dependency among the elderly, even under optimistic scenarios long-term care will need to expand significantly. In England, for example, if no account is taken of other factors, long-term care will need to expand by 61% between 1995 and 2031 to keep pace with the rising number of elderly (PSSRU, 1999).

Moreover, the rapid aging process is occurring despite a comparatively high birth rate in Israel. This trend is mainly due to increased life expectancy (the life expectancy at age 65 is 8.15 years for men and 9.17 years for women, an increase of 19% over the life expectancy 20 years ago) and a major influx of immigrants (especially from the former Soviet Union and Ethiopia) comprised of a sizable proportion of older immigrants. The elderly population in Israel reached 568,000 at the end of 1996, or 9.9% of the total population (Kop, 1998). Of this number, 231,000 were over 75 years of age. In 1997, 492,000 elderly received an old-age pension and 40% of these pensioners also received an income supplement from the government (Kop, 1998).

Israel’s elderly population has not only grown in size; its composition has also changed over time. Between 1955 and 1998, the population of Israel increased three-fold while the elderly population increased six-fold. The number of elderly above 75 years of age increased eight-fold. The number of elderly above 85, the most vulnerable age group in terms of disability, increased 100% during the 1980s alone and is expected to continue increasing rapidly. The proportion of women in the elderly population has also increased. It is expected to further increase by 37% by the year 2000 while the increase for men is projected to be 25%. In addition, the ethnic composition of the elderly population has been changing as the% age of elderly from the former Soviet Union and African and Asian countries has increased. Since the incidence of disability is greater among women than men and people of Asian-African origin (Kop., 1998), the changes in the composition of the elderly population have contributed toward a steady increase in the number of disabled elderly. Thus, the proportion of disabled elderly entitled to home care due to limited functional ability reached 11% of the total elderly population by 1998 (Brookdale Institute and Eshel, 1998).

In addition, a large proportion of elderly individuals have health and
income needs and require a wide range of home care services. In recent years, expenditure on the elderly population has represented a major component of total government expenditures on welfare and social services. In the early 1990s, expenditure on the elderly represented 33% of total expenditures while in the 1998 budget, the expenditure level rose to 41%. From 1990 to 1998, expenditure rose by 120%. (Kop, 1998).

2. The Principles and Goals of the Law
The Long-Term Care Insurance Law is a social insurance law operating according to universal principles. Initially, the law provided for equal employer and employee insurance contributions of 0.1% of earnings (0.2% in toto). Thus, the receipt of home care services by the frail elderly, in contrast to other services (e.g., services to the developmentally disabled, the unemployed, and rehabilitation services) is no longer dependent upon the vagaries of the state budget and shifts in policy or priorities which may affect service eligibility.

Several principles guided the legislators involved in framing the legislation. The following are the most important (Ben-Zvi, 1989; Cohen, 1988):
(1) The Long-Term Care Insurance Law covers elderly people living in the community - either independently or with their families - and not residents of aged care institutions.
(2) The law accords priority to benefits in kind, i.e., direct services for the elderly such as personal care and help with home chores. Only in cases where such services are not available can the benefit be exchanged for a cash benefit. The stipulation that direct services be provided was based on the assumption that cash benefits may otherwise be consumed as part of the family budget without being used for the intended purpose.
(3) The benefit is targeted on frail elderly people who are completely or partially dependent on assistance from others to carry out activities of daily living. It is not intended for elderly people with mild functional disabilities and who are not highly dependent on help from others.
(4) Personal benefits are not intended to replace the assistance provided by family members. Since these benefits are relatively modest, it is assumed that supplementary aid will continue to be given by family members as a natural obligation, and that they are not paid or otherwise compensated for the services they render. Personal benefits are intended to alleviate the burden of care borne by the family in such caring activities as bathing, dressing, feeding, mobility in the home, and protection of the elderly person against potential risks. However,
such help in the home does not replace professional health and welfare services such as physiotherapy, occupational therapy, medical services, and psychosocial counseling.

The insurance law, by nature, guarantees home care services for all eligible applicants according to uniform, legally prescribed eligibility criteria. No eligible person can be denied services on the grounds that funds are lacking. Eligibility is a function of age, dependency and income. Thus, eligibility for benefits begins at age 60 for women and at age 65 for men and is primarily based on an Activity Daily Living (ADL) test. However, eligibility for personal care benefits is also subject to an income test. This stipulation is at odds with the principles of contributory social insurance and is an anomaly among the range of social insurance provisions (e.g., age pensions, unemployment insurance benefits, etc) administered by the National Insurance Institute (NII). The income test was introduced into the law due to “… the economic difficulties of the country and the desire to complete the legislation at a time of considerable cuts in welfare services.” (Cohen, 1988, p. 9).

(6) The law provides for two levels of benefits, depending on the seriousness of the person’s functional disability. For those who are highly dependent on help from others to carry out most daily activities benefits are equivalent to a full (100%) disability allowance. In the case of those who are completely dependent on others to carry out all daily activities, benefits are equivalent to 150% of a full disability allowance.

(7) A central aspect of the law is the need for cooperation between all of the relevant agencies that provide care for the elderly, i.e., government, voluntary non-profit and for-profit organizations.

Responsibility for implementing the law rests with the NII, which is assisted by local professional committees. The members of these committees include a social worker from the local social services department, a nurse from the local health services and a clerk from the NII. These committees are responsible for determining the care plan and monitoring implementation. The committees also direct the elderly to the various service providers in accordance with government policy to contract out to service providers within the nonprofit and for-profit sectors.

