המוסד לביטוח לאומי

מינהל המחקר והתכנון

ירושלים, טבת התש"ן, ינואר 1990

דפי דיון מס. 3

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המחלקה לתיעוד
מס' מלאי.........................

המוסד לביטוח לאומי
המחלקה [illegible]
ע"ש ד"ר ג. לוטן, ירושלים

השפעתם של גורמים דימוגרפיים וחברתיים-כלכליים על הצרכים המשתנים של האוכלוסייה הזקנה מאוד*

מאת

ברנדה מורגנשטיין

212.1

* מכנס מומחים של איסס"א בנושא, "התפקיד של הביטחון הסוציאלי במתן טיפול מקיף לזקנים מאוד", אפריל 1989.

ירושלים, טבת התש"ן, ינואר 1990

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ה ק ד מ ה

כנס המומחים של איסס"א בנושא, "תפקיד של הביטחון הסוציאלי במתן טיפול מקיף לזקנים מאוד" נערך בירושלים באדר ב' התשמ"ט, אפריל 1989. המוסד לביטוח לאומי אירח את הכנס. נכחו בו 70 נציגים של הארגונים חברי איסס"א מ-23 מדינות, נציגים של ארגון הבריאות הבינלאומי ושל המוסד האירופאי לביטחון סוציאלי וכן חברי מזכירות איסס"א.

ישראל התכבדה בהצגת מאמר רקע לפתיחת הכנס, ודומתני שיש הסכמה מלאה בין כל המשתתפים, כי הכנס היה פורה ביותר, שכן העלה בפני כולם שאלות בעלות עניין משותף, הן באמצעות הדוחו"ת הרשמיים והן על ידי הערות המשתתפים, ואף בשיחות הבלתי-פורמליות שהתנהלו במשך ימי הכנס.

הפרסום הנוכחי כולל את המאמרים שהורצו בשלבים השונים של הכנס. מאמר הרקע שהופץ לפני הכנס, הרצאת הפתיחה והערות הסיכום בסופו מופיעים להלן באנגלית המקורית בלבד, ואילו הרצאת הפתיחה והסיכום תורגמו לעברית.

ברנדה מורגנשטיין
מנהלת מחלקת מחקר בגמלאות
ארוכות מועד

ה ר צ א ת   פ ת י ח ה*

* על פי מאמר הרקע (background paper) שהוכנה לכנס והופצה בו.

אחת הבעיות החריפות ביותר הניצבות היום בפני מגזרי הבריאות והרווחה היא כיצד להבטיח מתן מענה לצרכים הגוברים של האוכלוסייה הקשישה. ברוב הארצות ההוצאה לנפש בקבוצת הזקנים מאוד כבר גדולה יותר מאשר ההוצאה לנפש בכל קבוצת גיל אחרת. יש להניח שככל שמספר הקשישים הולך וגדל, הם יצרכו בפרופורציה משאבים רבים יותר מכפי שיצרכו הגילאים הצעירים יותר.

המדינות המערביות המתועשות נתונות היום ללחץ כבד לצמצם את ההוצאות להבטחת הכנסה ולתוכניות בריאות ורווחה. עם זאת חלקם של הקשישים, במיוחד של הזקנים מאוד, באוכלוסייה, הולך וגדל, והוא צפוי לגדול עוד במשך השנים הקרובות. במקביל, יגברו הלחצים להעניק טיפול לקשישים הפגיעים.

תופעת האוכלוסייה המזדקנת מציינת הן ארצות מתפתחות והן ארצות מפותחות. ברוב הארצות האוכלוסייה הזקנה גדלה בקצב מהיר יותר מאשר האוכלוסייה בכללותה. לפי דו"ח ה-WHO משנת 1987, בשנים 1980 עד 2020 האוכלוסייה הכללית של העולם המתפתח צפויה לגדול ב-95%, ואילו אוכלוסיית הזקנים בני ה-65 ויותר תגדל ב-240%. הגידול המהיר ביותר צפוי בעשורים השני והשלישי של המאה הקרובה.

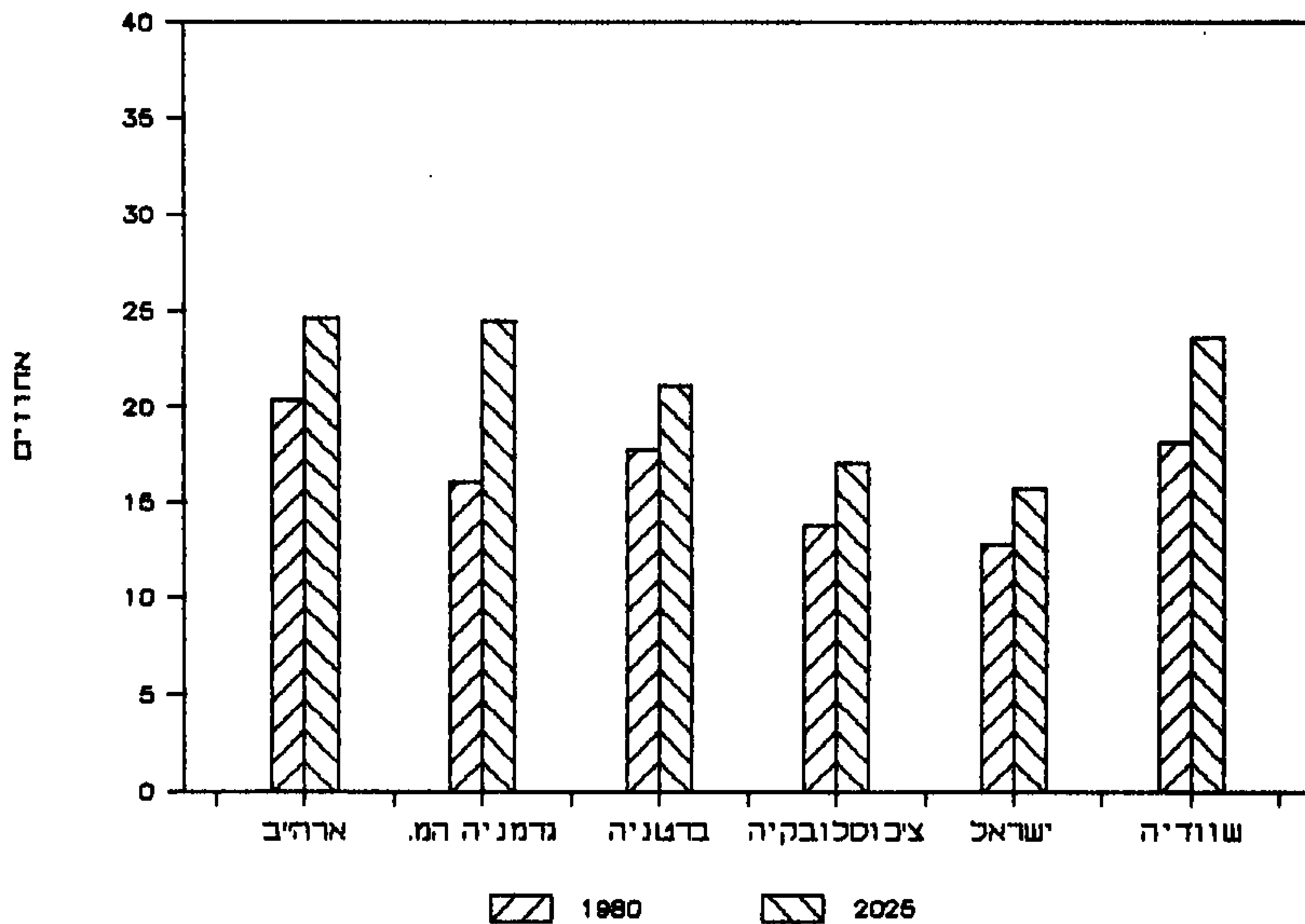
הקשישים שמספרם, כאמור, גדל במאה הנוכחית באורח מתמיד, היו בשנת 1980 כ-5.7% מאוכלוסיית העולם, ובשנת 2025 הם צפויים למנות 9.5% ממנה. באזורים מפותחים יותר, חלקם של בני ה +65 יהיה בממוצע 17.3% מהאוכלוסייה הכללית, ובארצות צפון-אירופיות ומערב-אירופיות מסוימות, כגון דנמרק, הולנד, גרמניה המערבית ושוודיה, חלק זה יהיה גדול מ-22%. יש לציין כי האוכלוסייה המזדקנת בקצב המהיר ביותר היא אוכלוסיית יפן.

תרשים מס. 1: <u>השיעור של בני ה +65 באוכלוסיה כולה</u>

תוחלת החיים בגיל 65 הולכת וגדלה, היא צפויה להגיע בארצות הברית בשנת 2035 ל-82 שנים בהתייחס לגברים ול-87.3 שנים בהתייחס לנשים. הספרות העוסקת בזקנים מאוד בדרך כלל מתייחסת לאלה שגילם עולה על 80 או על 85. לשון אחרת, ככל שבני אדם חיים עד גיל גבוה יותר, האוכלוסייה הזקנה לא רק הולכת וגדלה, אלא גם הולכת ומזדקנת. למעשה, הגידול יתבטא בעיקר בקבוצת בני ה-80 ויותר, ובארצות מסוימות (כגון גרמניה, דנמרק, אוסטריה ושוודיה) קבוצה זו תמנה כמעט רבע מהאוכלוסייה הקשישה.

ירידת התמותה הודות להתקדמות טכנולוגית ורפואית עתידית עשויה להשפיע לכיוון גידול נוסף באוכלוסיית הזקנים מאוד. אם תוחלת החיים תעלה עוד בעקבות תגליות חשובות בתחום הטיפול במחלות, כגון סרטן ומחלות לב, אזי התצפיות הנוכחיות בעניין גידול האוכלוסייה הקשישה הן בעצם הערכות חסר, ועוד ועוד אנשים יאריכו ימים עד שנות ה-80, ה-90 וה-100 לחייהם.

תרשים מס. 2: <u>השיעור של בני ה +80 באוכלוסייה הקשישה</u>



למעשה, מערכת הבריאות שלנו הולכת ומצליחה להחזיק בחיים אנשים חולים במחיר גבוה מאוד. יתכן, שאנשים החיים על הכנסה שלאחר פרישה ועל נכסיהם לא יוכלו לשאת בנטל הוצאות צפויות מסוג זה, שלכן הולכות ונתפסות כשייכות לתחום האחריות הממשלתית והציבורית. האם גישה זו ריאליסטית מבחינה פיננסית? האם ממשלות יכולות לתכנן מדיניות ולבנות תוכניות על פי תחזית של מחירים עולים בלי לשקול ברצינות אופציות אחרות, שחלק מהן אולי סותר עקרונות קודמים של הביטחון הסוציאלי?

לוח מס. 1 - סך הכל ההוצאה הציבורית על הקשישים וכאחוז מהתוצר הלאומי הגולמי, וסך כל הוצאות בריאות הציבור על הקשישים וכאחוז מהתוצר הלאומי הגולמי, במדינות נבחרות

מדינה	שנה	סך כל ההוצאה הצבורית על קשישים, לנפש		סך כל הוצאות בריאות הציבור על קשישים	
		סכום	% מהתל"ג	סכום	% מהתל"ג
ארה"ב	1981	6,366	5.9	1,212	1.1
קנדה	1982	6,096	5.4	1,370	1.2
דנמרק	1980	8,499	10.1	2,356	2.8
צרפת	1980	7,993	9.8	1,876	2.3
הולנד	1982	7,861	8.2	1,534	1.6
נורווגיה	1981	5,005	5.7	2,546	2.9
שוודיה	1982	12,293	14.5	*	*
הממלכה המאוחדת	1980	4,416	7.7	975	1.7

המקור: הסנט שבארה"ב (1984). הנתונים הם בדולרים של ארצות הברית.
* אין נתונים.

לפי ההערכות, ההוצאה הציבורית על בריאות לנפש מאוכלוסיית הקשישים בשנת 1984 נעו מ-$1,200 בארצות הברית ליותר מ-$2,000 בארצות הסקנדינביות. אפשר אפוא לראות, שההוצאה הציבורית על בריאות קשישים כחלק מן התל"ג שונה מארץ לארץ ומגיעה עד 3% בנורווגיה. ההוצאה הציבורית הכוללת לנפש מהקשישים נעה מ-5.4% בקנדה עד 14.5% בשוודיה. בארצות הברית, לדוגמה, החלק מהתקציב הפדראלי שמוקצה לתוכניות עבור קשישים הוכפל מאז שנת 1960. יתר על כן, הוצאות הבריאות הגבוהות ביותר הן בגיל הזקנים מאוד, שהם נושא כנס זה.

השאלות העיקריות הנובעות ממגמות התפתחות דמוגרפיות בהווה ובעתיד הדורשות מדיניות והנדונות בכנס זה הן:

א. האם הזדקנות האוכלוסיה תגרור אחריה באורח אוטומטי גידול משמעותי בהוצאה הציבורית על בריאות ועל רווחה, במיוחד של הזקנים מאוד? האם הגידול הצפוי בהוצאה זו ינבע ישירות מגידול האוכלוסיה ומגידול היקף השירותים הניתנים בדפוסים הנוכחיים, או שמא אפשר יהיה לענות על צרכים בעלות מבוקרת, כלומר לפי מדיניות המגבילה פרמטרים מסוג רמת הכיסוי, רמת הגמלה, הפיקוח על היצע המיטות המוסדיות והרחבת חלקו של הסקטור הפרטי?

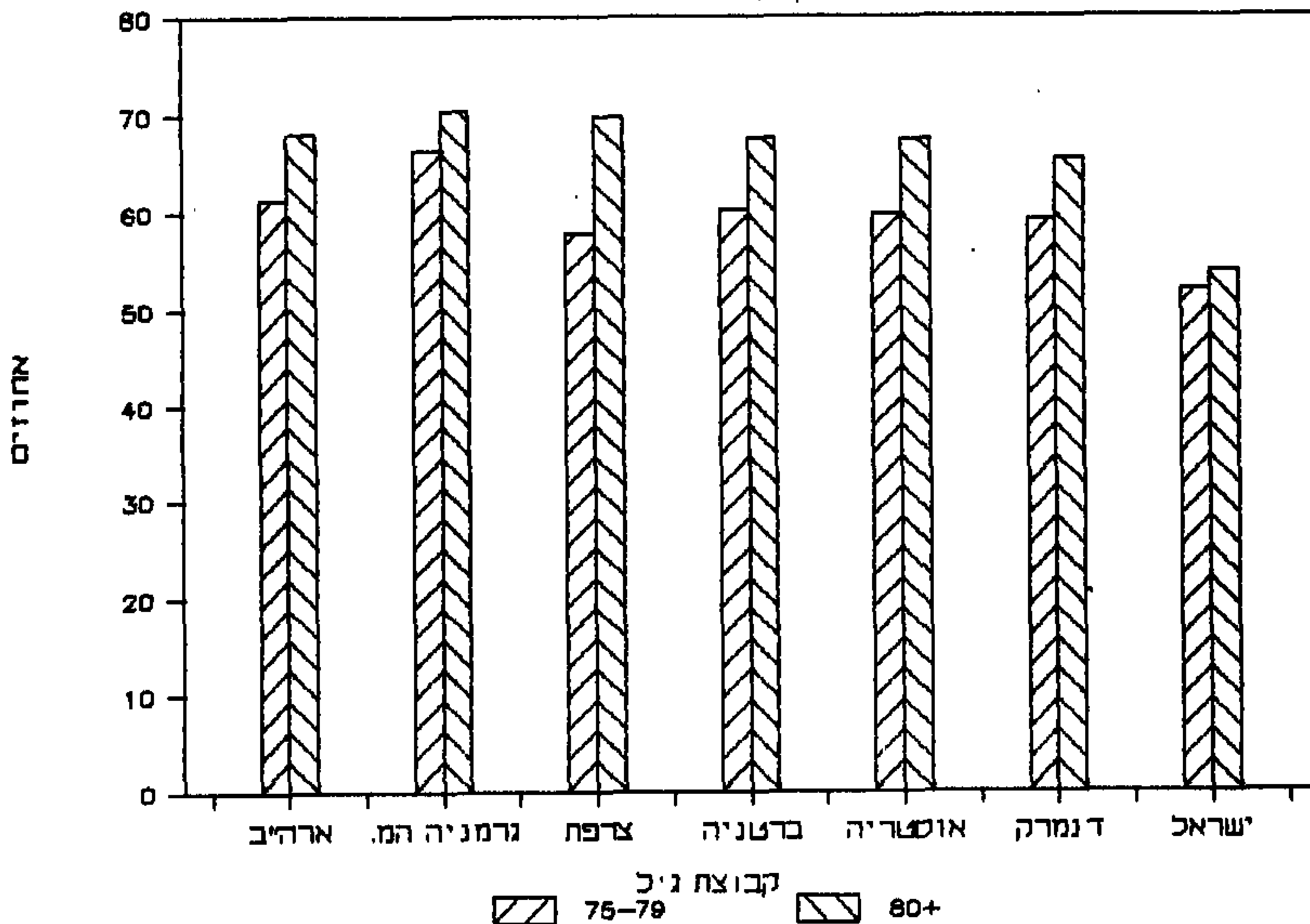
ב. אלו קבוצות בקרב הזקנים מאוד ידרשו שירותים שונים או תוכניות שונות? האם התוכניות אמורות לענות על צרכים חריפים של קבוצות קטנות בלבד, כגון המוגבלים מאוד, הפגיעים מבחינה קוגניטיבית, העניים ואלה שחסרים תמיכה משפחתית; או שמא התוכניות אמורות לספק טיפול וסיוע בסיסיים לקבוצה רחבה יותר של זקנים מאוד?

ג. אלו מן השירותים יכולים או צריכים להינתן במסגרת זכאות לביטחון סוציאלי, ואלו מהם צריכים להשאר במסגרת תוכניות סעד שלא על בסיס זכאות כללית, להינתן כטיפול בלתי פורמלי, או על ידי השוק הפרטי? מה האיזון הרצוי בין טיפול פורמלי לבלתי פורמלי, ובין טיפול פרטי לציבורי? אלו אילוצים כלכליים וחברתיים ישפיעו על האיזון האופטימלי בין סקטורים אלה?

ד. בדומה, מה האיזון הרצוי בין טיפול קהילתי לטיפול מוסדי, וכיצד אפשר להגיע לאיזון זה על ידי התמריצים הכלולים בתוכניות המתבצעות במימון ציבורי?

ה. השאלה, שכל מדינה תצטרך לתת עליה את הדעת היא, האם הגידול הצפוי בהוצאות הבריאות והסיעוד יעלה על הגידול הכלכלי הריאלי? האם החברה, בעיקר האוכלוסיה העובדת, תהיה מוכנה או מסוגלת לשאת בנטל הפיננסי הנוסף? איזו מדיניות כלכלית תבטיח צמיחה כלכלית בד בבד עם צמצום הוצאות?

תרשים מס. 3: השיעור של נשים, לפי קבוצות גיל



הזקנים מאוד, כקבוצה, נבדלים היום מהזקנים הצעירים יותר במספר דברים. אזכיר בקצרה כמה מהם:

א. כצפוי, בקבוצה זו יש שכיחות יותר של התחלואה והתמותה. יתר על כן, בארצות דוגמת גרמניה ויפן שיעור התמותה של גברים זקנים גבוהים ב-40% מאלה של הנשים.

ב. לכן בקרב בני ה-80 ויותר יש יחס מספרי מיוחד בין המינים, שמתבטא ביתרון גדול של הנקבות על פני הזכרים. מספר הנשים הזקנות גדול בהרבה ממספר הגברים הזקנים ברוב ארצות העולם, ואחוז הנשים גדל ברציפות עם כל קבוצת גיל, במיוחד באזורים עירוניים. בארצות מפותחות חלק מהנשים בקבוצת בני ה+80 מגיע ל-70%. לכן הבעיות החברתיות, הכלכליות והבריאותיות של הזקנים מאוד הן בעיקר בעיות של נשים.

ג. כתוצאה מכך, בקרב הזקנים מאוד גדולה יותר שכיחותם של אלמנות ושל מגורים לבד, ובצדם - של בדידות;

ד. בקרב הזקנים מאוד רמת ההשכלה נמוכה יותר, ואף

ה. רמת ההכנסה נמוכה יותר.

ו. נעשה שימוש רב בשירותים יקרים, במיוחד שירותים רפואיים דיאגנוסטיים ובשירותי טיפול בבתי חולים ובמוסדות סיעודיים. שיעור ימי האשפוז ל-1,000 נפש, לדוגמה, בקרב בני ה +85 כפול מזה שבקרב הזקנים הצעירים יותר. שיעור דיירי המוסדות הסיעודיים מהגברים בקבוצה הראשונה גבוה פי 11 מאשר הגברים שבקבוצה השנייה, ובקרב הנשים - פי 16, בהתאמה.

ז. שיעור התלות בביצוע פעולות יום-יום כמו ניידות, הלבשה, רחיצה וניקיון אישי גבוה יותר. למרות שההגדרות השונות מקשות על עריכת השוואה מדוייקת, ממחקרים שנערכו בישראל ובארצות הברית אפשר ללמוד שכ-7%-8% מהקשישים הגרים בבית זקוקים לעזרה משמעותית מהזולת לשם ביצוע פעולות יום-יום (ADL). שיעורי תלות אלה גדלים בתלילות עם הגיל, והם מגיעים לכ-25% בקרב בני ה +85.