The Contracting Out of Service Delivery
The introduction of quasi-markets in the delivery of human services (contracting out of services to a “mixed economy” of the government, voluntary nonprofit organizations, or VNPOs, and for-profit organizations, or FPOs) has typically
been driven by considerations of economic efficiency, enhanced consumer sovereignty, improved service quality, greater flexibility and innovation in service delivery arrangements, and the desire to reduce the role of the state in the welfare domain (Glennerster and Le Grand, 1994; Glennerster, 1996; Knapp et al., 1999). The role of governments in the mixed economy is, typically, to establish policies and standards and to monitor the delivery of the services for which they are the monopoly purchaser. The rationale for adopting the strategy of contracting out was based on the relative ease with which the government would be able to assure service delivery to a much larger beneficiary population as opposed to the difficulties involved in adding tens of thousands of home care workers to the civil service rolls. This strategy also allows for bypassing of rigid budgets and administrative rules and regulations, such as freezes on hiring of personnel or requirements for compliance with salary guidelines, and the avoidance of political constraints.

Studies of the implications of contracting out have revealed both benefits and problems associated with this strategy (e.g., Deakin, 1996). First of all, there is no doubt that the number of personnel directly employed by the government to implement the law is very small. Second, the relationship between the government and the service providers has stabilized over the years and management practices have been honed. Indeed, service providers even report increased access to policy makers and reduced bureaucratic and administrative difficulties. Third, the use of contractors allowed the government to save on the start-up costs involved in founding new services. Fourth, the government has also been able to successfully integrate FPOs and VNPOs into a single service delivery system. Finally, the government has been able to impose upon the provider organizations high professional standards by requiring them to employ professional personnel (social workers and nurses) and create preparatory and ongoing training programs for the home care workers.

The strategy of fostering the development of quasi-markets, however, poses several dangers - both actual and potential - arising from the relationship between the provider organizations and the government. One of these dangers is the creation of interdependency. Since the law took effect, the government has become increasingly more dependent upon the organizations as it has no alternative system for providing services to the eligible frail elderly living in the community. The government would be required to invest even larger sums of money in the provision of services in the absence of the providers. The result is that the government has found itself in a weakened position in relation to service delivery as the provider organizations have acquired great power.
knowing that the government is obliged to provide for a very large beneficiary population.

On the other hand, the organizations are dependent upon the government for funding. They derive 75% of their income from government budgets earmarked for services to the frail elderly. This dependence engenders such close compliance with government policy that the provider organizations are unwilling or unable to provide needed services beyond those required of them by the government, such as day care centers and transportation (Gronbjerg, 1998; Schmid, 1998). The provider organizations have almost become extensions of the government, mimicking both its bureaucracy and politics rather than being efficient and flexibly responsive to addressing unmet needs.

Another danger stemming from the dependency of the provider organizations on government financing is their vulnerability to changes in government policy. A change in policy could have direct implications on resource allocation and upset the financial stability of the organizations. Indeed, recent discussions within government circles and the National Insurance Institute have canvassed the possibility of replacing the personal in-kind benefit with a cash benefit and placing a quota on the number of authorized provider organizations.

Yet another potential problem arising from contracting out is related to the degree of autonomy enjoyed by the organizations versus government control. The organizations have sought to strengthen themselves and, while government should be interested in fostering this, at the same time it has also sought to develop a strong degree of control over the organizations to assure the quality of their services. Thus, the organizations have found themselves subject to policy restrictions such as who shall be served (client eligibility): by whom (staff restrictions): and how (service delivery). They have also experienced unwanted interference with internal management and operating policies, such as standards of supervision and control or requirements for office equipment (such as voice mail or fax machines). Government control, to some extent, indicates suspicion of and a lack of trust in the provider organizations, especially the FPOs. The result is restrictions on the autonomy and development of the organization.

Whether quasi-markets are a better way of delivering services than the alternatives of public bureaucracies or pure markets is an issue that is much debated in social policy circles. The Israeli experience of delivering home care services to the frail elderly leaves open the answer to this question. Indeed, there appears to be little in the experience of many other countries to support the contention that quasi-markets necessarily yield more efficient and better human services (Hodge, 1996). Consequently, in some countries,
e.g., Australia (House of Representatives Standing Committee on Family and Community Affairs 1998), there are signs of a retreat from the formerly staunch support for quasi-markets in the delivery of human services.

The Israeli experience, at least so far, indicates that the adoption of contracting out as a service delivery strategy enables the government to deliver a substantially increased volume of services within a relatively short period of time without adding employees to the civil service payroll. Nevertheless, the relationships that have been created between the government and the provider organizations raise some questions regarding their mutual interdependence and the development of the provider organizations as independent entities responsible for the provision of high quality services.

**Home Care Workers**

The home care industry’s single largest group of employees is, by far, its home care workers. Some 42,000 home care workers are directly responsible for providing services to the frail elderly. In addition, social workers employed by the provider organization are responsible for supervising and monitoring each client’s care plan. Social workers employed by the social services departments and the regional committees are also part of the industry’s labor force.

Most of the home care workers are unskilled women with a low level of formal education, and their average age is 43. The majority earn minimum wage and work part-time, so that their annual income is very low. As a class of workers, they are not unionized and have little job security, few fringe benefits and no opportunity for advancement. They are employed in positions with low prestige and their work is usually under-valued by their employers. Moreover, gender and racial stereotypes devalue salaries, especially when the jobs are not unionized, when they are traditionally associated with gender and race and when performance measurement is ambiguous - all traits of home care work (Schmid, 1993b).

The years immediately following passage of the law witnessed a rapid turnover of home care workers. Studies of the performance of home care workers (Schmid, 1998) have shown that, over time, the home care labor force has stabilized and that there has been a significant reduction in the turnover rate. In other countries, such as the United States, the labor force is quite unstable and turnover remains high (Neysmith and Aronson, 1996).

An important element of home care work is training. While the level of training was very low in the early years of the law, it has improved significantly
since then. Both FPOs and VNPOs recognize the importance of training home care workers and of engendering a greater sense of responsibility and commitment toward their work as a way of improving the quality of service (Rose-Ackerman, 1996). In the absence of proper training, there is a danger that service quality will decline as a result of the low level of expertise and management skills.

Research has also revealed that the home care workers’ low remuneration is likely to affect their personal investment in their work (Schmid, 1998). There is extensive anecdotal evidence indicating that workers may try to compensate themselves by reducing the amount of attention they give to the elderly client, reducing the number of hours they actually work while falsely reporting a larger total, not coming to work, changing the schedule or care plan, and reducing their effort and commitment to the aged client.

**Financing Long-Term Care**

As noted above, the law initially provided for equal employer and employee insurance contributions of 0.1% each (0.2% *ina toto*). When the collection of LTCI contributions began in 1982 following the passage of the framework legislation two years earlier, the employer’s payroll tax for all of the various forms of Israeli social insurance was 10.25% of the employee’s wages while the employee’s contribution was 3.8% of wages. Beginning in 1986, the rates of social insurance contributions paid by employers and the self-employed were gradually reduced as part of a policy of reducing labor costs in order to foster competitiveness. Thus, in April 1990, the employer’s LTCI contribution was reduced to 0.04% of wages and the government began to contribute 0.06% of employee’s wages. In this way, the NII was compensated for the loss of revenue deriving from the reduction in the employer’s contribution (this compensation is known in Israel as “treasury indemnification”), while the employee’s contribution remained 0.1%. Excluding the national health insurance contributions introduced in January 1995, today the employer’s social insurance contribution is 4.93% while the worker’s share is 2.66% of earnings up to half of the average wage and 4.90% of earnings in excess of the average wage. Clearly, relative to the overall social insurance contribution burden, the LTCI levy has always been quite modest.

Although the LTCI basic legislation was passed in 1980, collection of contributions did not begin until 1982. However, the first expenditures were not incurred until 1986. Thus, the LTCI scheme was able to accumulate a “start up” reserve—not unlike some other new social insurance schemes elsewhere. For
example, in the US, the 1935 Social Security Act was scheduled to take effect on January 1, 1937 and payment of benefits was to begin five years later. As it turned out, payment of benefits began in 1940, two years earlier than planned.

Regarding the financial impact of the law, after a decade the LTCI scheme is in deficit. Indeed, this has been the case almost from the outset. As noted, the LTCI component of total social insurance contributions is very modest in and of itself and in comparison with similar schemes elsewhere. Thus, for example, the ambulatory or domiciliary care component of Germany’s LTCI scheme introduced in 1995 was financed by an employer and employee contribution of 0.5% each of contributory income (Goerke, 1996). It was not surprising, therefore, that the LTCI’s start-up reserves were soon dissipated in the face of a rapid growth in the number of beneficiaries once personal benefits became payable in 1988. As early as 1989 LTCI expenditures began to exceed the revenues generated by the insurance levy, a situation which not only persisted but also escalated over the ensuing years (National Insurance Institute, 1996). The total expenditure on LTCI benefits in 1998 was 1.29 billion NIS while the estimated deficit was 803 million NIS. Clearly, the LTCI scheme has not been self-funding. Shortfalls have been financed from the surpluses of other social insurance programs (most notably children’s allowances), a practice permitted under Israel’s social security laws, and through drawing on reserves and interest on investments. In addition, the government covers all payments made to new immigrants in receipt of LTCI benefits (Yaniv, 1998; National Insurance Institute, 1999).

According to Morginstin et al. (1992): there has been ongoing concern about the deficit carried by the LTCI scheme. In recent years, however, the concern has become more serious as increased unemployment and a decline in the rate of economic growth have contributed to growing pressure to reduce public expenditure, including expenditure on the LTCI scheme (Stessman, 1998). The design features of several social insurance provisions have been the target of expenditure reduction proposals. Social insurance provisions are an issue on the agenda of those seeking to reduce public expenditure for at least two reasons. The first is that the government, under the National Insurance Law, participates substantially in the financing of some of these provisions, most notably old age and survivors’ pensions and children’s allowances. Second, because of the substantial growth in expenditures on these provisions and the expectation that this growth will continue unabated in the future, the government faces the prospect of ever-increasing levels of participation in their financing. Thus, in 1997 alone, government participation in the financing of social insurance
provisions increased by 11% (Yaniv, 1998, pp. E10-E11). Of particular importance in the context of this article is that, aside from unemployment benefits, the LTCI scheme has experienced the highest rates of growth in social insurance expenditures - a growth rate of approximately 20% in both 1997 and 1998 (National Insurance Institute, 1999).

In view of current and projected long-term care expenditure levels, 1998 witnessed efforts by the Treasury to reduce LTCI expenditure as part of its strategy to achieve cuts in Israel’s 1999 national budget (Gilbert, 1998). In the same year, the NII began its own internal review process with a view to identifying means to curb the growth in LTCI expenditures (Stessman, 1998).