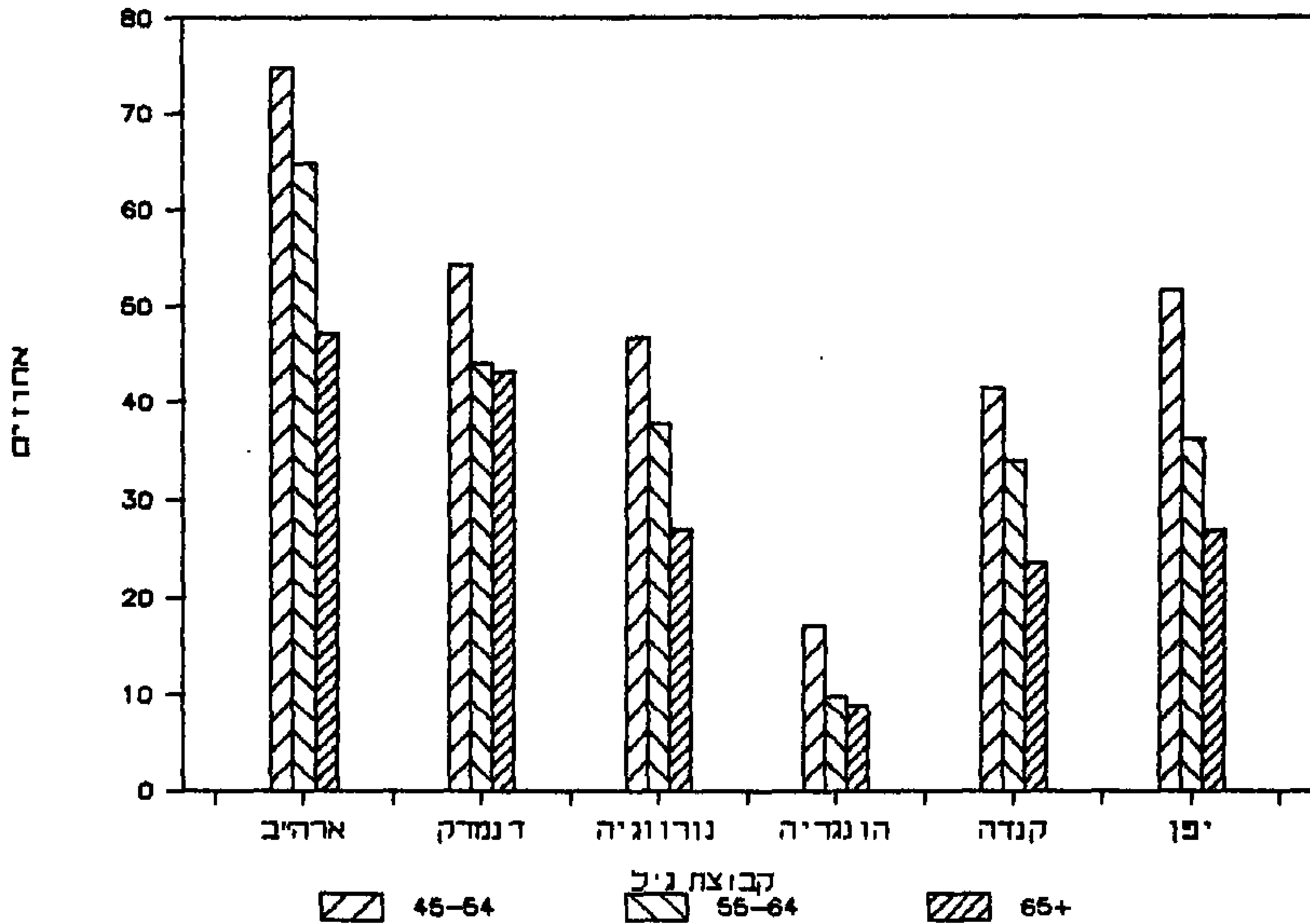
ח. כתוצאה מכך, לזקנים מאוד אופיינית תלות גדולה במשפחה לצורכי טיפול אישי וטיפול במשק הבית.

למרות תכונות כלליות אלה, אחת הסיבות הטובות לעריכת כנס מיוחד בנושא הזקנים מאוד היא דווקא אי היות אוכלוסייה זו הומוגנית או סטטית. אנו נוהגים להתייחס לקשישים כאל קבוצה אחת שטווח גילית בן כ-35 שנים, למרות ששונות רבה מציינת בפועל קבוצה זו. לשונות זו יש לתת את הדעת בזמן תכנון מדיניות בתחום הביטחון הסוציאלי.

נוסף על הרב גוניות של המחזורים הנוכחיים של הזקנים מאוד, טיבה של אוכלוסייה זו משתנה במשך הזמן. על מנת לדייק בתחזיות לגבי קבוצות עתידות, שומה עלינו להתייחס כבר למחזורים הצעירים יותר. לדוגמה, בעתיד בני ה+80 יהיו בעלי רמת השכלה גבוהה יותר. במחזורים צעירים יותר הפרופורציה של בעלי השכלה תיכונית עולה בהתמדה - הן בקרב נשים והן בקרב גברים. כתוצאה מכך יש לצפות, שקבוצות מסוימות ייהנו מרמת הכנסה גבוהה יותר ומבריאות טובה. יתר על כן, הגורמים המשתנים: מצב משפחתי, יחסי קירבה בבית וסידור מגורים חשובים מאוד לקביעת הטיפול הפורמלי והבלתי פורמלי ולעזרה שהזקנים מאוד נעזרים בטיפול הסיעודי, והם עצמם מושפעים

מגורמים כגון: אורח חיים, שיעורי ילודה וגירושין והשתתפות הנשים ההולכת וגדלה בכוח העבודה.

תרשים מס. 4: <u>השיעור של הגברים בעלי השכלה תיכונית, לפי קבוצות גיל</u>



אלו גורמים נוספים יש לקחת בחשבון בעת הגדרת צורכי הזקנים מאוד ובעת בדיקת אופציות של מדיניות כדי להתמודד עם לחצים להוצאות גבוהות יותר על הרחבת תוכניות?

יש להדגיש שהגדרת הצרכים וכן תכנון השירותים נובעים בהכרח מגישות שונות שמציינות כל חברה. אלה מתבטאות במבניה החברתיים והפוליטיים, במערכת הכלכלית שלה, במסורת השירותים המסופקים על ידה, בציפיותיה, בטיב התחלקות האחריות בין גופים ממשלתיים וציבוריים שונים, במערכות המימון, בתפקוד הסקטור הפרטי, ביעדים לטווח הקצר והארוך, באילוצים וביעדי מדיניות ספציפיים. ככם זה בוודאי ישקף הבדלים אלה בין החברות השונות.

ציור מס. 1: הגורמים המשפיעים על צרכים ותוכניות לקשישים

א. גורמי רקע

דמוגרפיים

- נתוני אוכלוסין
- מבני גילאים בעבר וחזויים לעתיד
- יחסי גיל/מין
- התפלגויות גיאוגרפיות
- דפוסי הגירה
- שיעורי תמותה, תוחלת חיים לקבוצות גיל
- שיעורי פריון
- שיעורי תחלואה

שיעורי התלות בפעולות יום-יום

חברתיים

- גודל המשפחה
- מצב משפחתי, שיעורי גירושין
- סידורי מגורים (במיוחד % הגרים עם בן/בת זוג ו-% הגרים לבד).
- רמות השכלה
- תפקידן המסורתי של נשים
- מגמות השתתפות נשים בכח העבודה
- דפוסי טיפול בלתי פורמלי
- ציפיות משתנות לשירותים, עדיפויות
- גיל פרישה
- מספר ילדים, קירבת מגורים

כלכליים

- מערכת כלכלית ספציפית
- מבני מס
- יחסי תלות/גיל
- גידול החל"ג
- שיעורי האינפלציה
- הוצאות על בריאות ורווחה (לפי קבוצות גיל)
- מצבים כלכליים של קשישים
- עלויות ישירות לקשיש על טיפול
- שיעורי השתתפות בכח עבודה של קבוצות ספציפיות: קשישים, נשים

ב. דפוסים נוכחיים של היענות לצרכים

א. סוג השירותים והגמלאות הכלכליים, בריאותיים וחברתיים (העברות כספיות ובעין)
ב. כיסוי: שיעורי מיסוד והספקת טיפול ביתי
ג. הלימות, כיסוי והבשלת תוכניות לבטחון סוציאלי ופנסיה מעבודה
ד. מבני מימון וחלוקת אחריות
ה. תפקיד הסקטור הפרטי

ג. נושאי מדיניות

- משאבים זמינים, פרטיים וציבוריים
- יציבות כלכלית וצמיחה
- כיסוי אוניברסלי לעומת גישה סלקטיבית, פלוריסטית
- דאגה לאיכות
- הרכב שירותים פרטי/ציבורי
- שיקולי עלות/תועלת של טיפול ביתי לעומת מוסדי
- אלטרנטיבות מימון, כמו חלוקת עלויות, רה-ארגון של הוצאות, הפחתות סלקטיביות ברמות הגמלה, שינויים בגיל הפרישה, וכו'.

ד. יעדי תוכניות

בטחון כלכלי	מניעה ושמירה על בריאות	טיפול מרפא/משקם	סיעוד
שכר, חסכונות	בריאות הציבור	טיפול רפואי ראשוני	טיפול אישי בבית
בטחון סוציאלי	אמצעים לבטיחות אישית	טיפול אקוטי בבי"ח	טיפול יום למבוגרים בקהילה
פנסיות מעבודה	תמיכות חברתיות	שיקום	טיפול מוסדי
דיור		תמיכות חברתיות	

הספרות המתייחסת להערכת סוגי הצרכים של הזקנים מאוד ולהיקפם - או לדרישה לשירותים - על פי רוב מתמקדת בעיקר בנתונים דימוגרפיים של האוכלוסייה בעבר ובאומדנים לגבי העתיד.

בתיאור הרקע שהכנתי ניסיתי להציג מודל בעל גורמים נוספים הקשורים זה בזה, שאפשר לקחתם בחשבון בעת תכנון. למעשה, גורמים אלה נותחו בישראל בקפדנות רבה בזמן עבודת הכנתו של חוק ביטוח סיעוד, שאותו אתאר ביתר הרחבה בהמשך.

מודל זה מציע מספר גישות לתכנון טיפול מקיף במסגרת הביטחון הסוציאלי:

א. בדיקת יחסי הגומלין בין המשתנים הדימוגרפיים, החברתיים והכלכליים בגישה פלורליסטית, במקום התייחסות לקשישים כאל קבוצה אחת. גישה זו מאפשרת לתת את הדעת לצרכים של קבוצות שונות באוכלוסית הקשישים, שלא כולן יזדקקו לשירותים במימון ציבורי. היא אף דרושה לאיתור הרב-גוניות של האוכלוסייה המבוגרת ושל קבוצות יעד בעלות צרכים אקוטיים ספציפיים. חשוב שכל חברה תקבע לעצמה אלו מגורמים דימוגרפיים חברתיים וכלכליים אלה הם אילוצים בלתי נמנעים המחייבים את המערכת, ואלו אולי ניתנים לשינוי.

ב. על כל חברה לבדוק את האפשרות לשנות דפוסים נוכחיים של היענות לצרכים, כגון: האיזון בין טיפול מוסדי לטיפול לא-מוסדי, ותפקיד הסקטורים הפרטיים והבלתי פורמליים. שינוי כזה ישקף בכל חברה יעדי מדיניות כפונקציה של מערכות חברתיות ופוליטיות, של חלוקת אחריות בין גופים ממשלתיים שונים, מסורות, עדיפויות, וכן של התייחסות לעלויות, למערכות מימון ולתפקיד השוק הפרטי.

ג. יש לבדוק את מגוון היעדים של מימון ופיתוח תוכניות שחלקן אולי סותרות מגמות מסוימות במסורת פיתוח מדיניות הביטחון הסוציאלי, ואת האופציות האפשריות למימושם. אופציות אלה חייבות להציע אלטרנטיבות לפחות בארבעה תחומים בסיסיים, הקשורים זה לזה והיוצרים רצף של טיפול: ביטחון כלכלי ודיור; מניעה ושיפור בתחום הבריאות; טיפול מרפא כולל שיקום; שירותי אחזקה או סיעוד. בהוצאה או בחיסכון אין להתמקד בתחום אחד בלבד, בלא התייחסות לתחלופות בתחום אחר.

ד. חיוני לקבוע סדר עדיפויות להקצאת המשאבים לתחומי התערבות אלה. משמעות הדבר - במיוחד מבחינת הביטחון הסוציאלי - היא מציאת איזון בין תוכניות להבטחת הכנסה לבין תוכניות לאספקת שירותים, וכן קביעת גבולות בין תוכניות העומדות על עיקרון הזכאות לבין אלה שאינן עומדות
על עיקרון זה.

לוח מס. 2 - שיעורי העוני* בקרב קשישים בני +65 ובסך כל האוכלוסייה במדינות נבחרות

מ ד י נ ה	בני 65-74	בני +75	סך כל האוכלוסייה
קנדה	11.2	12.1	12.1
גרמניה המערבית	12.7	15.2	7.2
ישראל	22.6	27.1	14.5
נורווגיה	2.7	7.3	4.8
שוודיה	0.0	0.0	5.0
הממלכה המאוחדת	16.2	22.0	8.8
ארצות הברית	17.8	25.5	16.9
ממוצע	11.9	15.6	9.9

* מוגדר כאנשים השייכים למשפחות בעלות הכנסה נקיה מתחת לממוצע עבור כל המשפחות במדינה הספציפית.

המקור:
Luxembourg Income Study מבוסס על .(1985) Heldstrom and Ringen

אחד המשתנים שבהכרח קובע את גודל האוכלוסייה הזקוקה לטיפול במימון ציבורי הוא הכנסה. על פי הנתונים, סיכוי לעוני בדרך כלל גבוה בקרב בני ה+75 יותר מאשר אצל קבוצות צעירות יותר. בתחום זה יש הבדלים ניכרים בין המדינות - בשוודיה, לדוגמה, כלל עוני בקבוצת גיל זו. מחקרים דוגמת ה-LIS, שבמסגרתם נאספים נתונים על פי הגדרות אחידות לאורך זמן, יאפשרו לנו לעקוב אחר שינויים במצבם הכלכלי של הקשישים בארצות שונות. הכנסת הקשישים עשויה לגדול עם הבשלת תוכנית הביטוח הסוציאלי ופנסיות הקשורות לעבודה, הודות לנכסים מצטברים ולגמלאות פרישה גבוהות יותר. עם זאת, אנחנו זקוקים לנתוני הכנסה טובים יותר של דורות הקשישים בעתיד. על מנת לחזות מראש מה יהיה מצבם הכלכלי של בני ה-85 בשנת 2020, עלינו לבחון את אלה שהיום הם בני 50, ולבדוק כיצד הם משפיעים עליהם גורמים כגון: כיסוי תוכניות פנסיה, עבר תעסוקתי, דפוסי שכר, תמורות בהשתתפות נשים בכוח העבודה וכו'. במדינות דוגמת אנגליה וארצות הברית מצבם הכלכלי של הקשישים, על פי הכנסה ונכסים (בעיקר ערך הבית), צפוי להשתפר במידה ניכרת עד שנת 2020.

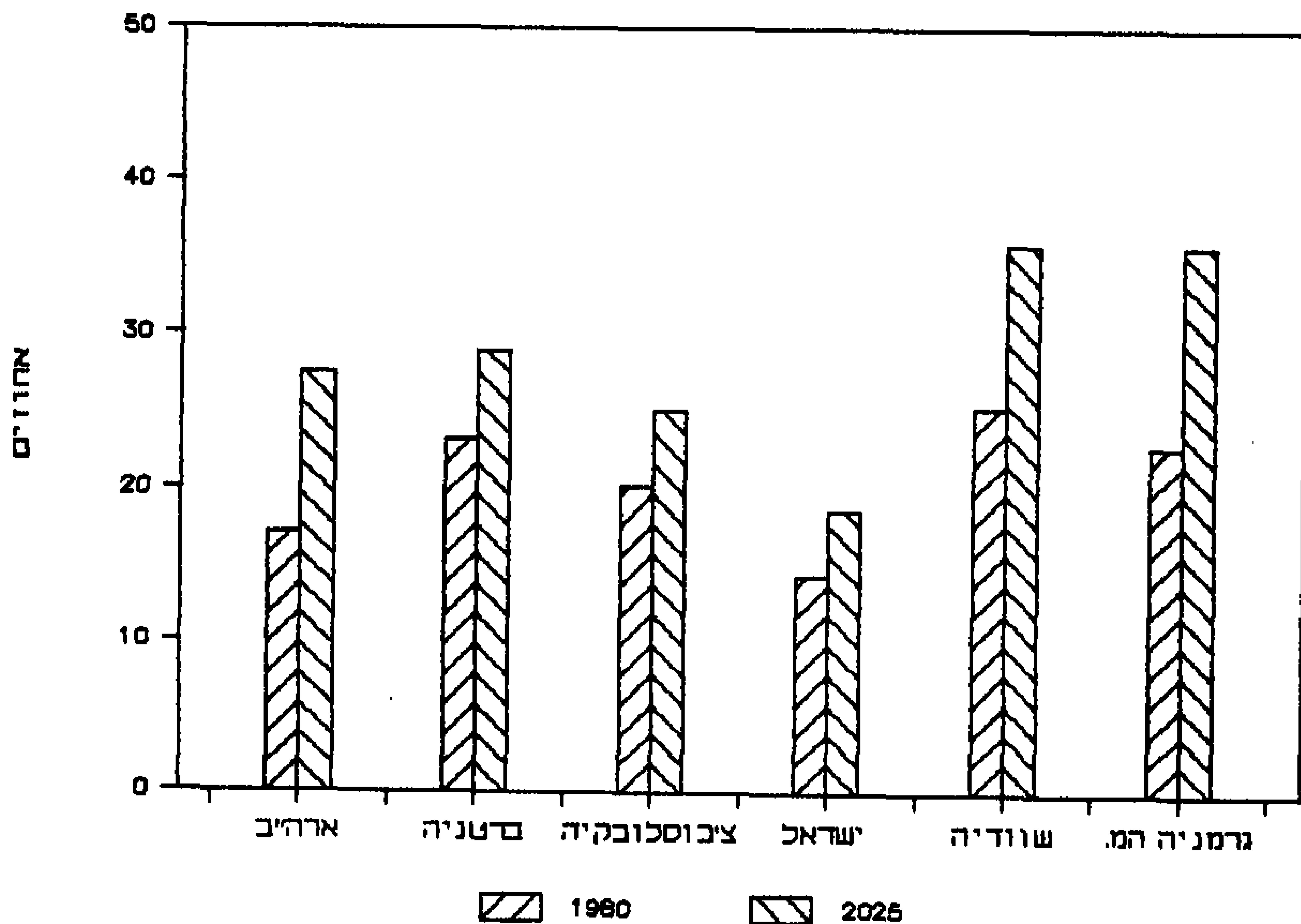
אך זאת - על סף הפרישה. מניתוחי חתך ידוע לנו רק מעט על השינויים החלים בדפוסי ההכנסה וההוצאה במשך תהליך ההזדקנות עצמו, ובמיוחד על הידלדלות המשאבים לאורך זמן. אלה דורשים מחקר. אמנם ידוע, שככל שהגיל עולה מצטמצם היקף הרכישות הבסיסיות, אך לא ידוע - ואף קשה לחזות - את ההוצאות על בריאות, על טיפול רפואי וכו'. מנקודת מבט של מדיניות השאלה היא, האם לדורות הבאים של הזקנים מאוד תהיה אפשרות לשלם עבור חלק גדול יותר מהוצאות הבריאות הגבוהות שלהם, או שמא משאביהם יאזלו בטרם יגיעו לגיל מתקדם.

נתונים על הידלדלות נכסים לאורך זמן רלוונטיים אפוא ביותר כאשר מנסים לשקול בזהירות ובאורח מציאותי את שאלת ההתחלקות בהוצאות ואלטרנטיבות אחרות של אספקת טיפול רפואי וסיעודי לזקנים מאוד. תוכניות המבוססות על השתתפות בהוצאות לא תוכלנה לצאת לפועל אם משאביהם של האמורים להשתתף בהן יאזלו.

הבה נבחן בקצרה אילוץ כלכלי בעל זיקה להזדקנות האוכלוסייה ולפוריות, המשפיע על הגדרת צרכים ועל אפשרותנו לשאת בעלות כיסוי צרכים אלה: יחס תלות, המוגדר כיחס האוכלוסיה בגיל +65 אל אלה שבני 15-64, כפול 100.

להזדקנות האוכלוסייה יש השלכות חשובות על גודל האוכלוסייה העובדת ועל המבנה הגילי שלה וכן על היחס בין אוכלוסיית בני ה+65 לאוכלוסיית בני ה-15-64.

תרשים מס. 5: יחס התלות* בארצות נבחרות



* מוגדר כיחס האוכלוסיה בגיל +65 אל אלה שבני 15-64, כפול 100.

על פי דו"ח של OECD שפורסם לאחרונה, עד העשור השני של המאה הבאה מספר האנשים בגילי העבודה צפוי לרדת כמעט בכל המדינות המתועשות. כפי שאפשר לראות בתרשים מס. 5, המייצג רק ארצות ספורות, יחס התלות צפוי לעלות בכל האזורים העיקריים בעולם. העליה הדרמטית ביותר צפויה בארצות המפותחות יותר ובאסיה המזרחית. ככל שאנשים יחיו שנים רבות יותר וככל ששיעורי תמותה הולכים וקטנים, כך יתגברו הקשיים הכרוכים בתמיכה הניתנת במסגרת תוכניות ביטחון סוציאלי מקיפות. ככל שההוצאות תעלינה וככל שחלקה היחסי של האוכלוסיה בגיל העבודה קטן, תצטרכנה מדינות העולם להתמודד עם עול פיסקלי הולך וגדל.

אולם, במספרים עצמם אין כדי לתת תמונה שלמה אודות התפוקה הכלכלית של שתי קבוצות הגיל האמורות, או על מידת יכולתו של המשק לשאת בעלויות הצפויות. למעשה, הקשיים עלולים להצטייר אף כחמורים יותר כאשר לוקחים בחשבון גם את רמות האבטלה, שממילא גבוהות במספר ארצות ושקשה לחזותן מראש.

אך מצד שני, עלינו לזכור, שיחס התלות משקף את נטל התמיכה באלה שאמנם אינם עובדים אך שלא בהכרח אין הם פרודוקטיביים, היות שלא כל תפוקה אפשר למדוד במונחים כמותיים. צורת התייחסותם של החברה ושל הפרט לנטל הטיפול קשורה לא רק לנתוני האוכלוסין ולהוצאה, אלא גם לגורמים נוספים. אחד מהם הוא גישת החברה לזקנים והערך שהיא מייחסת לתפקידיהם כצרכנים, כבני משפחה תורמים, כמתנדבים וכיו"ב.

היבט נוסף של נטל הטיפול בקשישים, שאינו נמדד במונחים כלכליים או ביחסי תלות דימוגרפיים, הוא המעמסה הממשית המידית הנופלת על המשפחה. בעת תכנון הטיפול המקיף בזקנים יהיה על כל חברה להחליט מה חלקה של המשפחה בכל טיפול הצפוי, שכן לחלק זה יש השלכות מעשיות על סוגי התוכניות שיש לפתח.

כמה מהגורמים העשויים להשפיע על דפוסי הטיפול הבלתי פורמלי, על ציפיות המשפחה ועל השימוש בשירותים, כבר צויינו בספרות, ואובחנו כמשפיעים על סוגי התוכניות שפותחו בחברות שונות, ויותר מכל על האיזון בין טיפול פורמלי לבלתי פורמלי ובין טיפול קהילתי למוסדי. על גורמים אלה נמנים: שיעורי הפריון במחזורים השונים, שיעורי הגירושין (שיש להם השלכה על מספר הילדים המסוגלים לתת טיפול בלתי פורמלי), מצבם המשפחתי של הקשישים (היות/אי היות בן/בת זוג מטפל/ת) והשתתפות הנשים בכוח העבודה (המתחרה במתן טיפול בלתי פורמלי בבית). על אלה יש להוסיף את צורת המגורים (כגון מגורים לבד), את המצב הכלכלי ואת רמת ההשכלה, שכולם משפיעים לא רק על הצורך בטיפול פורמלי ובלתי פורמלי אלא גם על הציפיות לגבי סוגי התוכניות שיש לפתח ועל האפשרות לשלם בעד שירותים.

גם המחקר וגם הניסיון ממשיכים ללמד, שהמשפחה היתה וממשיכה להיות ספק השירותים העיקרי לקשישים. מחקרים העלו, שלפחות 80% מהקשישים התלויים באחרים (לשם ביצוע פעולות פונקציונאליות יום-יומיות) מקבלים טיפול מבני משפחה. למעשה, כאשר בוחנים את הזכאים לקבלת שירותים במסגרת חוק ביטוח סיעוד בישראל, או את מקבלי השירותים במדינות אחרות (כגון במסגרת התוכנית להמשך טיפול במניטובה שבקנדה), מתברר ששירותי הסקטור הפורמלי מנוצלים ביעילות רק כשאחד מבני המשפחה נמצא בתמונה והוא האחראי על תיאום השירותים.

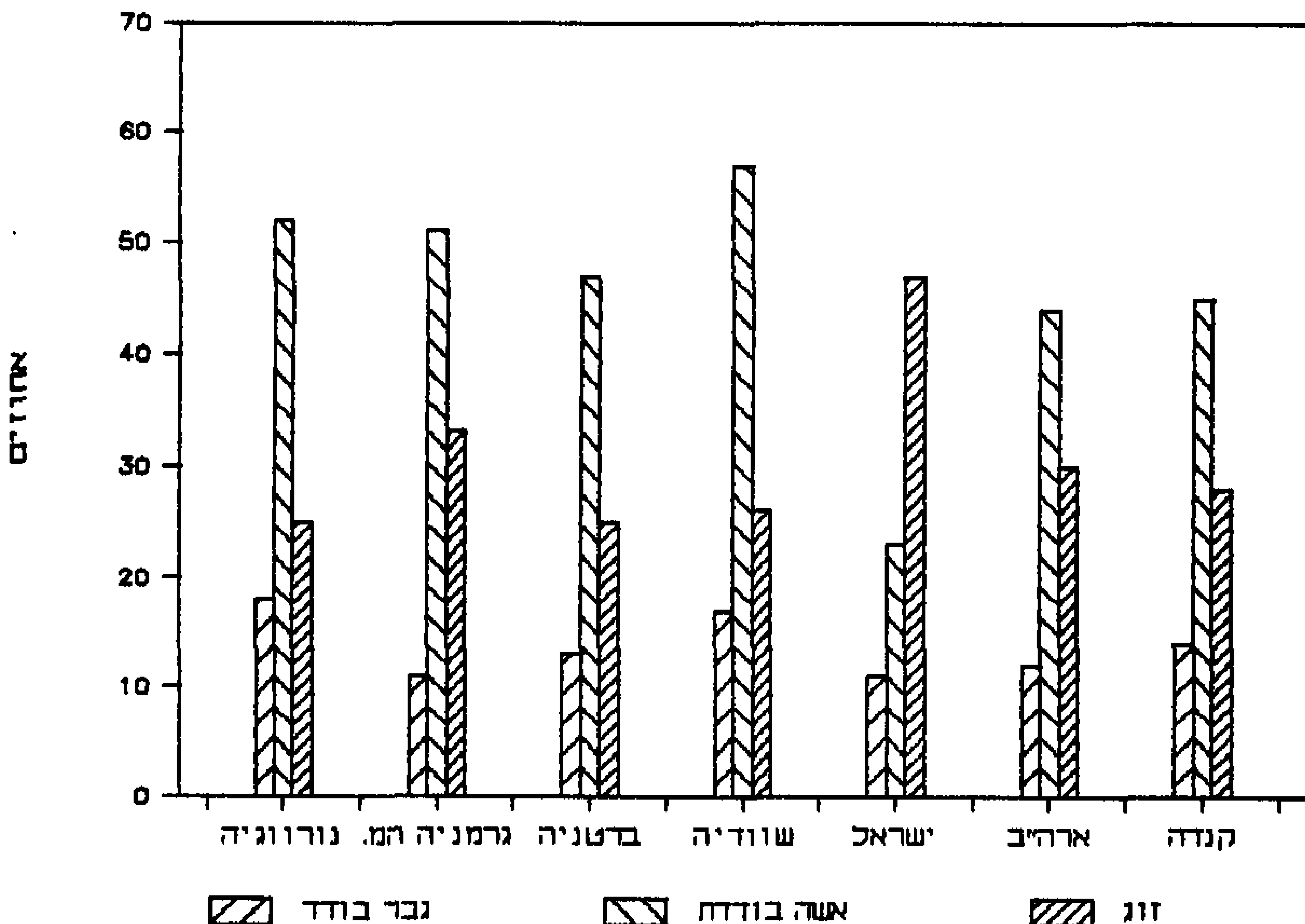
אי אפשר להמשיך לראות במשפחה משאב חינם. בחוק ביטוח הסיעוד שלה, ישראל אכן הכירה בחשיבות הפחתת העול המוטל על משפחות. יש איפוא לערוך אומדנים על כמות העול ועל העלויות הציבוריות הצפויות ולקבוע מדיניות ברורה איזה חלק מהעול הכולל ימשיך להיות מוטל על הסקטור הבלתי פורמלי, כלומר על המשפחה, או יישאר בידי השוק הפרטי.

מכל מקום ברור, שבצד ההכרה, א. במעמסה ההולכת וגוברת שהמשפחות נושאות בה, ו-ב. בצורך לספק סיוע מקדים שימנע משבר, תשישות, התמוטטות ובסופו של דבר אשפוז במוסד, יש לראות את אוכלוסיית היעד ראייה רחבה יותר, אשר לפיה יעדי תוכנית הטיפול הם גם הזקן התלוי וגם בני המשפחה המטפלים בו. בישראל גישה זו אומצה, למעשה, בחוק ביטוח סיעוד שתפקידו לשתף גם את הציבור בעול הטיפול בקשיש.

התייחסות לאוכלוסיית יעד רחבה זו צריכה להיות מלוות בגישה גמישה לתכנון סוגי הגמלאות והשירותים שייכללו בתוכנית המקיפה, ושחלקם יוכל להיות זמין אף למטפלים בקרב המשפחות. אם רוצים לתת תשובה הולמת לצורכי המשפחה ולציפיותיה, אזי דאגה למשפחה חייבת להיות חלק אינטגרלי מן התכנון, כמו במסגרת חוק ביטוח סיעוד בישראל.

כפי שנאמר, מידת הטיפול שקרובי משפחה יכולים לתת קשורה לגורמים דימוגרפיים, כלכליים וחברתיים. כך, לדוגמה, המטפלים בזקנים מאוד בדרך כלל גם הם עצמם זקנים: בני זוג או ילדים מבוגרים המתקרבים לגיל פרישה. מגבלות אלה וקרבת המגורים לזקנים משפיעים במידה רבה על מידת יכולתה של המשפחה ליטול על עצמה את האחריות לטיפול בקשיש ועל סוגי הסיוע הציבורי הדרושים.

תרשים מס. 6: <u>הרכב משק הבית של קשישים בני +75</u>



הרכב משק הבית של הזקן הוא גורם היוצר הבדלים בין מדינות שונות בשיעורי הזקנים המקבלים טיפול בבית או לחילופין במוסדות. כך, לדוגמה, בכל המדינות המפותחות, להוציא יפן, החיים לבד לעת זיקנה נעשים נורמה חברתית. גורמי מגמה זו הם חלקו הגדול של האלמנות בקרב הקשישים בכלל, ובקרב הנשים הקשישות בפרט, וכן השיעורים הגדלים של גירושין ופרידה.

עם זאת יש לציין, שעצם ההתגוררות לבד אינה מסכנת את הקשישים, כל עוד אין היא מלווה בסיכונים כלכליים, חברתיים, בריאותיים, פסיכולוגיים, טכניים וכיו"ב. למעשה, רוב הזקנים רואים בחיוב את חייהם העצמאיים שהם פרי בחירה חופשית שלהם. יתר על כן, למרות שמספר הזקנים החיים בגפם גדל, אין עדות לכך שילדים וקרובי משפחה אחרים אינם תומכים בהם בשעת הצורך.

ישראל נבדלת מארצות אירופיות בשיעור הנמוך של האנשים החיים לבד המציין אותה ובשיעורה הגבוה, יחסית, של הזוגות. באיפיון זה יש לתלות את נדירותו היחסית של הסידור המוסדר בישראל - 4.5% - ואת שכיחותה הגדולה של התמיכה המשפחתית.

תפקידן המשתנה של הנשים צויין במחקרים רבים כגורם המשפיע על דפוס הטיפול הבלתי פורמלי בקשיש ועל תגובת הסקטור הציבורי לצרכיו. שיעור הנשים המצטרפות לכוח העבודה הולך וגדל, והאישה העובדת אינה יכולה עוד למלא את התפקיד המסורתי של מטפלת במשרה מלאה. מעניין ביותר לבחון את שיעורי ההשתתפות בכוח העבודה של קבוצות גיל שהן בולטות במיוחד כמטפלות פוטנציאליות. בארצות הברית, בישראל, בשוודיה, ובקנדה שיעור הנשים העובדות בגיל 55-64 גדל במידה ניכרת ובמקביל עולה שכיחות הפרישה המוקדמת של גברים בגיל זה.

לוח מס. 3 - אחוז השינוי בשיעורי ההשתתפות בכוח העבודה לפי מין וקבוצת גיל
1965 ו-1985

מדינה	גברים		נשים	
	55-64	+65	55-64	+65
ארה"ב	-23.2	-16.3	+1.4	-2.6
קנדה	-16.2	-14.0	+6.8	-1.8
יפן	-3.7	-19.3	0.0	-6.1
צרפת	-25.9	-23.0	-5.9	-9.3
גרמניה	-27.1	-18.8	-6.3	-5.3
בריטניה	-26.3	-16.1	-1.5	-3.3
איטליה	-16.6	-9.5	-3.8	-2.6
שוודיה	-12.3	-26.7	+20.7	-8.4
ישראל	-2.2	-7.5	+8.1	+0.5
פינלנד	-23.7	-7.4	-2.0	+1.0
הולנד	-27.0	-7.4	-0.4	-1.6
ספרד	-17.9	-20.0	-2.0	-5.6

להצטרפותן הגוברת של נשים לכוח העבודה שתי פנים: מצד אחד פוחת הזמן הפנוי הדרוש לטיפול בקשיש, אך מצד שני מצבו הכלכלי הטוב יותר - זכויות הפנסיה שלהן, חסכונותיהן וכו' - עשוי להיטיב עימן כצרכניות של שירותים. ממצאים (העומדים להתפרסם) שעלו במחקר כלל-ארצי שנערך בישראל מעידים, שבעוד שבקרב גברים, שיעור המכוסים על ידי פנסיה מעבודה כנראה מגיע למקסימום, בקרב הנשים צבירת זכויות פנסיה שכיחה אצל אלה העומדות על סף פרישה יותר מאשר אצל אלה שכבר פרשו. אם משפחות, שבהן האישה עובדת, עשויות לרכוש שירותי טיפול יותר ממשפחות אחרות, אזי ייתכן שרכישת השירותים מהסקטור הפרטי תגבר בעקבות הצטרפותן ההולכת וגדלה של הנשים לכוח העבודה.

לממצאי מחקרים המלמדים, שבניגוד לתחזיות, בני משפחה אינם מתנערים מאחריותם כמטפלים, שני מובנים: משפחות רבות יותר צפויות לטפל ולבחור שירותים באופן עצמאי; וככל שגדל כושר השתכרותן של הנשים, שמטבע המסורת דואגות לטיפול, כך תוכלנה לקנות שירותים רבים יותר. לכן עקרון התחלקות הציבור ומשפחת הקשיש בנשיאה בהוצאות נעשה סעיף מרכזי במספר תוכניות ממשלתיות לסיעוד בארצות הברית.

אכן, החרדה שהתעוררה בעבר לנוכח ההוצאה הציבורית ההולכת וגדלה בגין טיפול בקשישים, מתחלפת היום בנכונות לבדוק אופציות אחרות, לרבות התחלקות בהוצאות הכרוכות במתן טיפול לקבוצות בנות סיכון גבוה. לא רק הזקנים עצמם אלא גם האוכלוסייה העובדת, הצעירה יותר, יכולה להשתתף בהוצאות, שכן זו כבר מתחילה להכיר בחשיבות השקעתו של חלק מהכנסתה הנוכחית בביטוח מפני סיכונים שעלולים לדרוש בעד טיפול רפואי חיוני ויקר, או אף כדי להבטיח טיפול סיעודי בבית או במוסד.

אופציות אלטרנטיביות נוספות שנדונו ושאולי עוד תעלינה בכנס זה הן:

- שינוי מבנה ההוצאות החברתיות בהתאם לשינויים דימוגרפיים ולצרכים משתנים, דהיינו הפניית משאבים מתוכניות עבור צעירים לתוכניות עבור זקנים.

- צמצום היקף האוכלוסיות הזכאיות לגמלאות במסגרת הביטוח הסוציאלי (לדוגמה, על ידי דחיית גיל הפרישה).

- עידוד התפוקה בקרב האוכלוסייה העובדת.

- הגברת הצטרפותן של קבוצות מסוימות, כגון נשים וזקנים, לכוח העבודה.

- צמצום שיעורי ההחלפה של הגמלה, בד בבד עם העלאת רמות שכר ריאליות.

- קביעת כללי זכאות קשוחים על מנת להעניק שירותים וגמלאות רק לקבוצות ספציפיות (targeting).

- הועדת תפקיד רחב יותר לסקטור הפרטי בהשלמת תוכניות ביטוח סוציאלי כדי להפחית את הלחץ על תוכניות ציבוריות בסיסיות.

- בדיקת אפשרויות להרחבת בסיס המס כדי שיכלול חלקים מסוימים מן האוכלוסייה הזקנה, בלי לפגוע בקבוצות בעלות הכנסה נמוכה.

- ולבסוף, איזון נטיות הקיימות היום לכיוון טיפול מוסדי יקר על ידי תוכניות דיור וטיפול אישי בקהילה, המספקות שירותים לצרף הצרכים המשתנה של הקשיש.

מספר מלים על טיפול בבית ובקהילה לעומת טיפול במוסדות. מחקר בין-לאומי שנערך על ידי איסס"א בשנת 1986 לימד, שגורמים אחרים מלבד נתוני אוכלוסין, שנקבעו על ידי חיוץ, משפיעים על שיעורי הקשישים השוהים במוסדות, ויש לקחת אותם בחשבון בחיזוי מספר המיטות הדרושות בעתיד.

רוב המדינות המתועשות רואות בשיעור הקשישים שלהן השוהים במוסדות שיעור גבוה מהדרוש ומן הרצוי. המדיניות הנקוטה על ידי רובן היא הרחבת שירותי הסיעוד הניתנים בבית ובקהילה. למעשה, השאלה היא האם אכן יש תחלופה בין שני הסקטורים, והאם טיפול בבית הוא פחות יקר מטיפול במוסד. שאלה זו שנויה במחלוקת, אף על פי שמספר מחקרים שנערכו בישראל עונים כנראה בחיוב על שאלה זו, לפחות כשמדובר בזקנים הפחות תלויים. בימים אלה, עורכים מכון ברוקדייל והמוסד לביטוח לאומי בישראל, מחקר על השפעת חוק ביטוח סיעוד על דפוסי המיסוד בישראל ועל שיעוריו. אך בהנחה שמיטה פנויה במוסד סיעודי או בבית חולים אקוטי איננה נשארת בלתי מאוישת, טענתי היא שהורדת שיעורי המיסוד, הממאלצת לדחות את כניסה למוסד סיעודי, היא למעשה שאלה של מדיניות הפיקוח על היצע המיטות, ולא רק שאלה האם לתת טיפול בבית במקום במוסד.

רק כשיוחלט להגביל מאוד את מספר המיטות, יקטן מספר השוהים במוסדות. לכן אין הצדקה, לדעתי, לתכנן לטווח ארוך את בניית המוסדות ואת הרחבתם אך ורק על פי שיעורי השימוש הנוכחיים במיטות. יש לשים את הדגש על הקטנת מספר המיטות ולפתח בד בבד סידורים אלטרנטיביים בקהילה עצמה, גם לתקופות קצרות. חוק ביטוח סיעוד בישראל הרחיב אופציות אלה, כי השירותים הניתנים בבית לקשישים המופיעים ברשימות ההמתנה למוסדות מאפשרים לדחות את המעבר מהבית למוסד.

בחוק ביטוח סיעוד הישראלי יש לראות המשך הגיוני של המדיניות החברתית המתייחסת לקשישים במסגרת מערכת הביטחון הסוציאלי. לאחר שבמשך 15-20 השנים האחרונות התפתחה התחיקה בעניין הבטחת ההכנסה לקשישים, החוק החדש משקף שינוי חשוב במדיניות החברתית בהתמקדו בהקצאת משאבים לקשישים התלויים מאוד בעזרת הזולת על בסיס זכאות אישית.

החוק בא להגדיר באופן פורמלי את המחויבות החוקית של המדינה לספק שירותים ברמה בסיסית לזקנים הסיעודיים. זאת על בסיס זכאות אישית ולפי כללי זכאות המוגדרים היטב, כדי לענות על צורכי הקשישים הזקוקים לטיפול וכדי לסייע לבן המשפחה שהוא המטפל העיקרי בקשיש. כפי שציינתי, לחוק ביטוח סיעוד יש אפוא שתי אוכלוסיות יעד: הקשישים המוגבלים ומשפחותיהם.

חוק ביטוח סיעוד הוא חוק חדשני לא מפני שהוא מבטיח שירותים לזקנים אלא בזכות היותו חלק בלתי נפרד ממערכת הביטחון הסוציאלי בישראל. הוא כפוף לעקרונות הביטוח הלאומי, וממומן על ידי דמי הביטוח הנגבים מהאוכלוסייה המבוטחת. תכליתו לאפשר לאנשים התלויים בעזרת הזולת להישאר בבית זמן רב ככל האפשר, ולחזק את כושר הטיפול של המשפחה בעזרת מתן שירותי <u>בית</u> ושירותי <u>קהילה</u>, בנבדל מהעברה למוסד. לפי החוק, קשיש זכאי לשירותים אלה <u>רק</u> כל עוד אין הוא גר במוסד סיעודי. אולם יש להדגיש, שאין בכוונות החוק לפטור את המשפחה מאחריותה לטיפול בקשיש ומהדאגה לרווחתו. כפי שכבר נאמר, הגמלה מכסה רק חלק מעלות הטיפול.

עיקרון בסיסי נוסף הוא המשכת הרחבת רשת השירותים וכוח האדם הקיימים, במימון הגמלאות עצמן, ובכספים שיוקצו לפיתוח שירותים בקהילה ובמוסדות. אחד ההישגים החשובים ביותר של חוק ביטוח סיעוד בישראל הוא גידולם המהיר של השירותים הזמינים במשך השנה האחרונה. זאת בעקבות גידול מספר הקשישים הזכאים לשירותי סיעוד במסגרת החוק פי שלושה.

ישראל פיתחה צירוף מעניין של תפקידים, מרוכזים ומבוזרים, לשם ביצוע חוק ביטוח סיעוד. יש הפרדה ברורה בין קביעת הזכאות לבין מתן השירותים. קביעת תוכנית טיפול, מתן השירותים ותיאום הטיפול הם תפקידים מבוזרים, ואילו קביעת הזכאות והמעקב, הנעשים לפי כללים ובכלים אחידים, נתונים לאחריותו של המוסד לביטוח לאומי. זאת על מנת להבטיח אחידות ושיוויון מקסימלי במסגרת החוק ויש לציין, גם את הפיקוח המקסימלי על קביעת אוכלוסיית יעד (targeting) ועל עלויות. פיקוח מסוג זה בשאלות מי יהיה זכאי, מה גודל האוכלוסיה הזכאית, ומה עלות התוכנית כתוצאה מכך, הוא אלמנט חיוני וחדשני בחוק.

מצד שני, הביזור במתן השירותים מבוסס על העיקרון החשוב, לפיו ברמה הבסיסית והמשמעותית ביותר, המשפחה שותף פעיל, בצד עובדים סוציאליים מקומיים ואחיות, בקביעת סוגי השירותים הדרושים לקשיש ובהחלטה מתי להעניק שירותים אלו. למשפחה יש תפקיד פעיל בתיאום השירותים. הדבר איננו משקף גישה של התערבות חיצונית בבחירה אישית ובהעדפה אישית, אלא מודל של הערכת צורכי המשפחה והעדפותיה, שהם למעשה יסודות תכנון השירותים במסגרת החוק.

הייתי רוצה להרחיב את הדיבור על חלק מעקרונות אלה של חוק ביטוח סיעוד:

1. מי זכאי לקבלת שירותים לפי חוק זה? - גברים בגיל 65 ומעלה ונשים בגיל 60 ומעלה אשר מוגבלים מאוד בכושרם לבצע פעולות יום יומיות, או זקוקים להשגחה מתמדת בגלל הסיכון שיזיקו את עצמם או לסביבתם. יש שתי רמות זכאות, הנקבעות על פי מידת התלות. דרגה זו נקבעת על ידי אחות בריאות הציבור העובדת במשרד הבריאות, שנעזרת בכלי מדידה אחיד ואובייקטיבי. בביקור בית שהיא עורכת, כל אדם מקבל ציון של יכולת התפקוד. נקודות זכות נוספות ניתנות לאנשים הגרים בגפם ולאלה שזקוקים להשגחה אישית מתמדת.

2. כפי שנאמר, הגמלה מיועדת לקשישים הגרים בבית ובקהילה. לכן רק אנשים הגרים מחוץ למוסדות סיעוד ולמחלקות סיעודיות רשאים לתבוע גמלה. אנשים הגרים בדיור מוגן או בבתי אבות, שפחות ממחצית עלות החזקתם הינו במימון ציבורי, רשאים גם הם להגיש תביעה. קשיש הגר בבית והמקבל גמלה, יפסיד גמלה זו כשיעבור למוסד סיעודי.

3. זכאות לגמלה נקבעת על פי מבחן הכנסות. הכוונה להכנסות הזקן ובת זוגו. מבחן ההכנסות איננו נוקשה מאוד. לפי נתוני שנת 1988 רק מעט מאוד תובעים נדחו בגלל רמת הכנסתם.

4. כאמור, הגמלאות מאפשרות טיפול ברמה בסיסית. רמת הגמלה הנמוכה מספקת ל-11-12 שעות טיפול אישי בשבוע, ואילו הרמה הגבוהה - ל-17-18 שעות טיפול בשבוע. השירותים ניתנים בעין ולא בצורת גמלאות כספיות. רק במקרים מוגדרים היטב, קרי כאשר אין שירותים זמינים עבור הזכאי המטופל על ידי בן משפחה הגר עמו, מותר להעניק גמלה כספית עד שאפשר יהיה להשיג שירותים בעין.

5. סוגי השירותים שאפשר לקבל במסגרת חוק ביטוח סיעוד מוגדרים. סל השירותים כולל עזרה אישית במקומות מאורגנים בקהילה (כגון מרכזי טיפול יום), עזרה בבית (כולל עבודות בית בסיסיות), שירותים מיוחדים, כביסה, הכנת ארוחות והגשתן, הספקת מוצרי ספיגה. שירותים רפואיים, פרה-רפואיים, ושירותי תמיכה חברתית, כגון סיעוד בבית ופיזיותרפיה אינם כלולים במסגרת החוק, והאחריות הבלעדית עליהם נשארה בידי מוסדות הבריאות והרווחה.

6. האחריות הכללית לביצוע החוק ולמעקב אחר ביצועו נתונה בידי המוסד לביטוח לאומי. אך האחריות לביצוע החוק בפועל מתחלקת בין סניפי המוסד לביטוח לאומי, משרד הבריאות, משרד העבודה והרווחה וקופת חולים של ההסתדרות. לוועדות מקצועיות מקומיות, המוגדרות בחוק, יש סמכות לקבוע תוכניות טיפול, לספק שירותים, לעקוב אחר שינויים ולדווח. ועדות מקומיות אלה מונות עובד סוציאלי בכיר ממחלקת הרווחה של השלטון המקומי, אחות מקופת החולים ופקיד של המוסד לביטוח לאומי.