While successive Israeli governments appear to have been “resigned” to the sizable deficit carried by the LTC scheme, these recent initiatives suggest that this is no longer the case. The simplest solution would appear to be to increase the LTCI contribution levels imposed on employers and employees in order to bring income and expenditure into closer alignment with one another. Indeed, some of those involved in devising the LTCI scheme had recommended that 0.75% of the insured’s income be contributed (divided equally between the employer, the employee and the government). However, it was not politically possible to set LTCI contribution levels at this higher level when the legislation was being prepared (Mann, 1988, p. 25). Thus, it was realized from the outset of the LTCI scheme that the “meagre” (Mann, 1988, p. 27) total contribution of 0.2% would not generate sufficient funds from contributions to cover expenditures (Mann, 1988; Morginstin, Baitch-Moray and Zipkin, 1992).

The prospects today for an increase in LTCI contribution levels are poor, just as they were during the scheme’s formative days. This is because Israelis already pay high direct and indirect taxes as well as high social insurance (including national health insurance) premiums. The high levels of taxation are, in large measure, attributable to high levels of national expenditure on security. Governments remain averse to raising taxes in general and those that would add to labor costs in particular. In an environment of fiscal constraint, drawing even further on general revenues to subvent the LTCI scheme is also unlikely. In the absence of a willingness to generate more funds or draw further from existing sources, only two options appear to remain. The first is cost containment and the second is to pass on some of the cost.

The avenues for achieving cost containment include, for example, tightening eligibility criteria, reducing benefit levels, or reducing the number of items included in the basket of services. It should be evident that cost containment is tantamount to a rollback in the coverage and scope of the LTCI scheme. Yet,
as we have shown elsewhere (Borowski and Schmid, 1999), after a decade of implementation there is strong reason for seeking the exact opposite, i.e., broader coverage to include those elderly who are less severely disabled, higher benefit levels, and an expansion in the items comprising the service basket.

Another alternative is to encourage private long-term care insurance coverage. But the myopia of the young and the high premiums that would be necessary for those who purchase such insurance later in life when infirmity begins to loom suggest that, even with the tax incentives, coverage will remain very limited. Indeed, this is precisely one of the rationales for adopting a social insurance approach to the funding of long-term care.

Given that the state and the market do not seem to be viable avenues for dealing with the funding “crisis” faced by Israel’s LTCI scheme, another option is to somehow pass on the costs to the remaining institutional pillar involved in aged care, viz., the informal caregivers. Indeed, in Israel and elsewhere (Rein, 1999) pressure appears to be growing to take this course. It can be achieved through various means, including co-payments for services or cashing out in-kind benefits at a discount. Both approaches would add to the financial burden borne by caregivers seeking to maintain the previous level of care, a burden that the LTCI seems to have effectively eased since its inception. If they could not sustain the additional financial burden, then the qualitative burden of care borne by the caregivers could be expected to grow as well. Here again, this would undo some of the good work done by the LTCI scheme.

It would seem, then, that Israel must face some hard choices regarding the future of its LTCI scheme. One choice is to take the difficult political decision of either raising contribution levels or increasing the level of subvention of the LTCI scheme at the expense of other areas of government expenditure. Alternatively, Israel can adopt some of the cost containment or cost-shifting strategies referred to above at the expense of some of the important achievements that the scheme has already realized. The size of Israel’s frail aged population in need of community care will continue to grow – even without unanticipated events that would further increase the LTCI beneficiary population (e.g., the major influx of immigrants from the former Soviet Union, which began in 1989 and comprised a high proportion of older people). In the view of the authors, if the Israeli Government seriously wishes to protect elderly citizens against some of the costs associated with the normal life event of functional incapacity and to build on the successes of the LTCI scheme to date, it cannot escape the reality of the high cost involved, even in the case of a scheme which is as limited in scope as Israel’s.
Benefits in Kind versus Cash Benefits
A number of countries have either proposed or actually provided clients with cash, which can be used to obtain services in kind at a reduced fee under their home care schemes. This proposal/option is fundamentally driven by cost considerations. However, debates on the issue of cash versus in-kind services are not triggered solely by such considerations.

The LTCI law provides mainly services in kind and not cash benefits. According to the law, elderly persons are eligible to receive a monetary allowance only when the services they require are not available. Advocates of services in kind emphasize the need to increase the scope and availability of the services, as well as the need to improve the quality of services in the community and even in institutions. The main argument in favor of services in kind is that the elderly population is not normally distributed in terms of its consumption of required services. Therefore, a large gap may emerge in the level of services provided among populations that invest the cash benefits in ensuring the elderly clients’ quality of life, compared with populations that use the benefits to promote their own goals at the expense of the elderly client’s well-being.

Indeed, when the law was first implemented, about 80% of the elderly population and their families were in favor of receiving benefits in kind (Schmid and Sabbagh, 1991). Now, a decade later, policy makers are reconsidering the issue of providing services in kind, and the issue of the “brokerage gap” deriving from payments to organizations providing the services. The “brokerage gap” refers to the difference between the amount paid by the NII to service providers, and the wages paid by the provider to the workers serving the clients. It is argued that this gap is wide, and that its main purpose is to increase the profits of provider organizations at the expense of the quality of services received by the frail elderly. This is one of the main arguments against benefits in kind. Specifically, many policy makers object to legitimizing profits at the expense of the quantity and quality of services for the elderly. Moreover, proponents of cash benefits argue that such payments increase the clients’ choice of services and empower them by giving them autonomy to use their money as they wish. According to this view, cash benefits even give elderly clients an opportunity to control the quality of services themselves, since the government has difficulty monitoring the work of service providers. Furthermore, cash benefits free the government from responsibility for ensuring the elderly person’s well-being, and give elderly clients and their families more power in their relationships with service providers. This generates competition between organizations, which ultimately contributes toward improved service quality.
Comparison of in-kind services with cash benefits reveals that provision of cash benefits generates inequality, owing to the above-mentioned differences between the elderly clients’ consumer habits and culture. In this connection, elderly people are limited in terms of the information at their disposal and their ability to seek the services they need. Services in kind, by contrast, ensure equality between different socioeconomic populations. Nonetheless, given the current orientation toward empowering clients and broadening the range of options available to them, cash benefits may be still preferable. It should also be mentioned that these allowances may be preferable, owing to the large deficit in budgets available for funding of these services by law (see also the above section on financing long-term care).