כפי שנאמר, הסדר זה מבזר את התפקידים המקצועיים החשובים ביותר ברמה של ניהול הטיפול. יסוד הביזור הוא ההכרה, שתפקידים אלה מובנים ביותר ומטופלים בצורה הטובה ביותר ברמה המקצועית המקומית על ידי עובדים סוציאליים ואחיות, המייצגים את מוסדות הבריאות והרווחה האחראיים.

7. תוכנית הטיפול שמכינה הוועדה המקומית אינה מציינת רק אלו שירותים יש לתת אלא גם אלו גופים יספקו את השירותים. התוכנית כולה מתבצעת באמצעות קבלנות-משנה המחייבת רישיון מוכר, מעקב, בדיקת איכות ופיקוח. מותר לשכור שירותים לפי חוזה אך ורק עם גופים פרטיים, בעלי מעמד חוקי, הפועלים שלא למטרת רווח והמאושרים על ידי משרד העבודה והרווחה. אסור להעניק גמלאות לאנשים פרטיים המספקים טיפול.

הדגש מושם, אם כן, על צירוף המלים: זכאות ושירותים - שאין דומה לו במדינות אחרות. יש בצירוף גישה אוניברסלית וביטוחית המתבטאת בזכאות לשירותים, והתאמה לדרישות אינדיווידואליות, עצמאיות ומשפחתיות.

תרומה חשובה תרם חוק ביטוח סיעוד בישראל בהעלותו נושאים רבים, נחלת הספרות המקצועית, למישור הציבורי, לדיון ולהכרעה. אחדות מסוגיות אלה הן הסכנה האורבת לתפקיד המשפחה מן הטיפול הפורמלי, סכנת תלות היתר בתוכניות ציבוריות, הקשר בין הטיפול הבלתי פורמלי לבין שירותים פורמליים, מניעים ציבוריים להעדפת טיפול בקהילה על פני טיפול במוסד, גמלאות בכסף לעומת גמלאות בעין, ריכוז הביצוע לעומת ביזורו, תפקידי גופים פרטיים וציבוריים בפיתוח שירותים ובהספקתם; ובישראל - גם החסרונות, היתרונות והעלות של תוכנית ביטוחית חברתית המבוססת על זכאות לעומת אלה של תוכניות ציבוריות המבוססות על מיסוי כללי ועל הקצאה סלקטיבית של משאבים. התשובה לחלק משאלות אלה כבר ניתנה בחוק, חלקן עדיין נתון בדיון, ואני מקווה שהן תעלינה בפורום זה בימים הקרובים.

לחוק ביטוח סיעוד כבר היתה השלכה חשובה על מערכת הטיפול הממושך בישראל. הצלחת החוק בהשגת יעדים חברתיים ובהיענות לצרכים תלויה במידה רבה בתיאום ובשיתוף הפעולה הקיימים והעתידים להתפתח בין הגופים והארגונים השונים. כבר יש סימנים ראשונים לאי הישארותן של גמלאות הסיעוד מערכת נפרדת. הן נעשות בהדרגה חלק מתוכנית משופרת, בעלת פוטנציאל תיאום רב יותר בין מסגרת חוק ביטוח סיעוד לבין מסגרות אחרות.

הוועדות המקצועיות המקומיות יצרו, למעשה, הזדמנות להפחתת הפיצול בין מערכות ושירותים ולשיפור שיתוף הפעולה בין הגורמים. אנו מקווים כי שינוי זה יאפשר לגשת ביתר כוללנות להערכת צורכי הקשישים ולמתן המענה לצרכים אלה זאת ברחבי הארץ כולה, באזורים עירוניים וכפריים.

אם נשכיל להיעזר בוועדות המקומיות, הן תוכלנה להתפתח למוקד מקצועי (single-entry point) של מערכת הטיפול והשירותים לקשישים. במוקד זה תיעשנה ההערכה הבסיסית וההפניה לשירותים נוספים, כנדרש. בשלב מאוחר יותר הוועדות תוכלנה לשמש מקום סינון ראשוני לצורך סידור מוסדי. כך יובטח רצף הגיוני יותר של הקצאת שירותים לפי צרכים, ותקטן המעמסה הכבדה מנשוא הנופלת על כתפי אוכלוסיית הקשישים ובני משפחותיהם דווקא במצבים הקשים ביותר, של התרוצצות מארגון לארגון.

יתר על כן, עצם היות חוק ביטוח סיעוד תוכנית ביטוח סטטוטורית, כבר תרם במידה רבה להאחדת הכלים והנוהלים המשמשים להערכת צרכים ולאספקת שירותים. אלה כבר אומצו על ידי אנשי מקצוע בתחומים שונים. העבודה במסגרת חוק באה לידי ביטוי בביקורי בית של עובדים סוציאליים ואחיות, בקביעת תוכנית הטיפול, באשרור עבודת ספקי שירות ובהעסקתם, במעקב וכיו"ב. הודות לחוק החדש, קשישים תלויים, שאולי לא היה להם כל מגע עם אנשי מקצוע, זוכים היום בקביעות לביקורי בית של אנשי מקצוע.

במשך השנה שלאחר חקיקת החוק, הגדלנו את אוכלוסיית המבוטחים פי שלושה. כאשר יסתיים הטיפול בכל התביעות הצפויות, נגיע לכסוי של כמעט כ-5% מהאוכלוסייה הקשישה הפוטנציאלית (נשים בגיל +60 וגברים בגיל +65). כשמוסיפים להם את הקשישים ששוהים במוסדות - 4.5% מהאוכלוסייה הקשישה - מסתבר שישראל נותנת מענה לנזקקים לסיעוד ברמה סבירה וכן מספקת, באמצעות חוק סיעוד, אופציה ריאלית של טיפול בקהילה.

לתוכנית מסוג זה יש, כמובן, בעיות משלה, במיוחד בתקופה זו של מעבר ממערכת למערכת. לא אחת דומה בעיני, שאנו עוסקים בשאלות יותר מאשר בתשובות. כיוון שמדובר בתוכנית שירותים אוניברסליים הנותנת מענה לצרכים רק ברמה בסיסית, בהכרח יש קשישים הזקוקים לשעות טיפול רבות יותר מכפי שמתאפשר במסגרת החוק. מי יספק שירותים אלה? עדיין מרחפת סכנת קיצוץ תקציביהם של גורמים אחראיים ושל שירותים חיוניים לקשישים, ויש למנוע אותה. בעיה אפשרית נוספת היא שהמאמצים הרבים המושקעים בקליטת מספר התביעות הגדול (כ-8% מהאוכלוסייה הקשישה הגישו בשנה האחרונה תביעה) הן מבחינה ניהולית והן מבחינה מקצועית, יגרמו להזנחת שירותים חשובים אחרים או להזנחת קבוצות אוכלוסייה קשישות בעלות צרכים שונים. איך אנו יודעים, לדוגמה, מה עולה בגורלם של אלה שאינם זכאים לגמלאות סיעוד אך זקוקים לשירותי תמיכה, או של קשישים שזקוקים לשירותים לטווח קצר - בביתם באורח מידי לאחר אירוע בריאותי. תחום טיפול זה תמיד היה נתון בידי קופות החולים, וכך על הדבר להימשך גם בעתיד. לכן חשוב לוודא שארגונים ציבוריים לא ישתחררו מאחריותם לקשישים בתחומים שונים: מתן שירותי רפואה, טיפול אישי-סיעודי, דיור, פסיכותרפיה ושירותי תמיכה חברתיים על בסיס סלקטיבי. אל ארגונים אלה לקצץ מתקציביהם. שומה עליהם להתאים את הקריטריונים שלהם ואת תוכניותיהם כדי להשלים את חוק ביטוח סיעוד.

למרות הספקות המוקדמים, מהישגיו החשובים של החוק הוא גידול היקף השירותים וכוח האדם, בטור גיאומטרי מאז חקיקתו. דומה היה, ששיעור משמעותי מאוכלוסיית הקשישים הזכאים יקבל גמלאות בכסף מחמת היעדר אפשרות לספק לו שירותים. אולם בפועל רק 150 מ-17,000 המקבלים גמלת סיעוד מקבלים גמלה כספית. שירותי הטיפול האישי הקהילתיים התפתחו במידה מספקת, כך שהיום ניתן טיפול לזכאים הרבים באזורים העירוניים.

כחלק מגידול זה בהיקף השירותים מאז תחילת ביצוע החוק, גדל מאוד מספר הגורמים הפרטיים העובדים למטרות רווח. לנוכח התפתחות זו חובה על המוסד לביטוח לאומי לפתח במהירות ובקפדנות מערכת לבדיקת איכות השירותים ולפיקוח על אספקתם ועל מחיריהם הן כשמדובר בגופים פרטיים והן בגופים ציבוריים. במילים אחרות, יש לוודא שהגורמים השונים אכן מספקים שירותים ביעילות, על ידי מטפלים טובים ובהתאם להחלטת הוועדות המקומיות, הן במונחי כמות והן מבחינת איכות.

לבסוף, אילו התבקשתי להצביע על ההשלכה החשובה ביותר של חוק ביטוח סיעוד, הייתי מציינת את השינוי הבסיסי שחולל בתשומת הלב הניתנת לאוכלוסייה חשובה שהיתה מוזנחת בעבר מבחינת שירותי רווחה. לקשישים התלויים ניתן עתה המקום הראוי מבחינת תכנון, פיתוח ומתן שירותים בפועל ומבחינת המשאבים המוקצים וההתערבות המקצועית. זאת, לדעתי, ההצדקה העיקרית לכלילת תוכנית מסוג זה במערכת ביטוח הסוציאלי.

הערות סיכום

כבוד הנשיא, המזכיר הכללי, יושב הראש ועמיתים נכבדים,

מטבע הדברים סיכום זה חייב להיות קצר וכללי למדי, ועל כן אין הוא יכול לשקף נאמנה את הרמה הגבוהה של הדיונים ושל העבודות המצוינות שהוצגו כאן במשך ימי הכנס. לכן אבקש מראש את סליחתכם על שלא אכסה די הצורך את כל הפרטים ואת כל הנושאים שהועלו על ידכם בימים האחרונים. כל מה שיישמט מדברי בוודאי ייכלל בדו"חות הכנס העתידים להתפרסם.

לאחר שלושה ימים אינטנסיביים של הקשבה להרצאות, השתתפות בדיונים והחלפת דעות ואינפורמציה, אני סבורה שכולנו קרבים לסיום הכנס בהרגשה ברורה, שהועלו כמה מן הנושאים הרלוונטיים ביותר בתחום שכולנו עוסקים בו בצורות שונות, לשם פיתוח מדיניות ביטחון סוציאלי, איש איש בארצו הוא. שם הכנס, "תפקיד הביטחון הסוציאלי במתן הגנה חברתית לזקנים מאוד", כולל מספר מונחים שבמובהק לא עוררו מחלוקת לגבי מה ומי הם מוקד עניינו, כפי שקורה לעתים קרובות בישיבות הפתיחה של כנסים מסוג זה. כך לדוגמה, האם עלינו להגדיר את אוכלוסיית "הזקנים מאוד" על פי קנה המידה של הגיל, או על פי מצב התפקוד? לאלו סוגים של הגנה ורווחה אנחנו מתייחסים? המסקנה שלי היא, שכבר קיימת תחושה של קונצנסוס באשר להגדרת אוכלוסיית היעד שלנו, וכן שהמושג "הגנה סוציאלית" מתייחס בעיקר לאתגרים הניצבים בפני החברה בדבר טיפול בזקנים תשושים ולהקלת מצבי בדידות חברתית.

מגמות דימוגרפיות

כל המשתתפים שהציגו כאן את עבודותיהם תיארו מגמות דומות של הזדקנות בארצות שונות, וכן התפתחויות חברתיות המשפיעות על דפוסי טיפול פורמליים ובלתי פורמליים כאחד. לאור התפתחויות אלה, כל חברה חייבת לשקול פתרונות אלטרנטיביים ולהתקדם לקראת החלטות מדיניות מכריעות, יהא תהליך זה קשה ככל שיהא. בחלק מהדו"חות צוין, שארצות מסוימות כבר החלו לעסוק בפעילות תחיקתית בנושאים הנידונים.

אולם הייתי רוצה להדגיש, שבהתייחס לנתונים דימוגרפיים וכלכליים, דיוני הכנס חיזקו בהחלט את הגישה שעלתה בישיבת הפתיחה: הווה אומר, הזקנים מאוד הם אוכלוסייה הטרוגנית ומשתנית, ותכנון תוכניות ותחיקה בעניינה חייבים שלא לראותה כמקשה אחת אלא להתייחס לצורכיהן של תת-קבוצות ספציפיות שונות, המוגדרות על פי צורכיהן. נציגנו משוודיה חזר על הדבר היום, כאשר ציין שתכנון בסיסי על פי מגמות דימוגרפיות כלליות פחות רצוי מתכנון על פי נתונים ספציפיים של קבוצות בעלות צרכים אקוטיים. שמענו גם מספר הערות - מעמיתנו מצרפת, למשל - כי מגמות דימוגרפיות אינן אמיתות אבסולוטיות. עמיתנו מצרפת הציע לנו לאמוד את הנתונים מחדש באופן שוטף, וקבע, שהבנת השלכותיה של הדימוגרפיה טעונה מעקב זהיר בחברה המשתנית במהירות, מבחינת הטכנולוגיה הרפואית והמגמות החברתיות. לכן יש לעקוב אחר אפיוני כל שנתון חדש של זקנים - כפי שהציע גם נציגנו מארצות הברית.

בהתבסס על הטענה, שאנו אכן מדברים על אוכלוסייה משתנית והטרוגנית, ציינו כאן שאין בהכרח מתאם ישיר בין הגידול המספרי של אוכלוסיית הקשישים לבין גידול באי-יכולת ובתלות. למעשה, אנחנו יכולים אף לצפות לשיפורים בבריאותן ובעצמאותן הכלכלית של מספר קבוצות בקרב שנתונים עתידיים, כלומר, בקרב אלה שזה אך מגיעים לגיל זיקנה. הממצאים שהוצגו לגבי צרפת אינם מוחלטים לגמרי, אך הם מרמזים על שיפור אפשרי בכלכלה הכוללת של ההזדקנות, במונחים של ירידת שיעורי גידול ההוצאות הרפואיות והחברתיות, במיוחד בהשוואה לתל"ג במדינה זו. ממצאים מסוג זה מחזקים את הגישה, שעל כל אחד מאיתנו, איש איש בארצו שלו, לעקוב מקרוב אחר מגמות לאומיות הקשורות להזדקנות האוכלוסייה, להוצאות חברתיות ובריאותיות וליכולת המשק לשאת בהוצאות אלה.

היה מעניין ומשביע רצון לשמוע בחלק מההרצאות הדים להערות הפתיחה של המדיין הראשון שלנו. לדבריו, בעוד שעלינו להיות ערים ללחצים ולצרכים הנובעים מגידול אוכלוסיית הקשישים, חשוב להימנע - גם במשך הכנס וגם בעבודתנו בבית - מתחזיות מפחידות על אוכלוסיות שהולכות ומזדקנות ועל משברים פיסקליים הקרבים ובאים. נקודת מבט מרעננת זו חזרה והופיעה שוב ושוב בהרצאות ששמענו אתמול, מפי הנציג מצ'כוסלובקיה, לדוגמה, שתיאר תוכנית פרגמטית ספציפית לפיתוח שירותים, ושהדגיש שתי נקודות חשובות הקשורות זו לזו:

הנקודה הראשונה היא, שיש להימנע מהסכנה של הטחת אשמה בזקנים עצמם על מספרם ועל צורכיהם ההולכים וגדלים. האשמה כזו יוצרת אקלים פוליטי בלתי רצוי לגבי ההשלכות הפיננסיות והעול הכרוך בהיענות לצרכים אלו. אך יחד עם זאת, חובתנו לעודד ולהגביר את תחושת האחריות של כל פרט להזדקנותו שלו, במיוחד בקרב האוכלוסייה הצעירה יותר של היום, זאת - על ידי נקיטת אמצעי מניעה וחינוך החברה הצעירה לאורח חיים בריא יותר אשר יאריך את תקופת אי-התלות התפקודית. יתר על כן, על מנת להקטין את הצורך בשירותים יקרים בעתיד, אל לנו להזניח <u>היום</u> את הזקנים העצמאיים יותר שזקוקים לפעולות מניעה.

הדגש, אם כך, מושם גם על מניעה, ולא רק על טיפול רפואי לחולים, על שיקום או על שירותי תמיכה, שהם ללא ספק חשובים לכשעצמם. מספר נציגים ציינו את המניעה כנושא חיוני לדיונים נוספים במסגרת איסס"א ואף כבעל עדיפות בתכנון בשנים הבאות.

<u>גמלאות בכסף לעומת שירותים בעין: מערכות טיפול מעורבות</u>

ההרצאות האינפורמטיביות והדיונים המצוינים שהתנהלו אתמול הוסיפו ממד חדש למספר גישות בסיסיות, חשובות מאוד, שהוצעו לראשונה ביום שלישי אחר הצהריים על ידי הנציג מגרמניה המערבית. נראה, שמדינה זו שוקלת מודל אלטרנטיבי לזה שאומץ בחוק ביטוח סיעוד הישראלי - חוק שנועד להעניק שירותים בעין, בנבדל מהעברת כספים לזכאים. הנציג האמור הדגיש שיש לעגן את הזכויות הסוציאליות של הזקנים בחוק אשר יבטיח את האוטונומיה של הזקן ואת חופש הבחירה האישית, ההעדפות האישיות וההגדרה העצמית כגורמים המרכזיים בתכנון הקצאת משאבים. כל תוכנית שתיקבע חייבת לאפשר לזכאי לבחור לפי העדפתו האישית שירותים בבית או במוסד, במסגרת רווחה גמישה המציעה מגוון רחב של אלטרנטיבות וספקי שירותים. תוכנית כזו צריכה להציע כבסיס גמלאות כספיות או רמת הכנסה נאותה לזכאים, כדי שיוכלו להשתמש במשאבים אלה לפי העדפותיהם האישיות.

הסוגיה של גמלאות כספיות לעומת שירותים בעין היא, למעשה, שאלה של הבדלי דגש בלבד, כפי שמסתבר מדיונינו כאן - כלומר, היא איננה שאלה של גישות המוציאות זו את זו. למעשה, במוקד עומדת שאלת שלב התפתחותה של כל חברה: כל חברה נתקלת בבעית ההזדקנות בשלב שונה של התפתחותה מבחינת יעדיה החברתיים, אופן ביצוע יעדים אלה ומצבה הכלכלי.

לאור זאת, ההרצאות שנישאו ביומו הראשון של הכנס והעמידו במוקד את קיומן של שתי מערכות בסיסיות נפרדות לטיפול בצרכיהם של הזקנים מאוד - המערכת המוכרת של סעד סוציאלי (social assistance) וזו של הביטוח הסוציאלי (social insurance). מערכות אלה נבדלות זו מזו גם לפי צורת הטיפול הנותן שירותים בעין מסל שירותים ספציפי לעומת העברת תשלומים באמצעות הבטחת רמת הכנסה מסויימת או גמלאות כספיות. הבחירה המעשית באחת משתי המערכות בלתי תלויה בשאלה האם החברה מעריכה את עצמאות אזרחיה. בחירה זו תלויה גם בשלב התפתחותה של החברה וגם בהחלטתה כיצד תוכל באמצעים מוגבלים להשיג את יעדיה החברתיים בצורה הטובה ביותר.

למעשה מתברר, שברוב החברות מקובלת וכנראה גם תמשיך להיות מקובלת, כלכלת טיפול מעורבת, שיש בה אלמנטים משתי המערכות ומשתי הגישות לכיסוי צרכים ולמתן שירותים. כל אחד מאיתנו יצטרך להחליט עבור החברה שאותה הוא מייצג, לאיזו מערכת ולאיזו צורת הקצאת משאבים ינתן בעתיד דגש רב יותר בחקיקה המתייחסת לנושא הזיקנה. למספר ארצות, כגון אנגליה ואוסטריה, יש כבר גמלת שירותים מיוחדים או תוספות עבור זקנים תשושים, כי ארצות אלה מכירות בצורך לכסות הוצאות מיוחדות הקשורות לטיפול בתלויים. ארצות אחרות, כגון הולנד וגרמניה המערבית, מבטיחות הכנסה גבוהה, יחסית, שמאפשרת לזקנים לשאת בעלות הטיפול הלא-רפואי או בעלות המיסוד לעצמאים בלי גמלאות נוספות. כלכלות מעורבות אלה בדרך כלל נובעות מכך, שהתוכניות נבנו בשלבים, בהתבסס על גישה "אינקרימנטלית", הדרגתית, כפי שהסביר לנו היום המדריך מפינלנד. יתכן שגישה זו לא תמיד אידיאלית, אך היא מאפשרת לנו לשפר את המערכות שלנו גם במגבלות של אילוצים כלכליים ופוליטיים. בישראל, לדוגמה, גם בתחום ביטוח הסיעוד עדיין יש כלכלה מעורבת, שעלולה לעורר פה ושם בעיות מסוימות, כפי שציינו היום עמיתי הישראליים. אך כשנותנים את הדעת לבעיות אלה, אין להתעלם מהשיפור העצום שחל במערכת. גם כשמדובר בשירותים בכסף ובעין, יש לנו בישראל תערובת - שוב כתוצאה מהשלבים האינקרימנטליים של פיתוח מערכות הביטוח הסוציאלי - מערכת הסעד והביטוח הרפואי. לכן, לדוגמה, זקנים נכים שקיבלו בצעירותם גמלת שירותים מיוחדים במסגרת חוק ביטוח נכות כללית רשאים לבחור בגיל הזיקנה האם להמשיך לקבל גמלה כספית זאת במקום שירותי סיעוד. יש לנו אפוא שתי צורות שונות ושתי רמות כיסוי שונות עבור קבוצה קטנה בעלת צרכים דומים לאלו של הקבוצה הגדולה יותר של זקנים מוגבלים, המקבלים שירותים בעין במסגרת חוק ביטוח סיעוד. יתר על כן, כפי שציינתי קודם, יש שירותים אישיים של עזרה ביתית וטיפול אישי עדיין ניתנים גם באמצעות שירותי הבריאות והרווחה שלנו וכן על ידי קופות החולים.

בדומה לישראל רוב הארצות המיוצגות כאן גם הן טרם פיתחו מערכת אחת שלמה, רציונלית, יעילה ואפקטיבית להקצאת משאבים להערכת צורכי הזקן ולהיענות להם, ועדיין יש להן כלכלות מעורבות שאותן הן מנסות לשפר. עקב קיומן של כלכלות מעורבות אלה, אי-שיוויוניות, אי-רציונליות, בזבוז, פרגמנטציה ותיאום בין המרכיבים השונים של המערכת הם בעיות אקטואליות מאוד, ועלינו לתת עליהן את הדעת. אולי לא ליבנו די הצורך בכנס זה כיצד אנו מתמודדים עם הבעיות הבלתי-נמנעות האלה של תיאום בין מערכות, וייתכן שעניין זה ישמש נושא לדיונים בעתיד.

עם זאת הייתי רוצה להוסיף, שמערכות מעורבות אינן חייבות לנבוע רק מהתפתחות הדרגתית של מדיניות חברתית. אפשר לבנות אותן במתכוון ולראות בהן פתרון רצוי ואופטימלי, כפי שהציעו מספר נציגים. אפשר לומר, שמבחינת צרכים והבדלים אינדווידואליים יש יתרון מסוים לרב-גוניות של המערכות. מערכת מעורבת, מהסוג שהוצע, אשר תעניק הן גמלאות כספיות והן שירותים בעין - תרחיב את מגוון האלטרנטיבות, שמהן הזקן הזכאי ומשפחתו יוכלו לבחור במתאימה ביותר עבורו. פיתוח מערכת מסוג זה מניח, שזקנים תשושים ומשפחותיהם, המגיעים לשלב הקשה, הרגיש והמתוח של הידזקקות לשירותי טיפול אישי, לדוגמה, יבחרו את המתאים לרווחתם ולטובתם של הזקנים עצמם ויהיו ערים להשלכותיה של בחירתם. יתר על כן, אנו מניחים שהיעדים החברתיים העיקריים של הרחבת היקף הטיפול והפחתת העול הרובץ על המשפחה אמנם יוגשמו הלכה למעשה באמצעות בחירתו של הפרט. כאשר מעדיפים, לדוגמה, לקבל גמלה כספית, ההנחה היא שהזקן אכן ירכוש באמצעותה את השירותים הדרושים לכיסוי צרכיו, ולא ידרוש שירותים נוספים במימון ציבורי. אלולא כן, פירוש הדבר היה שהגמלה הכספית משפרת את מצבו הכלכלי של הקשיש, אך לא את מצבו הטיפולי ואף אינה מקטינה את מעמסת הטיפול המוטלת על בני המשפחה. הניסיון מלמד, שגמלת שירותים מיוחדים (attendance allowance) הניתנת לאוכלוסיות מוגבלות צעירות יותר משמשת בעיקר את מה שאולי נועד לשמש השלמת הכנסה. כספי הגמלה בדרך כלל אינם משמשים לרכישת שירותים. לכן קשה לצפות, שגמלאות כספיות אלה אכן תתרומנה במישרין לשיפור מצב הזקן ולהפחתת נטל הטיפול בו (זאת - במונחים פרקטיים של מתן שירותים פורמליים, שיפור איכות הטיפול ופיתוח שירותים). לעומת זאת, אלה בדיוק הן המטרות האופרטיביות של חוק ביטוח סיעוד המבטיח שירותים בעין. יש אפוא מקום לשאול, האם גמלאות כספיות שנוספות להכנסה אכן ממלאות את יעדן העיקרי - שיפור מצב הזקנים. מדיווחה של הנציגה מאנגליה עולה, שאפשר לעשות שימוש בלתי נכון גם בכספים שמיועדים למטרה מסוימת ולאבד את השליטה עליהם, ולדבר זה עלולות להיות השלכות חברתיות בלתי רצויות מבחינת השימוש בשירותים. בדברי אחד המשתתפים הופיעה דוגמה אחת כיצד חקיקה, שבפוטנציה עשויה להביא תועלת, עלולה להאיץ לגידול בלתי רצוי בשיעורי ההסדרים המוסדיים, שחברה זו מבקשת למנוע. דרוש, כמובן, מחקר נוסף בנושא זה כדי להבינו טוב יותר.

נקודה שברצוני לציין ושזכתה להסכמה כללית בכנס היא שכל מערכת שחברה תחליט לבחור לעצמה חייבת להיבדק לפי אותם קני המידה של התוצאה המושגת, דהיינו: שיפור מצבם של הזקן ושל בני משפחתו המטפלים בו, הפחתת עול הטיפול, טווח הבחירה המוגדל, מתן אפשרות לזקן להישאר בבית כאשר זה רצונו והכבוד הניתן לזקנים הן מצד עצמם והן מצד הדור הצעיר. בהקשר זה, כפי שהעיר אחד הנציגים, חובה על העוסקים במחקר לפתח קריטריונים משמעותיים ושיטתיים למדידת תוצאות - תפקיד לא קל בתחום הסיעוד, במיוחד כשהכוונה להעריך תוצאה במונחים של אפקטיביות ואיכות, ולא רק של יעילות.

קנה מידה חשוב, שעל כל מדינה להשתמש בו בהערכת תוצאות היא עלות-תועלת. שאלה חשובה שעלינו להיות מודעים לה היא: כמה מן המשאבים המושקעים בביטוח סיעוד אומנם מגיעים לזקנים הזכאים, במונחים של איכות שעות שירות נטו, ואיזה חלק יוצא על מינהל ושכר עובדים. המחקר בעתיד בוודאי יעקוב אחר שאלות אלה.

הדיון בשאלת סוג המערכת שאנו מבקשים לפתח מחזיר אותנו לנושא שעלה בשלושת ימי הדיון: כיצד כל ארץ המיוצגת כאן רואה את תפקיד המשפחה, ומה היא מצפה מהמשפחה מבחינת הטיפול בבני משפחה זקנים תשושים. לא ניכנס לתיאוריות כלכליות וחברתיות על חוזים בין-דוריים ועל העברת כספים ומתן שירותים בשלבים שונים של מחזור החיים ונתייחס לנקודה שכבר עלתה בעניין תפקיד המשפחה בכל חברה. כל חברה מתמודדת היום עם בעיות הזדקנות האוכלוסיות בשלב שונה של התפתחותה החברתית והכלכלית, במונחים של רמת החיים מצד אחד ושל היבטים חברתיים חשובים, כגון דפוסי מגורים ותפקיד האישה בחברה, מצד שני. ייתכן שהמצב בישראל יוצא דופן - שיעור גבוה של זקנים גרים עם בני זוג, ואילו בארצות אירופה הצפונית יש שיעור גבוה של זקנים הגרים בגפם. דבר זה, נוסף על המרחקים ועל המוביליות הגדולה יותר של צעירים, משפיע על אפשרויות המשפחה לטפל בזקנים.

כללית אני תוהה האם אתם שותפים למסקנה שהסקתי מההערות ששמענו, והיא - שיהא התפקיד המצופה של המשפחה בכל חברה מבחינת האחריות לנתינת טיפול לזקניה, אשר יהא, אין גם חברה אחת שרוצה לפתח מערכת טיפול פורמלית, המניעה והממריצה הפחתת אחריות מצד המשפחה. השאלה, אם כן, איננה האם "לאלץ" או להטיל על בני משפחה את עול הטיפול בניגוד לרצונם, אלא יש להציע למשפחות את סוגי התמיכה האלטרנטיביים שיאפשרו להן להמשיך לתת טיפול, להיות מעורבים ולקבל אחריות בכל צורה או ברמה שנראית להן מתאימה. כלומר, לבחור בין ביצוע תפקידי טיפול פרקטיים וישירים, ניהול ותיאום שירותים, או מתן תמיכה חברתית ופסיכולוגית לזקן בביתו או במוסדות סיעוד. בהקשר זה נקודה חשובה מאד הועלתה על ידי הנציגה מאנגליה - בני משפחה מחפשים דרך להתחלק בעול הטיפול. הם מבקשים התחייבות כלשהי מהחברה - חוזה בין עצמם בין הזקן ובין החברה, שבו מוכרים גבולות הטיפול הבלתי פורמלי.

לפי סקרים שונים שנערכו בתחום הטיפול הלא-פורמלי, רוב המשפחות בחרו לתת טיפול מתוך הרגשת אהבה וחובה, אך הן זקוקות לסיוע ולתמיכה מוגדרים, מסקטור השירותים הפורמליים, שאפשר לסמוך עליהם. אנו מקווים שתמיכה מסוג זה ניתנת בישראל מכוח חוק ביטוח סיעוד. אולם, כפי שהציעו מספר מרצים, אנו זקוקים בדחיפות רבה למחקר שיבדוק את תפקידיהם של בני המשפחה המטפלים, את גישותיהם ואת ציפיותיהם וכן את גבולות הטיפול.

מכל מקום, תהא המערכת המועדפת אשר תהא - גמלאות כספיות, שירותים, או צירוף של השניים - כל חברה חייבת להתמודד עם הבעיה של אספקת שירותים איכותיים והיצע כוח אדם נאות. כמו כן, עליה לוודא שיש מדיניות ברורה לפיתוח מערכת רחבה של שירותים זמינים אלטרנטיביים לטיפול איכותי העונים על הקריטריונים של תועלת-עלות. האמת היא, שארצות דוגמת גרמניה המערבית יכולות לשקול ברצינות אימוץ תוכנית סיעוד המבוססת על גמלאות כספיות, רק מפני שיש לה כבר מערכת שירותים מפותחת מאוד המופעלת על ידי ארגונים התנדבותיים, בלא מטרות רווח. אלה מעסיקים מספר עצום של אנשים מוכשרים ומנוסים, כך שהזכאים יכולים לנצל את הגמלאות בנקל לרכישת שירותים בקהילה. לא בכל חברה יש היצע שירותים כזה.

סוגיות למחקר ולדיון בעתיד

מספר נושאים חשובים נוספים הועלו בכנס זה, כגון האיזון בין סוגי השירותים השונים הדרושים ברצף המתמשך של צרכי הזקן, וקשרי הגומלין בין שירותים אלה. לדוגמה, מספר מרצים ציינו שעלינו להימנע ממתן דגש יתר לטיפול רפואי יקר על חשבון שירותים חברתיים. כן צוינה חשיבות פיתוחם המוגבר של טיפול מניעתי ושיקומי ושל שיפור הטיפול בבריאות הזקן על מנת למנוע התדרדרות. לבסוף, מספר עמיתים, כגון אלו מאוסטריה ומארגנטינה, הדגישו את הצורך הדחוף לפתח סידורי דיור מוגן, שיש בו שירותים מתאימים לזקנים, כאלטרנטיבות לבחירה רק בין נפילה לעול המשפחה לבין מעבר למוסד.

מאחר שתוארו כאן המודלים השונים של פיתוח שירותים, אחד הנציגים הציע כדרך אפשרית לבדיקת אפשרויות היישום והאפקטיביות של אלטרנטיבות את המפעל הניסיוני המבוקר. זו השקעה כדאית שתאפשר התנסות מעשית ועמידה על טיבן של אלטרנטיבות כחלק מפיתוח מדיניות לפני הנהגת תכנית מסוימת בקנה מידה ארצי. כמו-כן, הוצע להשתמש בכלי מחקר לפתרון בעיות ולבדיקת מקורות מימון חדשים לביטוח סוציאלי.

תחומים נוספים שהתייחסנו אליהם במשך הכנס ושראויים למחקר מעמיק ולדיון בעתיד הם:

א. האיזון הרצוי בין שירותים פרטיים וציבוריים

אולי כדאי היה לשמוע עוד על הניסיון שהצטבר בארצות שונות עם הסקטור הפרטי, מכיוון שלכל ארץ יש גישה כלכלית, חברתית ופוליטית שונה לנושא זה. לדוגמה, חשוב ללמוד מה האפקטיביות של תוכניות ביטוח פרטיות המשלימות תוכניות ציבוריות, כגון ביטוח מדיגפ (Medigap) בארה"ב, ומה אפשר ליישם מהן בחברות שונות.

ב. טיפול מוסדי וטיפול לא-מוסדי - עירוב ואיזון

נושא זה ראוי לתשומת לב רבה יותר. בצד הסכמתנו לכך שבשלב מסוים טיפול מוסדי הוא בלתי נמנע עבור שיעור מסוים של אוכלוסיית הקשישים, מפאת מגבלות הזמן אי אפשר היה להרחיב את הדיבור על מספר נושאים שעלו בדיונים, כגון: איכות הטיפול ועלויות הסידור המוסדי בהשוואה לאלה של שירותי הקהילה, והתערבות מתוכננת, דוגמת זו שבהולנד, המיועדות להפחית את שיעורי המיסוד.

ג. קבוצות בעלות צרכים חריגים

בנושא זה נגענו, אך לא יכולנו להקציב לו זמן. מדובר בצורכיהן של קבוצות קטנות של זקנים, שיש להם צרכים מיוחדים הדורשים טיפול יקר, כגון דמנציה ובעיקר אלצהיימר. נושאים דומים שהעלה, לדוגמה, נציגנו מקמרון, הם עלותה הגבוהה של הטכנולוגיה הרפואית והדיאגנוזה הרפואית הדרושות לטיפול במחלות מסוימות בעת זיקנה. על אלה הייתי מוסיפה את חשיבות הרחבת הידע על מחלות הזיקנה ומגבלותיה במסגרת החינוך והרפואה הגריאטריים, ואת יישומם בטיפול הרפואי המעשי.

ד. נושאים של עלות-תועלת

דרושים מחקר וביקור מעמיקים יותר לשם שיפור העלות-תועלת הכללית של טיפול חברתי, רפואי, בריאותי, שיקומי ותמיכתי בזקן ולשם מניעת שימוש בזבזנו בשירותים יקרים - כגון שירותים רפואיים - במקום בשירותי תמיכה, שעלותם נמוכה יותר. בנושאים אלה קיבלנו דוגמאות, כגון השימוש במיטות בתי החולים כבמיטות סיעודיות, רק בגלל שהמימון ממשלתי, במקום אספקת שירותים מתאימים הנימנים במסגרות תמיכה זולות יותר המומנות על ידי רשויות מקומיות.

ה. תפקיד האישה

תפקיד האישה כמטפלת בחברות מודרניות צוין על ידי מספר עמיתים, במיוחד נציגתנו מפולניה, שדנו בקשייה של אישה לתאם בין תפקידיה השונים כעובדת, עקרת בית, אשת מקצוע, בת זוג והורה. כן הוצע, שנשקול אפשרויות לפצות נשים מטפלות על אובדן הכנסה, זכויות פנסיה וכו', ועל סכנת התרוששותן הכלכלית בעתיד, כשהן עצמן תהיינה זקנות.

ו. איכות הטיפול

כיצד נוכל למדוד טוב יותר את איכות השירותים? יש צורך לחקור בהקדם כיצד אפשר לפתח קני מידה משמעותיים ומוגדרים להערכת השפעת הטיפול - הניתן בבית, בקהילה ובמוסד, וכן ליצור כלי ביקורת איכות ומעקב. בתחום זה אמנם לא מאוד התקדמנו, אך יש לו חשיבות תיאורטית ומעשית מידית לאלה האחראים למעקב אחר האפקטיביות של תוכניות.

ז. מ נ י ע ה

כמו-כן, יש צורך מידי ללמוד איש מרעהו על אפשרויות למנוע, או להפחית גורמי סיכון, הן בגילים צעירים והן בעת זיקנה, על עלויות חלופיות של שירותי מניעה ושל תוכניות טיפול, ועל אפשרויות לשימוש נרחב ויעיל יותר בטיפול הרפואי, כולל נתינת תרופות ושיקום. זאת, כדי להפחית את מה שלפעמים מוגדר - שלא בצדק - כתלות בלתי הפיכה, ולצמצם בדרך זו את הצורך בשירותי סיעוד בעתיד. יש לחקור עוד תחום זה, שכן אם נוכל לצמצם צרכים ותלות, אזי קבוצות מקצועיות תוכלנה לענות בעתיד ביתר קלות על מה שנתבקשנו אנחנו לענות: כיצד לתכנן את הטיפול בזקנים במסגרת הביטחון הסוציאלי.

NATIONAL INSURANCE INSTITUTE
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The Impact of Demographic and Socio-Economic Factors on the Changing Needs of the Very Old*

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by
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* from ISSA Expert Group Meeting on "The Role of Social Security in Providing Social Protection to the Very Old", April 1989.

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Preface

The ISSA Expert Group Meeting on "the role of social security in providing comprehensive care for the very old" was held in Jerusalem in April 1989, hosted by the National Insurance Institute of Israel and attended by 70 representatives of ISSA member organizations from 23 countries, as well as representatives of the World Health Organization and the European Institute of Social Security, in addition to the ISSA Secretariat.

Israel had the honor of presenting a background paper at the opening session of the meeting, and I believe that I express a consensus among participants in stating that the meeting was enlightening and productive, bringing to the fore issues of common concern through the official reports presented, comments of participants and informal talks carried out throughout the meeting.

The present publication includes the papers prepared for the various stages of the conference. The background paper distributed prior to the conference, the oral presentation given at the opening of the conference and the brief summary of the various reports presented at its close, are all included here in the original English, while the oral presentation and summary alone have been translated into Hebrew.

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Background Paper

1. Introduction

The aging of the population in developed countries has presented new challenges to the development of health and social policy. One of the most acute and visible problems facing the health and social service sectors today is that of meeting the rapidly increasing needs of the elderly. Although there is considerable disagreement about future morbidity patterns, it would seem that demographic trends in the size and proportion of the elderly are compounded by some epidemiological studies showing increasing rates of debilitating chronic disease and disability, particularly among the very old (Brody, 1982, Davies, 1984; Rice and Feldman, 1983; Rice, 1984; U.N., 1986). Especially problematic is the growth of high-risk, hard-to-manage groups of elderly who suffer from some form of cognitive impairment and who require high-cost services at home, in the community or in institutional settings. At the same time that Western industrialized nations are under great pressure to reduce expenditures on income security, health and welfare programs, the proportion of aged in the population, especially of the very old, has been growing and is predicted to further increase over the next several decades.

As an OECD report (1988) succinctly points out:

> "The key social policy concern arising out of current demographic trends is whether the aging of populations is likely to lead to a major increase in the cost of public social programmes and whether society, and in particular the working population, will be able or willing to bear the additional financial burden."

However, beyond demographic trends and expected shifts in age structure, which in themselves are based on past and projected changes in fertility and mortality rates, a range of other factors will influence how we define needs and the nature of public expenditure for the very old. These factors, some of which will be explored in this paper, are expected to similarly influence demands, economic climate and social policy, and deserve rigorous methodical consideration for purposes of planning. Given these projections, it is necessary to consider what other developments may exacerbate or reduce the pressures of population aging and what social security policy alternatives need to be considered.

One of the best reasons for holding a special meeting on the subject of the very old is the fact that we have been traditionally studying and providing data for the elderly as a single group spanning 35 years whereas in fact there is a great deal of diversity among this group, diversity which should be addressed in planning social security policy. First, in terms of resources, as the number of very old increases, proportionally more resources are likely to be used by them than by younger age cohorts. Per capita costs for the very old are already larger

than for any other age groups in some countries (US, GAO, 1986).

How do we define the group of very old, even in terms of age? Reports addressing this meeting will variously refer to persons aged 75, 80, or 85 years old and over and perhaps one of our first tasks will be to standardize ISSA's definition of this age group for future statistics and cross-national comparisons.

What we do know, however, as has been pointed out in an introduction to a special issue on the very old, published by the Milbank Memorial Fund (Riley 1985), is that relatively little is known about what seems to be the fastest growing segment of the population in industrialized countries. How many elderly will actually survive to the oldest ages? How many will be healthy and how many disabled? How is the postponement in mortality related to the morbidity of survivors? What will their expectations be? What will their service requirements be? How much will it cost to provide these services?

As a group, the oldest old today are distinguished from younger elderly in a number of ways:

a) A unique sex ratio with a predominance of females as compared to males;
b) A higher rate of institutionalization;
c) A greater probability of widowhood and living alone;
d) Lower income levels;
e) Lower educational attainment levels;
f) A higher incidence of morbidity and mortality;
g) Extensive use of high-cost services, especially acute hospital and long-term institutional care.

During this meeting, it will be important for future planning to keep in mind that we are not examining a homogeneous or static population. In addition to existing heterogeneity within current cohorts of the very old, this population is changing in nature, and in order to make predictions about future groups we should already be looking at younger age cohorts. Thus, for example, future cohorts of over 80's will have achieved higher education levels, and some groups will enjoy higher income levels and good health. The interrelated, changing factors of income, marital status, kinship status and living arrangements are important determinants of formal and informal care options and utilization of long-term care by the very old which in turn are affected by longevity, changing birth and divorce rates and increasing participation of women in the labor force (Riley, 1985).

An understanding and systematic analysis of these changing factors are a basis for proposing alternatives in planning for comprehensive care of the growing population of the very old. It may become necessary and possible for some groups of the elderly to assume a share of the increased costs of providing health and social security. Options for restructuring of expenditures, cost-sharing to redistribute the financing burden between working and non-working populations, for example, may require reductions

in kinds and levels of benefits for some groups of elderly. Improvements in the relative income and wealth of some elderly groups may increase the viability of considering alternatives of this sort, although the needs of low-income and poor health groups need to be met. On the side of services, biases toward high-cost care, such as institutional care, could be balanced by community-based programs of social services, housing and personal care. Finally, the private sector is likely to emerge as having a greater role in supplementing basic public pensions and health care programs in some countries.

In any case, over the next few decades, industrialized nations can expect an intensified demand for health and social support services and especially for long-term care, accompanied by inevitable pressures for greater expenditures in the areas of economic security, health and social welfare. Our response, then, to these demands ought to be four-fold:

a) moving towards a better understanding of what determinants affect needs of the very old, how to monitor these factors and how they are changing over time;

b) adopting a pluralistic approach to meeting the needs of diverse groups of elderly; identifying the nature of heterogeneity within the older population as well as specific target groups with acute needs;

c) beginning to examine a variety of options for funding and program development, some of which may clash with some tenets of social security policy development;

d) setting forth priorities in resource allocation.

The main issue this paper addresses is: What factors are to be taken into account in defining needs? It is clear that meeting needs of the elderly at home, in the community and in institutions will continue to require extensive funding. In anticipation of increasing concern with cost-containment, many countries are searching for policy options for the provision of services in a more organized and efficient manner in order that funds be used to meet most acute needs. What will be the order of priority in the use of funds? How should current funds be allocated or reallocated, or new funds infused into the system in an effective, efficient and equitable manner which will meet needs while preserving balance in service provision and use? In other words, what kind of system are we aiming at that will provide an appropriate response to requirements?

2. Factors Related to Defining Needs of the Very Old

It is important to emphasize that operational definitions of needs and subsequent planning for services require different approaches in each society, based on its social and political structures, economic system, tradition of service provision, expectations, division of responsibility among government bodies,

funding structures, role of the private sector, desired short and long-term program goals, program constraints, and specific policy objectives.

Traditionally, the literature relating to estimating kinds and scope of needs, or demand for services, for the very old, has focused primarily on past and projected demographic population data which over the past decade have increasingly been raising concern about the implications for economic, social and health expenditures and policy.

Current population projections, however tentative, indicate that all western industrialized nations can expect and will have to plan for growth in the number and relative proportions of the elderly and the very old. Changes in the age structure of populations have important implications for the demand for social transfers and services, for the kinds of resources necessary to finance these services and for the structuring of financing mechanisms.