The Home Care Industry
The home care industry evolved, both worldwide and in Israel, as a solution to the growing pressure on governments to provide an alternative to institutional care for the aged (Ruchlin et al., 1989). In addition to the fiscal constraints faced by governments, these efforts were motivated by the early discharge of elderly patients from hospitals as a result of problems and difficulties emanating from health budgets and the increasing awareness of the negative effects of institutional care on the elderly person’s well-being. Although research on the effectiveness of home care service is limited and contradictory, there are a number of studies indicating that the elderly clearly prefer to stay at home and the quality of their life may be enhanced by doing so (Kaye, 1995).

In response to the rapidly increasing demand for home care, a burgeoning home care industry emerged in Israel. The industry is comprised of voluntary nonprofit and for-profit organizations whose services include personal care, companionship, shopping, house cleaning, provision of hot meals and household management. The cost of the services provided by these organizations to those receiving LTCI benefits are covered by the law.

The law created a new ecological niche which provided a total of 5 billion NIS (1.2 billion US$) between 1988 and 1998 to the providers of home care services to elderly clients. During the initial period after the law came into effect (1988-9), about 7,000 elderly clients were entitled to home care services. Today, 114,000 (32,000 men and 82,000 women. NII, 1998) are in receipt of services. In 1988, 70% of home care services were provided by VNPOs, 18% were provided by FPOs and the rest by kibbutzim.

During the course of the last decade, this niche has not only changed in size but also in composition. The proportion of home care services provided by
VNPOs has dropped to 41%, while the proportion for FPOs has increased to 57%, with the remainder of services provided by kibbutzim. There are now 150 organizations, with 420 branches, operating in the two sectors that provide home care services. This change can be attributed to the government’s apprehension, when the enabling legislation was being formulated, about the ability of VNPOs to provide the required volume of services. Therefore, the government adopted a strategy of contracting out to service providers. In doing so it promoted the most significant process of privatization in Israel in the domain of personal service provision. Rather than depending upon one sector alone, the government also sought to encourage competition between nonprofit and for-profit organizations, i.e., to foster the development of a quasi-market. It did so with a view to trying to decrease the risk associated with an over-reliance for service delivery on one sector alone and also possibly in order to contribute to improved service quality. As a result, a mixed economy was created comprised of the government and nonprofit and for-profit organizations. The government is responsible for: (1) determining policies regarding the implementation of the law and standards, (2) funding the services, and (3) monitoring service delivery. The organizations are responsible for delivering the services.

The first years following implementation of the law were characterized by a high level of fluctuation in the entry of new organizations into the pool of service providers, by uncertainty regarding ways to deliver the services, and by a lack of stability in the relationship between the government and the service providers. All of these characteristics are unique features of industries operating in a turbulent environment (Schmid and Hasenfeld, 1993), and have been especially evident among the FPOs which entered the home care service industry with the encouragement of the government. In spite of this, and in contrast to the familiarity with the government enjoyed by the VNPOs, the FPOs needed to prove themselves as service providers. Although formally accredited by the government authorities, informally the FPOs had to fight to establish their legitimacy in the eyes of the government, elderly clients and their families. Further, neither the government nor the clients had reliable information available to them concerning the performance of the FPOs or the quality of their services even though the services were specified by the government. In contrast, the VNPOs were trusted by the government since their relationship with the government had been long-standing and stable and because they had been the almost exclusive provider of such services prior to the enactment of the law.

During the ten years of the law’s operation, there have been major changes in the market, primarily in terms of the rapid growth in the size of the beneficiary
population and in the increasing share of services provided by FPOs compared to VNPOs. Uncertainty has been reduced and both the government and the service organizations have more information regarding client needs, solutions and the mutual expectations that they have of each other. The market has stabilized in terms of the number of service providers and the level of resources made available to them by the government (on average, 75% of the income of both FPOs and VNPOs is provided under the law). Contrary to trends in other parts of the world, especially in the United States, the mortality of the provider organizations is minuscule (from 1988 to 1998, less than 10 organizations have closed due to mismanagement or financial difficulties). The low mortality rate is primarily due to their substantial dependence on government funds provided under the law. This dependence guarantees a steady flow of resources to the provider agencies as long as they fulfill the requirements of the law and the government. In fact, most of the organizations in both the FPO and VNPO sectors primarily supply services specified by the law and have not developed new types of services or programs. Furthermore, over the years a mutual dependence has developed between the government and the service suppliers. The organizations are dependent on the government for resources (i.e., the elderly clients, much of their income) and the government is dependent on the organizations for delivering services to 114,000 frail elderly. This interdependence encourages the government to assure the survival of the organizations in order to be able to implement the law.

The ability of the government to apply sanctions against the provider organizations is constrained and complicated by legal considerations and the role played by interest groups. From a legal perspective, the government is faced with a number of constraints that prevent it from terminating the activities of provider organizations, even when the competence of the organizations is in doubt. In addition, the market is characterized by private and public interest groups that defend the providers and are interested in assuring their existence because of a formal or informal relationship between the groups. For example, the umbrella organization of associations for the elderly does all it can to protect the provider organizations, as funds from the law represent the main source of the latter’s income. Thus, interest groups associated with the provider organizations protect their interests, applying both covert and overt pressures on the government to assure their continued survival.