However, it is impossible to isolate the impact of pure demographic change from other factors which influence needs and the development of social expenditures. How heterogeneous will the over 80's group be? Will future cohorts of elderly be well or chronically ill? What will be their economic resources, their educational level, their marital and living arrangement status? Should we in fact be defining the specific needs of the over 80's in terms of age or should we be examining more carefully the specific requirements of specific groups against the background of changing social and economic factors? If one of the goals of this meeting is to find a common denominator for collecting data, defining needs and examining possible alternative responses to changing needs on a cross-national basis, it would seem worthwhile to begin developing a basic model of factors which are common to most societies and which ought to receive careful consideration in examining ISSA programs and planning for the future. In general we should be aiming at developing as comprehensive as possible a model which may be operationally different in each society but which will constitute a basic approach to the issues involved in planning for the adequate care of the very old. The model depicted in Figure 1 includes a number of interrelated components:

a) <u>Demographic, social and economic factors</u>
Some of these are more in the nature of givens, cannot be modified and are therefore program constraints. Others, equally important, are in flux and reflect behavior or trends that might be modified in the long term by policy and existing programs.

b) <u>Current patterns of meeting economic, health and social needs</u>
These include current program characteristics in the areas of:

(1) patterns of informal care;
(2) mix of public and private provision and utilization of services and benefits;
(3) existing funding arrangements.

c) <u>Policy objectives</u>
Society-specific objectives reflecting traditions, expectations and order of priorities of each culture

d) <u>Program objectives</u>
Specific strategies for change; feasible program alternatives in four main areas of care:

(1) economic security;
(2) prevention and health promotion;
(3) curative, ameliorative care;
(4) maintenance or long-term care.

Several points should be made in examining the model:

1) This type of outline delineates areas for discussion, data collection and cross-cultural comparison. The specific content included under each component of the model will vary for each society. In general, however, it is suggested that the very manner in which societies will define and relate to needs and to the types of program responses elicited to meet these needs, can be systematically examined by studying the interrelated factors schematically described in Figure 1.

2) This is not a static nor all-inclusive model. The demographic, social and economic components include examples of a range of factors, some of which (eg. ADL dependencies) do not have clear-cut classification. Some of these factors are not easily quantified and extrapolated, but their impact on policy concerns and program objectives are extensive.

3) Policy concerns are important intervening parameters affecting program objectives and will be defined differentially in each country.

4) Program objectives should be the outcome of policy concerns as influenced by preceding factors, taking into consideration existing resources as well as short and long-term goals. Each society will determine to what degree economic security, preventive care, curative care or maintenance will be emphasized.

5) Finally, this model can be utilized for current age groups, or for planning on the basis of monitoring characteristics of succeeding cohorts that will in the future constitute whichever age group, such as the over 80's, is the focus of analysis.

FIGURE 1 Factors Affecting Needs and Programs for the Elderly

A. Background Factors

Demographic

- population data
- past and projected age structures age/sex ratios
- geographic distributions
- emigration patterns
- mortality rates, life expectancy for age groups
- fertility rates
- morbidity rates

ADL, IADL depndency rates

Social

- family size
- marital status; divorce rates
- living arrangements (especially % living with spouse and % living alone)
- education attainment levels
- traditional role of women
- women's labor force participation trends
- informal care patterns
- changing expectations for services; preferences
- retirement age
- number of children, proximity

Economic

- specific economic system
- tax structures
- age dependency ratios
- GNP growth
- inflation rates
- technological advances
- health and social expenditures (by age group)
- economic circumstances of elderly
- out of pocket costs incurred in providing care
- labor force participation rates of specific groups: elderly, women,

B. Current Patterns of Meeting Needs

a) Type of economic, health and social services and benefits (cash and in-kind transfers)
b) Coverage: rates of institutionalization and home care provision
c) Adequacy, coverage and maturation of social security and work pension programs
d) Funding structures and division of responsibility
e) Role of private sector

C. Policy Concerns

- available resources, public and private
- economic stability and growth
- universal coverage versus selective, pluralistic approach
- concern with quality
- public/private mix
- cost/effectiveness considerations of home vs. institutional care
- funding alternatives such as cost-sharing, restructuring expenditures, selective reductions in benefit levels, changes in retirement age, etc.

D. Program Objectives

Economic Security

labor force productivity
earnings, savings
social security
work pensions
housing

Prevention and Health Promotion

public health
personal safety measures
social supports

Curative, Ameliorative Care

primary medical care
acute hospital care
rehabilitation
social supports

Maintenance (long-term care)

personal care at home
community adult day-care, meals
institutional care

3. Demographic Factors: An Aging Population

Changes in the age structure of a population are determined by trends in fertility, mortality and migration. The aging in developed and industrialized nations has in the past been caused primarily by long-term declines in fertility and very little by increases in life expectancy, which did not have a major effect on the age structure of populations in the first half of this century since it affected all age groups.

In 1980 average life expectancy at birth was 77.6 years for females and 70.9 years for males ,while life expectancy at age 60 was 21.5 years and 17.1 years, respectively (OECD, 1988). In the United States, between 1984 and 2035 life expectancy at age 65 is expected to increase by 2.5 years for males, from 79.5 to 82.0 years and for females by 3.6 years, from 83.7 to 87.3 years (US, GAO, 1986). In the future, however, reductions in mortality for persons aged 65 and over due to possible technological and medical advances may have an additional effect on the size of the very old population. If there are further increases in life expectancy due to major breakthroughs in treating such diseases as cancer and heart disease, current projections in the growth of the elderly population may in fact be understated, and more people will be living into very old age.

Both developing and developed countries are experiencing population aging. According to a WHO report (1987), in several countries the elderly population is increasing at a faster rate than the population as a whole. The same WHO report finds that between 1980 and 2020 the total population of the developing world will be increasing by an expected 95% whereas the aged population will rise by 240%. An OECD report (1988) shows very clearly that in 24 OECD countries the numbers of those over age 65 are projected to rise from 90.6 million in 1980 to 115.7 million by the end of the century and to 189.3 million in 2040, returning to 182.7 million by 2050. The period of most rapid growth is expected to be the second and third decades of the next century when the elderly population of the OECD area is expected to increase at an annual average rate of 1.6%.

The number of elderly, which has been growing steadily in this century, represented in 1980 an estimated 5.7% of the world population, and by the year 2025 is expected to have reached 9.5% (Table 1). Large differences are predicted between less developed and more developed regions. In more developed regions the proportion of 65+ will constitute an average of 17.3% of the total population and, in some Northern and Western European countries such as Denmark, Netherlands, West Germany and Sweden, will reach over 22%, using medium variant population projections (United Nations, 1985).* The major increase in the number of elderly between 2010 and 2025 reflects the large numbers of individuals turning 65 who were born during the "baby boom" generation, between 1946 and 1964.

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* US figures for 2025 are based on US census data.

TABLE 1. Total Population Aged 65 +; Changes in Proportion of 65+ and 80+ Groups Out of Total Population; Proportion of 80+ Groups out of Aged Population, 1980 and 2025

	Number of Elderly (in 1000's)	% 65+ of the Total Population		% 80+ of the Total Population		% 80+ of Elderly Population	
	1980	1980	2025	1980	2025	1980	2025
World	255,939	5.7	9.5	0.76	1.4	13.4	14.8
More developed regions	129,791	11.4	17.3	1.9	3.4	17.0	19.4
Less developed regions	126,148	3.8	7.8	0.4	1.0	9.7	12.6
Europe	63,044	13.0	18.4	2.1	4.8	16.4	20.7
Eastern Europe	13,090	11.9	17.0	1.7	3.1	8.5	18.4
Northern Europe	11,907	14.6	18.8	2.6	4.0	17.8	21.1
Southern Europe	16,187	11.7	17.0	1.8	3.6	15.3	21.4
Western Europe	21,860	14.2	21.0	2.5	4.5	17.8	31.3
U.S.A.*	25,709	11.3	19.5	2.3	4.8	20.4	24.6
German Dem. Republic	2,731	16.3	19.6	2.8	4.5	17.1	21.9
Federal Rep. Germany	9,274	15.0	22.1	2.4	5.4	16.1	24.5
France	7,386	13.7	19.4	2.7	3.6	19.6	18.7
Argentina	2,307	8.2	11.0	1.1	2.1	13.1	19.2
United Kingdom	8,233	14.8	18.3	2.6	3.9	17.8	21.1
Denmark	730	14.2	22.3	2.6	5.0	18.5	22.3
Netherland	1,630	11.5	22.7	2.1	4.3	18.2	19.2
Austria	1,161	15.5	19.8	2.7	4.3	17.2	22.0
Chechoslovakia	1,946	12.7	15.9	1.7	2.7	13.8	17.1
Israel	326	8.4	12.1	1.1	1.9	12.9	15.8
Sweden	1,339	16.2	22.3	2.9	5.3	18.2	23.6
Canada	2,150	8.9	18.1	1.5	3.3	17.0	18.0

Source: World Population Prospects/*United Nations Department of International Economic and Social Affairs* Population Studies, No. 86, N.Y., 1985.

Projections are based on medium variant rates of population change. Other sources suggest even higher rates of population aging for some countries (see Boyle, et. al., 1987 - U.S. Census data; OECD, 1988).

* U.S. figures for 2025 are based on U.S. census data.

Not only is the aged population increasing, but the elderly population is itself getting older as more and more people survive to the highest ages. In fact, most of the growth will occur in the 80 and over group. In more developed regions of the world the proportion of persons age 80 and over out of the total elderly population (65+) will increase from 17% in 1980 to 19.4% by 2025 and in some countries (e.g., Germany, Denmark, Austria, Sweden) will comprise almost one-quarter of the elderly population.

According to Manton and Soldo (1985), the current process of population aging and rapid growth in the 85 and over group, the one with the highest per capita service needs, has not been sufficiently taken into account in development of policy. Adequate concepts and models of health change are lacking and are therefore not being taken into account in demographic and actuarial projections for social security programs.

Population aging has important implications for the size and age structure of the working population and the ratio of the population aged 65 and over to the population aged 15-64 (old-age dependency ratio). Past growth, during the 1960's and 1970's, in the number of working-age people in many industrialized countries, is already tapering off and will continue to do so, reflecting the decline in fertility from the mid-1960's. By the second decade of the next century the numbers of working age people are projected to be falling in almost all OECD countries (OECD, 1988). At the same time, the average age of the working population is expected to rise appreciably, so that by 2020, more than one in five will be over the age of 55. Germany and Japan will have already reached this situation by the turn of the century (OECD, 1988).

As a result of changes in population composition, the old-age dependency ratio is changing. The old-age dependency ratio is expected to increase in every major world region, with the most dramatic increases occurring among the more developed regions and in East Asia (Table 2). As people live longer, as mortality decreases, as demands for income support for a range of social services increase, the difficulties of supporting comprehensive social security schemes will be felt. Countries will face growing fiscal burdens as expenditures increase and the working age population shrinks.

Ogawa (1982; 1984) has predicted, for example, that in Japan the proportion of those aged 75 and over will increase from 34.4% of the elderly in 1980 to 53.5% in 2025. The shift in age composition will directly affect the demand for medical services: health benefits are expected to increase by a factor of 7.3-7.8 by 2010 as compared to 1978. Due to maturity in pension schemes, expenditures on public pensions will grow by a factor of 13. At the same time the contributions to social security are expected to increase by 8.3-9.0. In terms of the percentage of national income, this will constitute an increase from 9.8% in 1980 to as high as 28.7% in 2015.

TABLE 2. Old Age Dependency Ratios,* Medium Variant 1950-2025, World and Major Regions, and Selected Countries

Region	Old Age Dependency Ratios			
	1950	1980	2000	2025
World	8.9	9.8	10.5	14.4
Africa	6.7	5.9	5.9	6.3
Americas				
Latin America	6.0	7.6	8.4	12.4
North America	12.5	16.7	17.6	27.6
Asia				
East Asia	5.9	8.5	10.9	19.4
South Asia	9.2	5.9	7.0	10.8
Europe	13.2	20.1	22.0	29.2
Oceania	11.9	12.7	14.0	19.2
U.S.S.R.	9.5	15.3	18.4	23.6
U.S.A.	12.5	17.1	17.6	27.4
Austria	15.5	24.1	22.7	31.3
France	17.2	21.4	22.4	31.0
Argentina	6.4	13.2	15.5	16.9
U.K.	16.0	23.1	22.6	28.9
Denmark	14.1	22.0	22.4	35.1
Netherlands	12.3	17.3	20.3	36.7
Czechoslovakia	11.4	20.1	18.6	25.0
Israel	6.0	14.3	13.0	18.6
Sweden	15.5	25.2	25.6	35.9
Canada	12.2	13.1	17.3	29.1
W. Germany	14.0	22.7	24.4	35.8

* Old-age dependency ratio is defined as the ratio of the population aged 65+ years to those aged 15-64, multiplied by 100. Medium variant rates of population aging were used.

Source: U.N., World Population Trends, Population and Development Interrelations and Population Policies, Vol. 1, New York, 1985 (based on results of U.N. demographic estimates and projections in 1982).

4. The Burden of Caring for the Elderly: Support and its Costs

In planning programs for the elderly and their families at home, it is necessary to define carefully our concept of social policy in a way that closely reflects actual patterns of care, expectations and preferences of the older person and his family and expected family behavior in the future as influenced by changing social trends among successive age cohorts which will constitute future generations of elderly.

Several of the conditions that may affect patterns of care, family expectations and service utilization have been documented in literature which has examined determinants of the magnitude of long-term care (Brody, 1981; Luce et. al., 1984; Rice, 1984; Sang, 1982; Shanas, 1979; Vogel and Palmer, 1982), but generally not on a basis that permits cross-national comparisons. These factors might not affect the basic level of need but have been identified as influencing the types of programs which have evolved in various societies, especially the balance of formal and informal care. They include: differential fertility rates among age cohorts, divorce rates (affecting the availability of children to provide informal care), marital status of the elderly (availability of spouse caregiver) and female labor force participation (availability of women to provide informal care at home). To these should be added patterns in living arrangement and household composition trends, as well as economic status and level of education, all of which would influence not only emerging patterns of formal and informal care, but also expectations as to kinds of programs which might be made available, and the ability to pay for services.

Of key relevance to long-term care planning are estimates of dependency in terms of activities of daily living (ADL). These estimates vary according to the definition utilized. Although the majority of elderly are not seriously dependent, even at advanced ages, at least 5% are institutionalized at any one point in time. In the U.S., nearly one-fourth of those aged 85 and over are institutionalized (Riley, 1985). Of all elderly institutionalized in nursing homes, 42% are over age 85. This proportion will reach 51% by 2020 (Rivlin and Wiener, 1988).

Studies in Israel and the U.S. have shown that of the elderly living at home, approximately 7%-8% require the assistance of others in performing daily activities (ADL). These dependency rates increase sharply with age (Table 3).

Expenditures on health care - primary, hospital and institutional - and on personal care and support services for the elderly in the community are beyond their proportion in the population. As a result there has been an overriding preoccupation in Western countries with the growing, often unsupportable, cost of care (Rivlin and Wiener, 1988; Wells and Freer, 1988).

TABLE 3. Proportion of Non-Institutionalized Aged with ADL Dependencies by Age and Sex

Age	United States			Israel	
	ADL score*			Age	% requiring help with ADL**
	1-2 ADL's	3-4 ADL's	5-6 ADL's		
65-74	4.2	1.8	2.1	65-69	2.2
Males	3.4	1.7	2.4		
Females	4.7	1.9	1.9		
75-84	9.0	3.6	4.5	70-74	6.4
Males	6.5	2.5	4.6		
Females	10.3	4.3	4.4		
85+	17.4	7.8	10.4	75-79	6.8
Males	15.7	7.7	7.5		
Females	18.2	7.9	11.8	80+	24.3
Total 65+	6.6	2.8	3.5	65+	7.7
Males	5.1	2.3	3.3		
Females	7.7	3.2	3.6		

* Sum of number of activities of daily living with which respondent requires assistance.

** Requiring at least 3 hours per week of ADL assistance.

Source: Soldo, B.J. and K.G. Manton, "Health Service Needs of the Oldest Old", Milbank Memorial Fund Quarterly, 63:2 (286-319), 1985.

Israel figures: B. Morginstin, "The Need for Personal Assistance and Home Help and Their Provision by Family and Community", National Insurance Institute, Jerusalem, 1984.

In the United States (US, GAO, 1986), for example, whereas in 1960 less than 15 percent of the federal budget went to programs for the elderly, in the fiscal year 1985 that proportion nearly doubled to 28 percent. In 1970 pension and health care financing programs consumed 6.1 percent of the GNP, and by 1986 9.6 percent, an increase of over 50 percent. In 1985 federal expenditures for the elderly represented nearly half of all domestic program spending, $263 billion. Social security represented 55 percent of these expenditures and Medicare 23 percent. Health programs are expected to account for most of future growth due to the projected relatively higher rate of increase in the number of very old who are more likely to require health care and anticipated rise in general health costs which are expected to grow at a higher rate than the GNP.

In addition to expenditures on institutionalization, the oldest old also have the highest health costs. The differences in medical costs among the aged are striking. In the U.S., as income declines by 36% between ages 65-69 years and 85 years and over, Medicare costs increase by 77% (Torrey, 1985). Medicare costs have increased as a result of greater use of primary and hospital care. For example, the rate of hospital days per 1000 for those aged 85 and over is twice that of the younger old. The rates of nursing home residents is 11 times higher for men and 16 times higher for women as compared to the younger elderly population (U.S. figures, Rice and Feldman, 1983).

Esitmates of per capita public health expenditures for the elderly in 1980 ranged from $975 in the United States to over $2000 in the Scandinavian countries. The percentage of public health expenditures for the elderly was estimated at ranging from 21% in Canada to 50% in Norway (Rabin and Stockton, 1987; U.S. Senate, 1984). Total public expenditures on the elderly as a percentage of gross national product in various countries is shown in Table 4. Total public expenditures include pensions and other allowances as well as health and long-term care financed from public revenues.

Table 4. Total public expenditures on the elderly and as a percentage of gross national product, and total public health expenditures on the elderly, and as a percentage of gross national product, selected countries

Country	Year	Total Per Capita Public Expenditure For the Elderly		Public Health Care Expenditures For the Elderly	
		Amount*	% of GNP	Amount*	% of GNP
United States	1981	6,366	5.9	1,212	1.1
Canada	1982	6,096	5.4	1,370	1.2
Denmark	1980	8,499	10.1	2,356	2.8
France	1980	7,993	9.8	1,876	2.3
Netherlands	1982	7,861	8.2	1,534	1.6
Norway	1981	5,005	5.7	2,546	2.9
Sweden	1982	12,293	14.5	N/A	
United Kingdom	1980	4,416	7.7	975	1.7

Source: Long-Term Care in Western Europe and Canada: Implications for the United States. Special Committee on Aging, United States Senate, U.S. Government Printing Office, July 1984; as printed in Rabin and Stockton, 1987.
Figures are in U.S. dollars.

Projections for the year 2000 in the United States show that while benefits to the 65-69 age group will remain a stable $65 billion, benefits for persons 80 and older are projected to rise by $33 billion, from $49.8 billion to $82.8 billion, in constant 1984 dollars (GAO, 1986). Nursing home expenditures for the elderly in the United States are expected to rise substantially, from $33.0 billion in 1986-90 to $98.1 billion in 2016-20 in constant 1987 dollars. Medicare and Medicaid will account for 49% of total nursing home expenditures. Nursing home cost increases in excess of general inflation are as responsible for rising expenditures in the United States as are the size and age composition of the general population (Rivlin and Wiener, 1988). According to the same authors, the continued increases in long-term care expenditures will outstrip real economic growth, although the burden of these expenditures as a share of GNP does not seem to be insupportable from an economic perspective.

Research as well as experience continue to affirm that the family is the major provider of care for the elderly (Shanas, 1979; Shuval, 1982). Studies have shown that approximately 80% of the elderly, dependent in functional activities of daily living, are receiving care from family members. In Israel this figure reaches about 86% in some areas where research has been conducted. Formal services, provided by government and public agencies, cover a much lower proportion of the aged. In Israel, for example, only about 14% of the non-institutionalized

dependent elderly receive services for personal care and about 7% for home help.

In this context, however, it is important to expose a duality in professional thinking about family caregiving which is probably a result of the historical development of social welfare services for the elderly. These services have generally been provided on a selective rather than a universal basis. On the one hand, the existence of kin as potential and actual providers of care has repeatedly been documented as an invaluable resource, often the principal factor affecting the probability of institutionalization. In fact, family care has been and is viewed as the primary component of community care. On the other hand, while the growing burden of care is recognized by professionals, there is a tendency to consider family caregiving as a free resource. In fact, the family caregiver has in the past often been neglected by the formal service system which may provide care only after severe crisis, exhaustion and breakdown when the family is no longer able to care. Thus there is a significant need for additional services from the formal sector - mostly to complement family care or to reduce overburden on the family, especially in caring for the very old, by the old.

Given the recognition of the increasing burden on the family, a shift may be expected in emphasis on target population from the elderly themselves to the older person and his family. Recent concern with family support services is one indication of the increasingly accepted approach that the family is indeed becoming a target in comprehensive care planning (Montgomery, 1984; Wells and Freer, 1988). This broadened view of the target population should be accompanied by a flexible approach in designing the kinds of benefits and services which will be included in a comprehensive program. If we are to respond adequately to family needs and expectations, concern with the family should become an integral aspect of planning.

The degree to which relatives are able to provide care is related to a number of factors: demographic, economic and social. For example, the age of chidren of parents aged 85 and over is at least 60, so that caregivers of the very old are primarily the old themselves: spouses and elderly children. Thus the very existence of children, their age and proximity to the very old will determine how feasible it is for family to fulfill responsibilities for the future.

Household composition of the elderly is one important factor and one which may explain cross-national differences in proportions of individuals receiving care at home and proportions receiving care in institutions. Throughout the developed world, except for Japan, living alone in old age is become a social norm. This trend is a result of the high proportion of widowhood among the elderly, especially among women. The proportion of widowed of both sexes among the elderly aged 75 and over ranges from 50% to 60% in most countries. The ratio of widows to married women in this age group approaches 5 to 1 in some

countries. This, coupled with growing divorce and separation rates (6% in Denmark), contributes to the number of elderly living alone (Torrey et al., 1987).

Israel is distinguished from European countries by its much lower proportion of persons living alone and a higher proportion of couples (Table 5). As pointed out by Achdut and Tamir (1986), couples without children and single females are the two main groups among elderly famiies. In the 60-64 and 65-74 age groups, couples without children constitute the largest group. In all countries except Israel, single females, who are economically the most vulnerable group, become the most prevalent group among persons aged 75 and over. In Sweden, Norway and West Germany, single females constitute over 50% of all families in the 75+ age group; in the United States, Canada and the United Kingdom, 45%. In Israel only 23% of all families in the 75+ age group are single females while the percentage of couples without children is double: 47%. This difference between Israel and other countries apparently stems from the its relatively low rate of divorce and separation. The lowest percentage of single males in the 75+ age group is to be found in Israel and West Germany (approximately 11%) and the highest in Sweden and Norway (17%-18%). Family size is in large measure attributed to household composition. In Israel elderly families are larger than in other countries. Sweden is characterized by the smallest family size - 1.7 persons in the 65-74 age group and 1.4 in the 75+ age group.

It should be pointed out, however, that living alone does not in and of itself constitute a high risk factor for the elderly (Taylor, 1988), unless accompanied by other economic, social, health, psychological and support risks. In fact most old people value their independence and, far from being a risk factor, living alone would indicate personal decision and choice on their part. Moreover, although more and more older people are living alone there seems to be no evidence that they are not receiving support from children and other relatives when this is required (Wells and Freer, 1988).

Table 5. Household Composition of the Elderly 65+ by Age of Family Head

Household Composition	Norway		W.Germany		U.K.		Sweden		Israel		U.S.A.		Canada	
	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65+ 74	75+
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Single Male	14	18	7	11	11	13	18	17	7	11	9	12	11	14
Single Female	35	52	44	51	31	47	37	57	26	23	31	44	29	45
Couple without children	41	25	36	33	43	25	44	26	46	47	42	30	40	28
Couple + children	6	1	1	--	1	--	1	--	2	3	2	1	2	--
One-parent family	3	3	--	--	--	--	--	--	1	--	1	1	--	--
Other + children*	2	1	1	--	1	--	--	--	4	2	2	--	2	1
Other**	--	--	11	5	13	15	--	--	14	14	13	12	16	12
Average family size	2.0	1.5	1.9	1.6	2.1	1.9	1.7	1.4	3.0	2.2	2.3	1.9	2.3	1.9

* This type of family includes families with children and with additional adult persons.

** All families without children which are not included in the first three types.

Source: L. Achdut and Y. Tamir, Retirement and Well-being among the Elderly, National Insurance Institute, Jerusalem, 1986.
Based on data from LIS (Luxembourg Income Study), July, 1985.

5. Changing Trends -- Changing Expectations?

Social factors, as they affect the needs of the elderly, should be examined within the context of the economic data and trends. Thus for example the changing role of women, who are generally the primary caregivers, will inevitably have an effect on caring patterns, expectations regarding kinds of services required and on the response of formal services to these patterns. In general, even when there are several siblings, there is a tendency for one person to assume caring responsibilities. In most cases this single caregiver is a daughter or a female spouse. An increasing proportion of women who have traditionally been the caregivers in our society are working outside of the home and are thus unable to fill the role of caregiver on a full-time basis. This trend, together with the small number of siblings to share the burden of caring, aggravates the already heavy burden of care.

Labor force participation rates are especially interesting when we look at figures for age groups which are particularly vulnerable as potential caregivers. Experience shows that the problem of providing care to older parents or to a spouse is especially characteristic of persons in upper middle age and old age. Examining changes in labor force participation for persons aged 55+ according to sex, one finds that while other sex/age groups have experienced a reduction in labor force participation, in several countries, including Sweden, Israel and Canada, the proportion of working women aged 55-64 increased significantly (Table 6). This trend may be on the rise in succeeding cohorts.

Brody (1981) has pointed out that women's increased participation in the labor force will have an unknown impact on the caring situation in the family. The question is whether there will be a redistribution of responsibility among family members or an additional burden and strain on the working woman, thus aggravating the "woman in the middle" syndrome. The burden of care, if it is not relinquished, may be compounded. However, it should be emphasized that increased labor force participation rates for women may have a dual effect: while the time available for caring may be reduced, the improved economic situation of women, accrued pension rights, savings, etc., may enhance their position as consumers of services. There seems to be evidence that families in which the wife works are more likely to purchase care (Luce et al., 1984). In other words, the tendency to acquire services from the formal sector may increase as a result of women's increasing participation in the labor force.

In view of studies that, despite predictions to the contrary, families are not relinquishing their responsibility as caregivers, the implication of this trend is twofold: a greater proportion of women will expect to be able to exercise greater independence in the way in which they manage care and in their choice of acquiring services; and as their earning power increases, women, who are traditionally the managers of care, may be able to purchase more services.

Table 6. Labor Force Participation Rates in Selected Countries, by Sex and Age Group, 1965 and 1985

Country	Males						Females					
	55 - 64			65+			55 - 64			65+		
	1965	1985	Change	1965	1985	Change	1965	1985	Change	1965	1985	Change
United States	82.9	59.7	-23.2	26.6	10.3	-16.3	40.3	41.7	1.4	9.4	6.8	-2.6
Canada	86.4	70.2	-16.2	26.3	12.3	-14.0	27.0	33.8	6.8	6.0	4.2	-1.8
Japan	86.7	83.0	- 3.7	56.3	37.0	-19.3	45.3	45.3	0	21.6	15.5	-6.1
France	76.0	50.1	-25.9	28.3	5.3	-23.0	36.9	31.0	-5.9	11.5	2.2	-9.3
Germany	84.6	57.5	-27.1	24.0	5.2	-18.8	30.2	23.9	-6.3	7.8	2.5	-5.3
Great Britain	92.7	66.4	-26.3	23.7	7.6	-16.1	35.6	34.1	-1.5	6.5	3.2	-3.3
Italy*	54.8	38.2	-16.6	18.4	8.9	- 9.5	14.3	10.5	-3.8	4.7	2.1	-2.6
Sweden	88.3	76.0	-12.3	37.7	11.0	-26.7	39.2	59.9	20.7	11.6	3.2	-8.4
Israel**	84.6	82.4	- 2.2	35.4	27.9	- 7.5	17.9	26.0	8.1	6.1	6.6	0.5
Finland	81.5	57.8	-23.7	18.0	10.6	- 7.4	54.9	52.9	-2.0	3.8	4.8	1.0
Netherlands***	80.3	53.8	-27.0	11.4	4.0	- 7.4	14.9	14.5	-0.4	2.3	0.7	-1.6
Spain	84.2	66.3	-17.9	25.9	5.9	-20.0	22.0	20.0	-2.0	7.7	2.1	-5.6

* 60-64 age group was used for Italy

** For 1960 and 1980 respectively

*** Netherlands data is for 1970 instead of 1965

Source: OECD, Ageing Populations -- The Social Policy Implications, 1988.

Increases in educational attainment levels are a factor which may also contribute to growing expectations on the part of future cohorts of elderly to make independent choices regarding service options. In the United States, for example, in 1985 approximately 75% of persons aged 45 - 54, and 65% of those aged 55 - 64, had completed at least secondary level of education as compared to 48% among persons aged 65 and over. For all groups these percentages were higher than in 1980. Similar trends of increasing educational levels among succeeding cohorts are found for Denmark, Norway, Canada, Japan, as well as the Eastern European countries (Torrey et al., 1987, based on U.S. Census data), for both men and women.

Thus, trends in educational level for both sexes and in education level for both sexes and in labor force participation for women might be expected to affect the expectation of caregivers that the kinds of formal assistance available permit them to make more independent choices in service acquisition while, at the same time, some groups of caregivers may enjoy somewhat improved economic circumstances which may enable them to cover at least some part of the cost of caring.

As indicated earlier, our health care system is becoming increasingly capable of sustaining the survival of sick people at enormous costs. These costs may not be able to be borne by individuals living on post-retirement income and assets, and are therefore being viewed more and more the responsibility of government. Is this a financially realistic approach? Can governments design policy and plan programs which are predicated primarily on increasing costs without seriously considering alternative options, some of which may undermine previously held principles of social security?

According to Torrey (1985), even though the very old are one of the most important and growing beneficiaries of public spending, little information about their economic resources is known. Social security programs tend to consider them a single beneficiary group of people 65 years of age and over and historically utilize summary statistics to describe the economic circumstances of the elderly. The aged today not only constitute the largest single group of beneficiaries, but they are more diverse and complex economically than the non-aged. Our information about them has however lagged behind their growing size and importance and we tend to utilize aggregate data for program planning rather than look at more specific age groups of the aged (Torrey, 1985).

Most of the data we utilize refers to average income of the aged, sometimes according to age group, which does not adequately describe their heterogeneity. Sample sizes are often not statistically reliable for the very old. Moreover, people who are institutionalized, most of whom are in the 80+ group, are usually ignored by surveys. In the U.S., for example, the average income of people aged 85 and older is 36% less than the income of people aged 65-69 (Torrey, 1985), mostly due to lower

labor force participation and lower social securiy rates. Similar dispersion ratios were found in a cross-national comparison (Achdut and Tamir, 1986), indicating that relative mean net income declines as age increases (Table 7). Income differences seem to be attributable primarily to reduction in earned income and to the greater proportion of widowed persons in the oldest population. The death of a spouse can result in a substantial income loss due to reduced social security and pension benefits and loss of earned income (Atkins, 1985).

Although we have learned a great deal about income status of some age groups, we know little about the assets of the very old and about resource depletion over time, using a longitudinal approach. From a policy perspective the question is whether future generations of very old will have the resources to pay a greater share of the high health costs or whether they will have depleted their resources. According to Wells and Freer (1988), data for England suggest that considerably greater numbers in future generations of elderly will have substantial capital assets at their disposal which has the potential of being employed to promote a comfortable and secure existence. Rivlin and Wiener (1988) found in the United States, that the financial position of the elderly, as reflected by income and assets (primarily home equity), should improve markedly by the year 2020. Total income growth is greatest for the 65-74 year age group and less for the 85 and older group. In order to project, however, what will be the economic circumstances of people aged 85 in 2020, we should be looking at those aged 50 now, examining how they are being affected by improved pension availability, earning histories, women's labour force participation, etc.

However, simulations based on cross-sectional studies should be viewed with caution, since they tell us only about income differences between different age cohorts having different work histories and life experiences but not about income changes associated with the aging process itself. Longitudinal studies of aging might provide invaluable insights into this question. Data about income depletion over time are of special importance if we want to look carefully and realistically at cost sharing and other possible alternatives for providing health and maintenance care for the very old, since cost-sharing programs will be unviable if the resources of those expected to share costs have already been depleted.

Thus, an important factor influencing the way we define needs, demands, and utilization of public and private services is the economic resources available to current and future cohorts of elderly. Cross-national comparisons of programs and attempts to learn or extrapolate from one society to the next should be based not only on a good understanding of demographic and cultural differences and of differences in tradition of service provision, but also on reliable comparative data which describe the economic circumstances of the aged in relation to demographic factors. Policy and planning should take into consideration the changing economic circumstances of aging

TABLE 7: Composition of Gross Income by Income Types (all elderly units)

Income Type	Norway			W. Germany			U.K.			Sweden		
	55+	65-74	75+	55+	65-74	75+	55+	65-74	75+	55+	65-74	75+
1. Income before tax & transfer	69	54	24	53	31	24	69	51	39	46	21	15
Earnings	61	41	6	43	17	8	54	26	17	39	12	2
Property income	5	6	8	2	2	4	7	10	10	7	9	13
Occupational pension	3	3	7	10	8	12	12	8	15	12	--	--
2. Transfer income	31	46	76	47	68	76	31	49	61	54	79	85
Public transfers	30	45	76	47	68	76	31	49	61	54	79	85
(Social Insurance transfers)	30	45	75	46	67	75	28	46	54	51	77	78
(Means - tested transfers)	--	--	1	1	1	1	3	3	7	3	3	7
Private transfers	1	1	--	--	--	--	--	--	--	--	--	--
3. Other income	--	--	--	--	--	--	--	--	--	--	--	--
4. Direct taxes	23	19	8	13	5	4	15	11	8	30	28	17
5. Net income	77	81	92	87	95	96	85	89	92	70	72	83

Income Type	Israel			U.S.A			Canada		
	55+	65-74	75+	55+	65-74	75+	55+	65-74	75[illegible]
1. Income before tax & transfer	85	75	68	79	63	53	79	62	5[illegible]
Earnings	64	42	21	58	32	17	56	28	1[illegible]
Property income	10	13	22	13	18	24	17	22	[illegible]
Occupational pension	--	11	20	25	8	13	12	6	1[illegible]
2. Transfer income	15	25	32	21	37	47	20	37	4[illegible]
Public transfers	14	23	30	21	37	47	20	37	4[illegible]
(Social Insurance transfers)	14	23	29	20	35	45	18	35	4[illegible]
(Means - tested transfers)	--	--	1	1	2	2	2	2	
Private transfers	1	2	2	--	--	--	--	--	-
3. Other income	--	--	--	--	--	--	1	1	
4. Direct taxes	22	14	9	18	11	8	12	9	
5. Net income	78	86	91	82	89	92	88	91	[illegible]

Source: reprinted from L. Achdut and Y. Tamir, "Retirement and Well-being Among the Elderly", National Insurance Institu[illegible] Jerusalem, Israel, 1986. Based on Luxembourg Income Study, 1985.

cohorts especially in terms of work, retirement and earning patterns, capital income, cash and in-kind transfers, and occupational pensions. One would expect, for example, that the relative proportion of public and private expenditure on care, the emphasis on public or private service development, be related to the income available to groups of elderly upon retirement and as they age. That the economic circumstances of the elderly may have an effect on how we define needs and the concomitant response of health and welfare services is evidenced by the example of Switzerland. Gilliand (1983) has reported that in Switzerland a significant increase in old age pensions in 1966 significantly reduced the number of admissions to old people's homes which were primarily funded by the government.

Cross-national analysis and comparison of income data require reliable comparative data over time. A good beginning has been made in generating and analyzing this kind of data in the Luxembourg Income Study (LIS) mentioned earlier which has collated data from seven countries: Canada, Israel, Norway, Sweden, West Germany, the United States and the United Kingdom. From preliminary findings presented at the first LIS conference (July 1985), one finds some interesting differences in the economic well-being of the elderly at the beginning of the present decade (Table 8).

As expected, comparison of the extent of poverty in different age groups shows that the risk of poverty is generally higher amongst those aged 75+ than those aged 65-74. Significant differences are found between countries, with Sweden having virtually no poverty for these groups. The authors (Hedstrom and Ringen, 1985) point out that this is due to reform in public pension benefit levels. Between 1952 and 1976 the average Swedish pension increased by over 300% in real terms, as compared to a 97% rise in average income among full-time industrial workers.

Table 8. Poverty Rates in Several Countries

for Persons Aged 65+ and Total Population

Country	Aged 65-74	Aged 75+	Total Population
Canada	11.2	12.1	12.1
W. Germany	12.7	15.2	7.2
Israel	22.6	27.1	14.5
Norway	2.7	7.3	4.8
Sweden	0.0	0.0	5.0
United Kingdom	16.2	22.0	8.8
United States	17.8	25.5	16.9
mean	11.9	15.6	9.9

* Defined as persons belonging to families with an adjustable disposable income below half the median for all families in the specific country.

Source: Hedstrom and Ringen (1985). Based on Luxemburg Income Study, 1985. Data is for the early 1980's and some changes are expected. In Israel, for example, poverty rates in both age groups were reduced significantly by 1986-7 to approximately 14%.

Comparing the composition of the gross income of the elderly, one finds that the relative contribution of market income (before tax and transfer payments) to total income is reduced with age, particularly in Sweden, Norway and West Germany (Table 9). In Israel, the United States and Canada, market income remains a considerable share of total gross income. An examination of the components of market income indicates that about one-third and one-quarter, respectively, of the income in Canada and the United States (also Israel) are from property assets. Whether this is an absolute or relative increase in income is unclear. Longitudinal data, coupled with projected labor force participation rates, income from universal old age pensions and occupational related pensions, should be considered when estimating the kinds of resources which will be available to the elderly in the future. Although the elderly are still characterized by low incomes and a relatively high incidence of poverty, as social security and work related pensions mature, each successive cohort of retirees may have higher incomes because they will have earned more retirement benefits and accumulated more assets over their working lives. In the United States, the average income of the elderly is expected to continue to increase, even in real terms, although at a lower rate than in the past. Moreover, traditionally large differences in income between men and women living alone are expected to narrow as more women enter the labor force and as men continue to leave the labor force earlier (Luce et al., 1984).

TABLE 9: Relative Mean Income* by Age of Head of Family

Age of Head	Norway		W. Germany		U.K.		Sweden		Israel		U.S.A		Canada	
	all+	ret+	all	ret	all	ret	all	ret	all	ret	all	ret	all	ret
Total 55+	100	77	100	79	100	58	100	81	100	64	100	68	100	63
55 - 59	144	--	156	81	158	60	136	85	141	49	140	91	137	67
60 - 64	123	--	105	79	124	58	119	87	112	54	113	86	117	67
65 - 74	91	83	89	82	79	61	96	89	82	63	87	72	85	66
75+	62	72	75	75	63	53	72	71	78	71	67	60	65	58
ispersion atio**	2.3	--	2.1	1.1	2.5	1.1	1.9	1.2	1.8	0.7	2.1	1.5	2.1	1.2

) The mean net incomes of the retired families relative to the mean net income of all the elderly families (55+). Retired families are defined as those whose earnings do not exceed one-fourth of their net income.

) Dispersion ratio - the ratio of relative mean income for the 75+ to 55-59 age group.

all - all elderly families
ret - only "retired" families

Although individual differences will remain, some groups of elderly, such as working women, may therefore be expected in coming years to enjoy better economic conditions with a greater sense of independence. The economic independence of women might, for example, be reflected in ability to purchase adult day care in the community or to participate in sheltered housing arrangements where a range of services would be available if necessary. The proportion of public funding for these and other services, in the home, community or in institutions ought to reflect varying trends in income level. Thus planning for services and public allocation of funds ought to be based not only on forecasts of magnitude of needs, but also on a projection of the various specific groups who will be the consumers of services in the future, their preferences and their ability to acquire services privately from the formal sector or share in supporting costs of these services.

It is not suggested that improved economic circumstances means a reduced need for publicly-funded benefits and services. However, some groups of elderly may be able to pay for a part of their service requirements. Data identifying these groups is

invaluable for discussions of program and financing options.

The point is that increased awareness of changing social conditions and of demographic and income trends is crucial for a flexible and pluralistic approach in program planning and financing. Examining alternatives in planning will require the readiness of policy makers to adapt to individual differences and to differential capabilities and expectations for making independent choices in service acquisition. Trends in labor force participation of women, living arrangements and the availability of informal care, improved economic circumstances for some groups, as well as expected higher education level among the elderly would seem to indicate that at least some groups of caregivers may be able to make more independent choices in service acquisition within a program based on the concept of shared responsibility/shared cost between the older person and the government.

6. Current Patterns of Formal Service Provision: Institutional and Non-Institutional Care

A basic policy goal in long-term care then is the need to develop a broadly diversified system of benefits and services to meet a continuum of changing needs, from need in the home to the need for institutions. On the one hand, the long-term objective is to assist the family and to develop services so as to enable the disabled, dependent individual to remain at home and in the community for as long as feasible and to confine the use of nursing home beds to the most seriously disabled elderly having no access to family support resources. On the other hand, an acute and most visible need in most countries is the current demand for nursing home beds. The issue behind these two seemingly conflicting goals becomes a practical question of priorities in allocation of limited funds in a model where cost containment is in itself a basic issue.

Table 10. Comparison of Projected Versus Actual Institutional Use Rates — 1980

Country	Projected Rate*			Actual Rate		
	Medical Facilities	Non-Medical Facilities	Total	Medical Facilities	Non-medical Facilities	Total
United States	4.5%	1.2%	5.7%	4.5%	1.2%	5.7%
Argentina(1) 1984	3.9	1.1	5.0	N/A	N/A	<0.1
Australia(2) 1981	4.2	1.1	5.3	4.9	1.5	6.4
Belgium(3) 1981-1983	4.5	1.2	5.7	2.6	3.7	6.3
Canada(4)	4.2	1.1	5.3	7.1	1.6	8.7
Costa Rica(5) 1980	3.7	1.0	4.7	N/A	1.5-2.0	1.5-2.0
Denmark(6)	4.5	1.2	5.7	N/A	N/A	
France(7) 1982	4.8	1.3	6.1	5.3	1.0	6.3
West Germany(8) 1980	4.3	1.2	5.5	1.2-3.6	0.9-2.4	3.6-4.5
Greece(9) 1982	4.2	1.1	5.4	N/A	0.5	0.5
Israel(10) 1981	3.5	0.9	4.4	1.4	2.6	4.0
Japan(11) 1981	3.9	1.0	4.9	3.1	0.8	3.9
Netherlands(12) 1982-1983	4.6	1.2	5.8	2.9	8.0	10.9
New Zealand(13) 1982-1983	4.1	1.1	5.2	2.4-2.8	3.9	6.3-6.7
Spain(14) 1982	4.2	1.2	5.3	N/A	2.0	2.0
Sweden(15) 1980	4.5	1.2	5.7	4.6	4.1-5.9	8.7-10.5
Switzerland(16) 1982	4.5	1.2	5.7	2.8	5.0-7.2	7.8-9.0
Turkey(17) 1984	3.3	0.9	4.2	N/A	N/A	<0.2

N/A = Not available

Source: ISSA, Long Term Care for the Elderly Provided Within the Framework of Health Care Schemes, Geneva, 1986.

* Based on a standard U.S. age/sex specific institutional use rate (measured by the 1977 National Nursing Home Survey).

We find a great degree of variation among societies in the form and extent of institutional response to long-term care needs. However, the differential rates of institutionalization which have evolved in various countries cannont be attributed to demographic factors alone. A recent ISSA report (ISSA, 1986) which sought to estimate the effect of demographic variables such as age/sex composition on cross-national institutionalization rates found great variation when actual use rates were compared to projected use rates, using United States age/sex specific institutionalization rates as the comparative standard. It was found that whereas population characteristics alone would suggest similar use rates in the U.S., Sweden and the Netherlands, both latter countries use institutional services at almost twice the rate of the U.S. In the Netherlands, however, rate of use of medical institutions is one-third less than the U.S. rate, while the use of non-medical institutions is almost seven times greater (Table 10).

In the same study, reported institutional rates vary from a low 3.6%-4.5% in the Federal Republic of Germany to 8.7%-10.5% in Sweden. A striking finding is the difference in medical and non-medical institutionalization rates. There is a much higher use of non-medical residential care in Western Europe than in Canada and in the U.S. The Swedish use of medical institutions is similar to that of the U.S., but its use of non-medical facilities is almost five times greater.

In other words, it would seem that factors other than need defined in terms of population characteristics are responsible for institutionalization rates. Given the fact that current data regarding need for beds based on waiting lists and rates on institutionalization reflect exigencies of the existing system, defining future need for nursing home care on the basis of extrapolated population data alone is inadequate. Factors that need to be examined, such as the percentage of single and childless elderly, the number of children, labor force participation rates, the availability of institutional beds and home care services, as well as incentives for usage, are those that define the degree to which informal family support is available in each country.

Moreover, it also becomes necessary to examine policy issues and goals as intervening variables outlined in the model depicted in Figure 1. In fact, the aforementioned ISSA report notes that on the basis of responses to its questionnaire, most advanced industrial countries perceive their rate of institutionalization as higher than necessary or desirable. "Most of these countries are currently pursuing deliberate policies to expand home and community-based long-term care services in part as means of reducing the need for institutionalization" (ISSA, 1986). At the same time, however, some of these countries report experiencing considerable pressure to expand bed capacity to meet current unmet needs. In the Netherlands, during the last few years one finds a contradiction between forecasts of the increasing need for institutionalization based on current practices, and

national policy norms which call for a reduction in the proportion of aged in nursing homes and other institutional settings (Morginstin and Werner, 1982). In a broad sense, the need for institutionalization is not only a reflection of current requirements, but also becomes a question of long-term goals versus short-term pressures.

The costs of existing long-term care services point out the importance of formulating clear-cut policy regarding the optimal balance between community and institutional long-term care, and the role of whatever program is developed in promoting such a policy. Experience in other countries as well as findings for Israel indicate that although community and institutional services are theoretically part of a single continuum of care which should reflect differential population needs, there is, in fact, a trade-off between community and institutional services which may be the result of emphasis placed on one aspect of care at the expense of, or to compensate for, a shortage of the other.