In sum, Israel’s home care industry operates in an ecological niche, has been provided enormous resources under the Long-Term Care Insurance Law, has grown substantially, and has experienced major changes in the market
share enjoyed by FPO’s (an increase) compared with VNPO’s (a decrease). The home care industry has stabilized after ten years and the level of certainty has increased as far as resources are concerned. The provider organizations have been legitimized by the government and the target population eligible for services has been clearly defined. At least in Israel, the home care industry now enjoys a relatively high degree of certainty in its task environment. Both strategically and structurally, this has allowed the provider organizations to stabilize themselves.

The next section deals with the strategic behavior of provider organizations attempting to adapt themselves to the changing demands of their task environment.

*Strategic Behavior of Provider Organizations*

In the process of adapting to their task environment, organizations usually employ various strategies to increase their effectiveness and respond to the changing demands of the environment. The particular strategy employed by an organization is a product of the unique characteristics of the environment in which it finds itself, such as the degree of its certainty and stability, the richness or paucity of resources, and so on.

Analysis of the strategic behavior of different service providers during the period immediately following the implementation of the LTCI law reveals that the FPOs adopted a strategy of generalism. They did so in recognition of the fact that they were operating in an uncertain environment and required legitimation of their programs and activities by the government. In these circumstances, the organizations preferred to spread the risk by offering a variety of services that would guarantee their survival in the event that their primary source of income (i.e., payment for services funded under the law) was discontinued. Initially, their organizational structures tended to be less formal and bureaucratic. This allowed for flexibility and effective adaptation to the changing demands of the environment.

In contrast, the VNPOs, which had developed a stable relationship with the government when they were major providers in the home care services market, adopted a strategy of specialization which focused on specific services. Their formal and bureaucratic structure may be attributed to the relatively stable, certain environment in which they operated as a result of this relationship. Over the years, however, and given the increasing competition between these organizations, both the structure of the VNPOs and the strategy which they employed changed. The VNPOs’ market share decreased and they began to
recognize that they could no longer rely exclusively on the specialist strategy. As a result, they expanded their activities to new target populations, e.g., those frail elderly ineligible for services under the Long-Term Care Insurance Law and clients of the Rehabilitation Department of the Ministry of Defense. Nevertheless, most of their clients remain the frail elderly who have established eligibility for home care services under the law.

At the same time, due to the growing environmental stability enjoyed by the FPOs resulting from the legitimacy accorded them by the government as well as their organizational growth, the structure of the FPOs shifted from an informal, non-bureaucratic one to a more mechanistic structure. Indeed, the VNPOs and FPOs became increasingly similar as they began emulating one another and adopting similar service technologies. In this context, it is of interest to note Knapp et al’s (1999) observation that “…there are actually lots of commonalities of perspectives and motivations which cut across the different sectors and provider types at any given time. …all... organizations are sharing to some degree a common environment as contractors...they can face similar pressures and opportunities.” (p. 15).

In addition, both types of organizations have understood for some time now that in order to attain a satisfactory level of efficiency, they must adopt advanced management technologies and base their activities to some extent on pricing, monitoring, financing and marketing.

The Dilemma of Monitoring and Control

One of the most complex challenges in the delivery of home care services to the frail elderly is that of adequate monitoring and control (see also discussion in Schmid and Hasenfeld, 1993). The source of the challenge is the fact that home care requires the home care worker to function under conditions that are not readily visible to the employing organization. Further, the organization cannot rely solely on its consumer to supplant or complement its monitoring function. This is because frail elderly clients become highly dependent upon home care workers and, consequently, can experience a considerable power imbalance that precludes effective control over the behavior and activities of the workers.

Although home care organizations have developed rules and procedures and have supervisory arrangements and reporting requirements in place, they nevertheless face the same dilemma experienced by “street-level bureaucracies” (Lipsky, 1980). That is, the home care workers are quite removed from the control center of the organization, and the organization is highly dependent on its substantially autonomous workers for the information needed for monitoring
purposes. The home care workers, despite rules and procedures, can exercise considerable discretion in their interaction with clients. Hence, the capacity of the organization to exercise supervisory control - to detect deviations from organizational rules and procedures - is greatly diminished, especially when either the client or the worker chooses to ignore them. The absence of institutionalized standards and measures of effectiveness or service quality reduce the monitoring function to such observable behaviors as attendance, reported hours of work, and client complaints.

Most street-level bureaucracies regard the implications of these elements of the work environment for client outcomes (possibly negative) and organizational control (problematic) with great concern (Borowski, 1980). However, for some provider organizations this situation provides them with the opportunity to reduce the quality and quantity of the service that their clients are entitled to under the law. Home care workers, sometimes with the tacit understanding of their agencies, may take advantage of their clients’ dependence and fail to provide the required number of service hours and submit false reports on services rendered. This enables some providers to reap undeserved profits and some workers to supplement the minimal wages and benefits they receive. The absence of an effective control apparatus in an industry operating on a low profit margin invites unscrupulous practices (Fine, 1988).

One way to avoid this situation is to delegate more responsibility to workers, thus making them partners in addressing clients’ needs. Research has shown this strategy to be positively and significantly associated with worker satisfaction, trust in management, belief in the equity of rewards allocation, positive attitudes toward the organization and low levels of turnover and absenteeism. All of these, in turn, influence the stability and quality of the worker-client relationship (Alexander and Ruderman, 1987; Folger and Konovsky, 1989).

However, workers’ participation in service delivery decisions must also be coupled with frequent on-site inspections, close supervision and frequent communication with the elderly clients and their families. These are not common practices in the home care industry because of the costs involved and the lack of sufficient resources or incentives for providers to invest in such a control system (Harrington and Grant, 1990). Such incentives arise when there are outside demands for accountability, when the agency seeks a competitive advantage by emphasizing the quality of its services or when it has a strong client-oriented professional ideology. Similarly, an agency that provides a wide array of services to the elderly recognizes that the quality of home care can generate business for other services it provides. Professionally dominated home
care organizations also tend to invest more in monitoring and supervision, in keeping with their service ideology (Schmid and Hasenfeld, 1993).

The most common practice in systems providing personal services is to use clients and their families as monitoring agents to substitute for or complement the monitoring activities of the service-providing organization. Such a strategy has the obvious advantage of reducing administrative costs (Handler, 1990). This practice, however, places the agency in the position of having to rely upon a reactive monitoring system that, again, shifts to clients at least some of the responsibility for system failures. Undoubtedly, when an agency adopts a proactive monitoring strategy coupled with an active partnership with its clients and their families, both the clients and the agency benefit. Research has also shown that, to the extent that clients are involved in determining their care plan, they tend to cooperate with agency management and to be highly satisfied (Schmid, 1998).

Some Effects of the Law: Institutionalization, the Burden of Care, and Service Quality

There appears to be no universally subscribed framework for assessing the effects of the various arrangements that have been set in place around the world to fund and deliver home- and community-based long-term care services to the frail elderly. However, most of the various frameworks, at the very least, cast care outcomes in terms of the impact of these arrangements on admission to residential care, on the burden of care borne by primary informal caregivers, and on service quality.

1. Institutionalization of Elderly Persons with Disabilities

Research findings clearly indicate that receipt of services in accordance with the LTCI law delayed and sometimes even prevented elderly persons – particularly the frail elderly – from entering institutions. In this way, the law contributed directly toward economizing on resources for the elderly, their families, and the country (Naon and Strosberg, 1996). Comparative research on patterns of institutionalizing the frail elderly before and after enactment of the law has consistently revealed that the changes in patterns of institutionalization were greater among frail elderly patients with mild disabilities than among those with severe physical and mental disabilities. It was also found that expansion of the law for provision of community services primarily helped elderly clients without severe disabilities...
and enabled them to avoid institutionalization. However, in the case of frail elderly persons with severe disabilities, the law did not significantly reduce the need for institutionalization. This may be attributed to the fact that these services involve high expenses and cannot be provided in the elderly person’s home. It should also be mentioned that the frail elderly who applied to institutions after the law was enacted had more severe disabilities than those who did so prior to the enactment of the law.

The research findings also indicate that contrary to expectations, there was a substantial increase in applications to institutional facilities immediately after enactment of the LTCI law. Apparently, implementation of the law made it possible to identify a large population of frail elderly individuals who had not applied for services in the past. This evidence suggests that before the law was enacted many elderly individuals did not receive services at all. Thus, the law contributed toward identifying new populations whose needs were not addressed in the past.

2. The Burden of Care
The LTCI law was intended to ease the burden of care borne by primary informal caregivers, usually the family of the elderly person. The law has substantially reduced the financial burden of caring for a disabled elderly family member. It has not, however, resulted in a reduction in the hours of care provided by primary informal caregivers. This is rather surprising, at least on the face of it. While there was no expectation that formal service would displace any but the most marginal of informal caregivers, it was expected that the availability of formal services would decrease the load borne by informal caregivers. And this is especially so in Israel where women, the providers of much of the informal care received by their disabled elderly husbands and parents living in the community, enjoy comparatively high levels of labor force participation.

It has been suggested that the persistence of high levels of informal care despite the availability of formal services may be partially attributed to two factors: (1) The ethic of care in Israel (i.e., the strong tradition of duty and caring felt by children towards their parents); and (2) Israel’s small size, which limits geographic mobility and facilitates access of adult children to their elderly parents (Cnaan, et al, 1990). However, what may appear to be a shortcoming on the part of the LTCI scheme raises a broader question, regarding the relevance of attempts to ease the temporal aspect of the caregiving burden for schemes that provide home- and community-based care for the disabled elderly. This
situation can be attributed to the fact that Israel’s experience with the LTCI scheme in relation to easing the hours of informal caregiving is by no means unique. There is a growing body of research literature on home- and community care programs (including the prominent US National Long-Term Care (Channeling) Demonstration) which reports that the amount of formal care does not significantly reduce the amount of informal care received by the disabled elderly (see, for example, Chappell and Blandford, 1991; Hanley, Werner and Harris, 1991, and Shaver and Fine, 1995). There are a number of explanations offered for this phenomenon. These include, for example: (1) despite formal care many elderly have unmet needs which the availability of formal care now permit the informal caregivers to attend to; (2) while formal services may provide care with some of the same activities of daily living as those with which the informal caregiver provides assistance, the informal care is enhanced by the formal services (e.g., by sharing some of the physical tasks, by allowing more flexibility in the informal care’s use of time, by sustaining affective bonds between family members through alleviating the stress associated with caregiving thereby facilitating the ongoing commitment to care, etc.), and (3) the caring task is so large that modest amounts of informal care do not change the perceived scope of the burden.

This suggests that attempts to ease the temporal burden of care borne by all primary informal caregivers may not be relevant as a goal for community long-term care insurance schemes. Rather, the focus should be on formal and informal caregivers working cooperatively to reduce the unmet needs of disabled elderly residents living in the community.

3. **Quality of Care**

Quality of services may be measured in several ways. For example, it may be measured in terms of availability and coverage of the service, changes in the client’s functioning and physical condition, the relationship that develops between the client and service provider, and client satisfaction. According to most of these measures, the Long-Term Care Insurance Law has led to improvement in service quality. A comparative study of the status of the frail elderly before and after implementation of the law found that, among elderly clients who received additional services as a result of the law, there was a decrease in the quantity of need that remained to be addressed. In the same study, elderly respondents reported an improvement in the response to their needs and in their general well-being as a result of the services they received. They also reported a feeling of heightened security as a result of receiving the
services (Brodsky and Naon, 1993). In addition, 76% of the clients reported that their personal care plans were fully implemented and 87% reported that their home care workers came to visit them according to the care plan. Coverage of service hours (the ratio of hours of service to which a client is eligible and the hours of service actually delivered) was very high (Schmid, 1998). Clients reported that placement of home care workers and responses to complaints were rapid and efficient. They also reported a high level of adaptation of the home care worker to their needs.

Client satisfaction with the services they received was also high. Clients were especially satisfied with their relationship with the home care worker (Schmid, 1993a). This supports the previous finding of Eustis and Fischer (1991) that the quality of service is shaped, in large part, by the quality of the relationship between the client and the home care worker. On the other hand, it could be that the high level of satisfaction reported by the clients is attributable to their dependency on the service provider, a dependency which prevents them from complaining about the quality of service, since alternative services are few and limited. In fact, the rate of complaints (another measure of service quality) by the elderly is very low (Schmid and Sabbagh, 1991; Schmid, 1998). The responsiveness of the home care workers and their attentiveness to the needs of the elderly client is also a source of client satisfaction (see also Challis and Davies, 1986; Weisseret et al., 1988; Hughes et al., 1988; Rabiner, 1992).

Based on the measures referred to above, it seems quite clear that over the last decade the quality of home care services, the status of the elderly clients, and their satisfaction with the services they have received have all improved.

Conclusions
The Long-Term Care Insurance Law represents a significant advance in Israeli social legislation. Israel’s law, as well as related provisions in other countries, represents an explicit public acknowledgment of long-term care as a normal risk of growing old.

Israeli legislators sought to ensure that services provided to elderly clients by law are not dependent on state budgets. They also used legal means in an attempt to prevent political and interest groups from changing the goals and mission of the law. This independence is currently tenuous, since various government and nongovernment organizations have sought to introduce certain revisions in the law in light of processes that have occurred during the past decade, which the article describes in detail. The main change was the need to reconsider the type of benefits given to the frail elderly, i.e., cash benefits or services in kind.
Ideas for experiments related to this issue have been proposed by the National Insurance Institute, despite opposition by several organizations, including the service providers.

Considering the impact of the law, it is clear that during the ten years since the enactment of the law, the contracting out strategy adopted by the government has contributed to the sharp growth in the number of provider organizations. This, in turn, has led to rapid expansion in the coverage, volume, range and quality of services provided to the elderly who did not benefit from home care services before the law took effect. The services provided under the law are fulfilling their intended purpose, including alleviation of the burden of family care-giving.

Notwithstanding these important achievements of the law, a number of issues remain to be addressed by policy makers. Some of these issues concern the design of the Long-Term Care Insurance scheme and have been discussed in detail elsewhere (see Borowski and Schmid, 1999). They include, for example, the need to increase the number of service hours - despite the high cost involved - in order to further relieve the care-giving burden borne by families, and to provide for partially physically disabled elderly who, although ineligible for personal benefits, nevertheless need help in maintaining themselves at home.

The increase in hours of care for the elderly will clearly raise the expenses related to financing services that are already in a state of cumulative deficit. The government cannot avoid coping with this problem, and the article has dealt extensively with solutions for covering or reducing the deficit. As mentioned, however, there are still other issues that policy-makers will also have to address in the future, which derive from aspects of the home care industry that have emerged as a result of the law. One issue is the extent of government involvement in the internal processes of the provider organizations and their ability to respond to unmet needs - to move beyond merely providing those services prescribed by and funded under the law. Another issue is the inadequacy of supervision, monitoring and control, both by the government and the service organizations themselves, of the services provided by the home care workers. As Schmid and Sabbagh (1991) and Schmid (1998) have shown, no matter what techniques or methods of organizational control are used by the government or the provider organizations themselves, the frail elderly are still, ultimately, at the mercy of the individual worker who makes the home visits. Steps taken by provider organizations today (such as scheduled and surprise visits to the home of the elderly, telephone calls, etc.) are insufficient to remedy this weakness. More must be done to encourage the elderly and their families,
as well as formal and informal parties in the community (e.g., social workers and nurses), to assess the work of both the home care workers and the provider organizations, to listen to their complaints, and to reduce the vulnerability of the elderly to the service provider as much as possible. The provider organization must be made to feel that the continued demand for its services is dependent upon the desire of the elderly and the family to continue receiving them. Only when the balance of power and dependency changes will service providers do everything possible to improve their services and, thereby, assure their continued existence and inflow of resources. In addition, the service providers must invest more in professional development of the workers, for most of whom home care work is routine, stigmatized, and offers little opportunity for advancement. The lack of suitable working conditions, such as low wages, minimal benefits, and lack of opportunity for advancement, is likely to result in low motivation and commitment, which may affect the continuity and quality of care.

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