Examining long-term care schemes in several countries indicates some imbalance between the two sectors. In England, for example, where there is some overlap between acute and long-term care, chronically ill disabled aged are hospitalized due to the lack of sufficient long-term care services in the community. Since nursing homes are, in effect, hospitals, residential homes which were originally meant for the independent aged are slowly becoming transformed into nursing homes which are not always suited to the needs of residents from the point of view of physical condition, manpower, budget, etc. In Japan and Germany, rapidly aging societies, much medically oriented long-term care is provided in acute care facilities. In the Netherlands, one of the results of the ABWZ Law, which had originally provided reimbursement primarily for institutional long-term care, is that in the past insufficient resources were allocated to the community care sector. Indeed, the question that should be raised is whether the increase in institutionalization in some countries has been a result only of the increase in the number of chronically ill elderly, or whether it is also a result of policy which makes it easier and more efficient for the family, and especially for professionals, to institutionalize an individual in a government-funded nursing home rather than provide services in the community.

Experience has shown that state policy and, especially, funding practices give rise to increased demand and use of services which are publicly financed. Countries which did not sufficiently consider the desired balance between community and institutional long-term care have overemphasized the institutional end of the continuum of care, in terms of both policy and funding. In practice, such policy has constituted an incentive to the continued growth of costly institutional services at the expense of services provided in the home and the community. Today the U.S., Israel and several European countries are increasingly supporting the financing and growth of the home-care sector while attempting to reduce the role of institutions. For example, the

Netherlands has successfully pursued a policy of reducing institutional use over the past few years by expanding benefits under ABWZ to include reimbursement for services provided at home and in the community. In Norway, too, policy in the past decade has encouraged a growth in home care by making available reimbursements for such services.

Current trends emphasizing the growing importance of home and community long-term care have developed not only as a result of social policy recognizing the intrinsic benefit of staying at home as opposed to institutionalization, but primarily as a result of pressures for cost-containment, although there is no clear evidence that home and community services are less expensive than institutionalization, especially when one imputes economic costs to informal care and includes opportunity costs. One could argue, however, against this type of conceptual approach to cost analysis of care provided in different settings which gives the same weight to economic cost of formal service provision often funded by the public sector and to the private cost of informal care. It is unclear, for example, whether institutional care is less expensive if one looks only at public costs - the cost to the state of providing total care in an institution - as compared to public supplementing of informal care provided at home, as a form of sharing the cost of caring, either in the form of a cash transfer or in-kind home care service. These types of public costs are comparable over and above private out-of-pocket costs assumed by the elderly and his family, at their own choice and decision.

It is important to point out that the trend toward community care increasingly reflects not only cost considerations but also growing sensitivity to the preferences and needs of the dependent older person and his family and the desire to improve the **quality of life** and **well-being** of the chronically ill individual as well as to create more alternatives for care prior to institutionalization. Moreover, sufficient non-institutional services would make it possible to view nursing home care as only one option within a range of community services, an option which is not necessarily final and which can be utilized for short periods of time. Furthermore, there is a strong case to be made for normalizing and demedicalizing institutions so that for those no longer able to maintain their independence at home, institutional care might become a more humane type of community care alternative (Freer, 1988). For these reasons, it is essential to emphasize the importance of coordinating between the two sectors in order to maintain a continuum of appropriate, quality care.

Whatever program is chosen, there are several questions for each society - given its specific population data, changing social conditions, cost considerations and existing modes of service provision: what is the **desired** pattern of care aimed for? What balance, what mix of benefits and services, against the background of current practices and expectations, will sustain the continued provision of family care, which seems to be the

preferred vehicle in all societies? What programs will facilitate the important link between formal and informal care, between public and private expenditures, and will build on the resources of family care while reserving publicly funded services for those who require it?

7. Provision of Services

In contrast to the United States, most Western countries provide universal health care for their populations, although the means by which programs are financed vary, including national health insurance programs and sick funds, funded differentially by tax revenues, social insurance contributions with copayments for some items, and operated via a mix of public and private facilities and physicians. In most countries, there is a high rate of admissions of older people to acute hospitals with no attempt to regulate length of stay to specific episodes of illness as under Medicare in the United States (Rabin and Stockton, 1987).

Home care is generally the responsibility of social welfare authorities, as in the United Kingdom, Canada and most European countries. Definitions of institutions for long-term care vary between countries making cross-national comparisons difficult. Whereas the United States, Canada and Israel have a system of proprietary, voluntary non-profit and public institutions providing nursing home care, in Europe this type of care is also provided in acute hospital geriatric and psychogeriatric wards. Cash benefits are provided by some countries instead of services, such as Germany. In Sweden and the United Kingdom, cash attendance allowances or supplements may be paid to the disabled elderly and their caregivers. In Sweden a significant number of paid home helps are relatives of the elderly recipients (Rabin and Stockton, 1987; U.S. Senate, 1984).

Most countries provide health-related services at home, such as home help for personal care, homemaker services and meals on wheels, through their social welfare departments. This is often done on a subcontract basis in cooperation with private and non-profit voluntary organizations, or directly as in Manitoba. In some countries, services are available on a universal basis such as under Long-Term Care Insurance in Israel, or in Manitoba's Continuing Care Program, but universality is often dependent on the availability of services. More generally, provision of home care services is means-tested.

As part of a program for the very old, in addition to the important personal care services provided at home, it is necessary to develop a network of public and private services in the community, one that would allow the family flexibility in service acquisition and would enable it to continue performing its caring role. Some of the services which are being advocated are:

a. **Single Access Point for Long-Term Care.** This approach would provide a single address for the family in need of

consultation, assessment, services and referral. A model of this type has been successfully developed in Manitoba's continuing care program (Havens, 1988).

Experience shows that families do not apply for services until they are near the exhaustion point or in the midst of a crisis, at which time the potential effect of the service might be minimal. A single-access point for care, providing case management or case-coordination would make it easier for the already overburdened family to apply for assistance. The primary responsibility of case-coordination should be the coordination of a continuum of care, from the home to the institution if necessary. Although case management might be made available to all families, it has been shown to be most cost-effective for multi-service high-risk groups requiring intensive home care and professional involvement in introducing formal support services into highly personal, highly emotional caring situations. The role of the case-coordinator, coupled with the family's feeling of "belonging" and trust, facilitates the provision and acceptance of services.

b. **Adult Day Care/Psychogeriatric Day Care.** The importance of day care for the dependent elderly has been increasingly recognized over the past decade. This service seems to be insufficiently utilized for high-risk groups, however, because of the difficulties and costs involved in transporting and caring for these individuals. Given the increase in labor force participation rates of women, this type of service should receive higher priority in planning if we desire to enable working families to continue performing the caring role. An important population requiring day care is the growing group of elderly suffering from some form of mental deterioration and living at home. Some care might be made available in institutions interested in developing a more community-oriented approach. Similarly day centers could offer some home care services for those requiring additional individual care.

c. **Services for the Caregiver.** Some services geared to family caregivers themselves which are becoming available, especially in the U.S., are:

- **Family study and support groups** organized by service agencies which provide practical information instrumental to the caring task as well as the opportunity for generally isolated caregivers to meet and exchange views with others in the same situation.
- **Respite service,** both voluntary and paid, in the home or for short periods in an institution.
- **Organization of self-help groups** usually by families who have common problems in caring - such as those of Alzheimer victims.
- Services to families whose elderly relatives reside in **institutions** should not be neglected. Such services would be geared at counseling for placement and increased family involvement in the institution, including family

representation on public committees responsible for monitoring quality of care.

- **Volunteer services** - visits by volunteers which have generally been provided to isolated elderly should be extended to older people with caring families, thus sharing the burden of care.

d. **Congregate housing facilities** - should be extended to provide adequate long-term care so as to enable dependent residents to remain in their homes for as long as possible without having to move to a different facility.

e. Providing **medical services** at home is of the utmost importance. Often the decision to enter an institution is based on experience of the difficulties of obtaining the care of a doctor at home. Unfortunately, whereas other health sectors have recognized the importance of extending home services, home visits by doctors are still hard to come by. This remains one of the weak links of the home care system and deserves more extensive examination and discussion in geriatric education and training.

f. Finally, and least examined in the gerontological literature, is the area of preventive intervention and health promotion for the aging - in as diverse areas as personal safety measures, fall prevention, social supports, exercise and diet, continuing education, and preventive medicine - all of which will help in raising the quality of life during the aging process and, hopefully, in increasing the numbers of people living into their 80's and 90's who will be able to have full and productive lives.

8. Long-Term Care Insurance in Israel: An Israeli Case

It was in response to demographic trends, the inadequacy of existing programs in meeting needs, the growing burden of care of the elderly and their families, threatened cutbacks in services to the elderly during severe economic periods and the concomitant desire on the part of legislators to protect the most basic required services, that in April 1986 the Israeli Knesset (Parliament) completed the enactment of a law which created a community Long-Term Care Insurance branch (LTCI) within the framework of Israel's social security system. In addition to specifically defined personal care and home help services provided on the basis of personal entitlement, the law provides funds for service development in the community and in institutional settings, and for some additional beds in nursing homes.

LTCI in Israel should be viewed as a logical continuation and expansion of social policy for the aged under social insurance. Whereas for the past 15-20 years comprehensive measures for income maintenance for the elderly have been developed and refined, this next step in social policy reflects a shift in focus toward a statutory allocation of resources for the functionally dependent elderly.

In effect, the primary aim of the law is to formally define the State's statutory obligation to provide long-term care services to the seriously disabled among the elderly, on the basis of personal entitlement and clearly defined eligibility criteria, thus meeting individual needs of the eligible elderly and enhancing the family's role as a primary caregiver. LTCI therefore has two target populations: severely dependent elderly and their informal caregivers, where such exist. These specifically defined services and benefits will supplement those discretionary selective services currently being provided via the Health and Social Affairs Ministries and by the sick funds, but which are unable to respond adequately to the expected increasing need and cost of service provision.

An important contribution of the emergence of LTCI in Israel is that it brought to public debate and resolution, in the form of legislation, many issues that had previously remained solely in the province of professional literature - issues regarding the role of the family in providing care, and links between informal care provision and formal service structures; community versus institutional care; cash versus in-kind benefits; centralization versus decentralization in implementation; roles of private and public agencies in service development and provision; and, in Israel, the drawbacks, benefits and cost considerations of a social insurance-based program versus existing public programs based on more selective and discretionary modes of resource allocation. Some of these issues have now been resolved in the law; others are still undergoing debate and will continue to do so in the context of future research and evaluation.

The basic principles underlying LTCI are:

1. Personal entitlement to services and benefits in a social insurance program, paid for by contributions from the working population. The aim of the personal benefit is to enable dependent persons to remain at home for as long as possible, and to strengthen family caregivers by providing services. In fact, under this law the target population is the dependent older person as well as his or her family. The emphasis is on providing home and community services, not institutional care. Under the law, an individual is eligible for benefits ony if he or she does not reside in a nursing home. However, it should be emphasized that the role of benefits is not to replace family functions and responsibilities. The family will continue to have primary responsibility for the care and welfare of the individual, since the benefit will cover only part of the basic costs incurred in caring.

2. Continued expansion of the network of available services by allocating funds for service development in the community and in institutions. Increasing the availability and accessibility of quality services in the community, as well as of manpower for providing care at home and in day-care

centers for the elderly, are viewed as essential in order to enable use of benefits to provide in-kind services to eligible individuals.

3. Creation of a program which is based on a clear division between assessment for eligibility on the one hand and service provision on the other. Service provision and case coordination are decentralized functions, while eligibility determination and monitoring based on uniform guidelines and instruments is centralized so as to assure maximum equity under law and maximum control over targeting and costs.

Some of the main measures and provisions of long-term care insurance are as follows:

1. Responsibility for determining eligibility is solely that of the National Insurance Institute. Men over age 65 and women over age 60 who are severely functionally disabled in activities of daily living or require constant attendance due to danger of harming themselves or their environment are eligible for services or cash benefits.* Eligibility level is defined in terms of the degree of functional dependency, i.e., the degree to which the individual is dependent on the help of others in basic daily functions including mobility in the home, eating, dressing, washing, continence control, and the need for personal attendance or supervision. It does not take into account social and situational factors, met or unmet needs, etc. There are two levels of eligibility, according to the degree of dependency, as assessed by a public health nurse from the Ministry of Health in the home of the elderly person, using a uniform, objective assessment instrument for measuring ADL. Each person receives a score based on the home visit. Additional points are awarded to persons living alone who have accrued at least two points in ADL dependency, and to those requiring constant personal attendance. Total scores are translated into the two basic eligibility levels.

2. The benefit is intended for elderly living at home, in the community. Thus, only persons living outside of nursing homes and nursing wards may apply for a benefit. Persons residing in sheltered housing or old-age homes that are not publicly financed may also apply. For those elderly receiving a benefit while living at home, if a decision is made to enter a nursing home, the benefit will be halted upon institutionalization.

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* Functionally disabled individuals below this age are currently eligible for a cash attendance allowance under General Disability Insurance.

3. Eligibility for benefits is income-tested. Income taken into consideration includes that of the elderly and his spouse. In cases where the benefit will have to be provided in cash form (see below), the income test considers income of a son or daughter who resides with the elderly person and is defined as his caregiver. In such cases, only high incomes (those above three times the average wage) will be considered. Data for 1988 show that less than 1% of applicants were ineligible due to income level.

4. There are two benefit levels, parallel to the two eligibility levels, one equal to the National Insurance basic pension rate and the second at 150% of the basic pension rate.* The emphasis is on in-kind services, not cash benefits. Only in specifically defined instances where services are unavailable and the eligible person is being cared for by a relative living with him or her is it possible to receive a cash benefit, until services become available. Cash benefits are provided at a rate of 80% of the benefit level, reduced by what has been calculated as approximately 20% administrative costs of providing in-kind benefits. Today, out of a total of approximately 15,000 beneficiaries, less than 200 are receiving cash benefits.

5. The kinds of services which can be provided under LTCI are carefully delineated in a "basket of services." These services derive directly from the definition of eligibility in terms of dependency in activities of daily living, and are closely related to direct caring functions. They therefore include personal assistance in the home or in organized community facilities (such as day care centers), home help (with basic household chores), personal attendance, laundry, meal preparation and delivery, and supply of absorbent under-garments for the incontinent. Medical, paramedical and social support services are not covered under LTCI, and continue to remain the sole responsibility of other agencies, which, it is hoped, will complement LTCI care plans when necessary.

6. The National Insurance Institute has overall responsibility for the law's operation and its monitoring. However, there is a sharing of responsibility in implementation between branches of the National Insurance Institute, which has sole responsibility for determining eligibility on the basis of functional disability in ADL, and local professional committees, which are defined by law and have responsibility for determining care plans, providing services, monitoring changes and reporting. Although the committee is an organ of the National Insurance Institute, it is staffed by a senior social worker from the municipal authority who is the committee coordinator, a nurse from

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* These two basic levels are again pro-rated according to the income test so that in fact there are four possible benefit rates.

the sick fund and a clerk from the local branch of the National Insurance Institute. The committees operate via field professionals in the community - social workers from local welfare departments and nurses from sick fund clinics - who are in direct contact with eligible individuals and their families, submit care plan proposals to the committee and provide case management and coordination functions as required. This type of arrangement ensures that eligibility for benefits will be determined using uniform instruments and guidelines under the responsibility of a central agency, the National Insurance Institute, thus assuring an optimal measure of personal and regional equity in resource allocation. At the same time, it decentralizes the most important professional functions at the level of case management and service provision, recognizing that these are best understood and dealt with at the local professional level. Most importantly, this arrangement requires a level of previously unheard of interagency cooperation as defined under the law.

7. In addition to stipulating which services will be provided, the care plan indicates which agencies will provide services. The program operates strictly on a sub-contracting basis, raising important requirements of licensing, monitoring and control. The payment for services is transferred directly to the service provider agency. Cash benefits are paid to the eligible person. Only certified agencies having legal status and approved by the Ministry of Labor and Social Affairs can be contracted with to provide services. Benefits cannot be transferred to private persons providing care.

Issues Related to Implementation of LTCI

Several innovative aspects of the law will constitute the real challenge and test, not only in regard to the intricacies of implementation, but also in terms of whether Israel will be successful in improving the well-being of the law's target population - the elderly and their family caregivers.

LTCI has attempted to resolve the issue of cash versus in-kind benefits by firmly placing its weight on the side of services. The law defines eligibility for services, not cash benefits. A cash benefit will be provided only on a temporary basis until appropriate services can be developed in a given community. An underlying assumption of LTCI is that services are more effective than cash benefits in reducing the real burden of care, by sharing caring functions with informal caregivers. And, it is believed that, in the long range, the provision of in-kind services will have a more powerful impact on expanding the network of services available for long-term care.

The emphasis, then, is on the words eligibility and services, a combination which does not exist in other countries in the same

way as in Israel. What we have here is a combination of a universal approach in determining eligibility with a differential approach in service provision according to individual requirements. Although two people may have the same degree of disability and benefit level, the nature of services received will be affected by the specific social situation, family support resources, availability of services, and professional approaches in each community.

It is quite clear that in evaluating the impact of the law, it will be necessary to consider issues of cost and effectiveness in meeting unmet needs in terms of individual preferences. It will also be especially important to examine the cost of the administrative structure for implementing the law, including the important functions of monitoring, regulations, quality assurance and control.

To a great extent, the success of LTCI in meeting social goals and needs depends on the degree of coordination and cooperation between the various agencies and organizations. Will these benefits constitute a separate system or become an integral part of an improved program? What type of coordination will develop between LTCI and other frameworks? Will we be creating an additional, duplicate administrative structure or will it become a vehicle for coordinating administrative and case management functions, especially those of need assessment and monitoring?

Will there emerge clear boundaries between statutory provisions and those services that will continue to be provided on a selective basis? We do know that dependent persons and their family require a variety of services not covered by LTCI, including housing adaptations, paramedical services and social support services. Will these services continue to be provided on a selective basis by governmental bodies currently responsible for them? As a result of LTCI, will other government and public organizations relinquish responsibility for development and provision of services included in the basket of services offered by LTCI, reduce budgets or reduce the level of services currently being provided, or will they, hopefully, shift those budgets to other services and populations not covered by this law? What will happen in terms of equality and level of service provision for those elderly ineligible for LTCI, yet who require similar supportive services? What role will private agencies play in service development and provision and what will be the form of quality control as regards private agencies?

Research Issues

Because this is a new law, there are more questions than answers to some of these questions. Other issues that will have to be addressed in a future research evaluation of LTCI are the following:

- Will the overall availability of services and manpower expand as a result of the law's implementation? Since the

inception of LTCI the number of private service agencies has mushroomed. What will be the mix of public/private services? Will the increase in demand for services generate "healthy" competition, more efficient operation of public services and better quality, or the opposite? What effect will LTCI have on the hourly rate of payments for home care?

- What will be the law's effect on the rate and pattern of institutionalization in old-age homes and in nursing homes? Will we find, as predicted, that people will be able to defer institutionalization? What will be the effect of the law on patterns of acute hospitalization, discharge policies, etc.? A research study on this issue is currently being conducted in Israel by the Brookdale Institute.

- With regard to the basic objective of the law - to enable the elderly to remain at home - an important question is how will "home" be defined in practice? According to the *law's provisions, older people living in sheltered housing* arrangements or more traditional old-age homes can submit claims for benefits. There are generally pressures to relocate to nursing homes those who suffer physical and functional deterioration. It will be a challenge under LTCI to utilize funds for service provision to eligible persons in various forms of sheltered housing, and to examine the effect of LTCI on these types of living arrangements.

- What will be the ratio of provision of in-kind services and cash benefits?

- What effect will the new law have on existing procedures for need asessment and service provision, as well as on existing criteria for determining eligibility for other selective services in the community or for institutional care? Will the local committees operating under law provide a much needed impetus for developing a more comprehensive, coordinated approach to providing care?

- Most importantly, will the law have an impact not only on the well-being of the chronically ill elderly and the family's ability to provide care, but also allow services to be responsive to individual differences and preferences? Will the law encourage continued family responsibility and independent choices and decisions in caregiving or will families become overly dependent on public agencies?

9. Summary and Discussion

One of the key points in systematically assessing the changing needs of the elderly, especially the very old, is the interrelationship between a multitude of factors affecting the development of existing programs as well as present and future policy. Against the *background of shifting age composition of*

the population, the aging of the older population itself, increasing per capita expenditures on the elderly, maturation of pension schemes, and climbing dependency ratios, there is a growing awareness of the need to examine these factors carefully in order to expand much required services for target groups in a cost-effective manner.

There seems to be a consensus that during the first quarter of the next century, changes in the age structure of populations will be unfavorable for the financing capabilities of health care, pension, and social programs and will add to the already growing financial burden of long-term care, much of it being borne today by the working population in most industrialized nations, and by the elderly themselves in some countries.

A comprehensive, flexible approach to meeting the needs of the very old is one in which the elderly are characterized as a heterogeneous group, not all having needs which will require public funding. It is a group which is not only heterogeneous today, but will be changing as succeeding age cohorts enter into retirement and old age. The very old should thus be carefully examined to identify the strengths as well as the weaknesses of various sub-groups if, at the least, we wish to avoid much of the agism that has characterized attitudes towards the elderly in the past.

This approach requires an understanding of changing expectations for making independent decisions, and patterns of care, among the elderly, due to increased labor force participation and changing roles of women, as well as future cohorts of elderly having somewhat higher income levels, primarily in terms of occupational pensions and assets, and higher educational attainment levels. Data regarding these developments, together with increases in needs and costs of caring, ought to be carefully studied against the background of economic productivity and stability and social policy concerns, the objective being to create program and public funding options which can be economically sustained.

In addition to cross-sectional comparisons of income data such as market income and transfers for assessing the economic security of the elderly, longitudinal data is required that examines the threat of rising health care costs to the retirement income status of the elderly, and especially the depletion of funds and its implications as persons age. The question for social security may be: what type of unexpected risks associated with income depletion should be covered and how much will it cost to secure against these risks. These issues have been the focus for discussion in several countries; for example in the United States during the past decade in the context of long-term care bills and Catastrophic Care Insurance, in West Germany which is considering adopting a long-term care insurance program under social security, and in Israel which has already done so.

Part of the alarm raised at growing public expenditures for the care of the elderly are being replaced by willingness to examine

cost-sharing options in covering the expenses involved in providing care for specifically identified high-risk groups. We may in fact be moving toward a more pluralistic policy in social security in designing options for coverage and funding based on a concept of shared responsibility - shared costs. This approach, adopted in Israel's Long-Term Care Insurance Law and in Manitoba's program of continuing care, recognizes the fact that the family is already and will continue to be the main provider of care. Services should therefore be designed to facilitate and encourage independent caring as much as possible while providing public supports up to economically feasible limits. These supports would be aimed not at covering total needs, but at sharing and easing part of the physical, emotional and financial burden of caring, as a complement to family care.

Using the approach that requires us to anticipate future cohorts of the very old to be a heterogeneous group - from the standpoint of health status, functional dependency, economic circumstances, social resources, expectations - a pluralistic approach to identifying and meeting the needs of specific high-risk groups is required, while recognizing that other groups will be able to lead independent lives with little or no public support. The challenge is to find ways in which the total population, including the elderly themselves, can equitably contribute to sharing the cost and burden of care, while targeting public spending toward its most efficient use. Important vehicles for attaining this goal are more clearly defined eligibility criteria aimed at contained targeting and ceilings set on benefit levels, keeping them within available resources. Keeping costs within available resources also means curbing coverage within targets by designing reassessment mechanisms that monitor how long recipients remain eligible, making certain that those who are no longer eligible in terms of need levels, do in fact leave the system.

Some questions are: how can we achieve an optimal balance, both in terms of cost-effectiveness and social security principles, in the links between informal and formal, public and private sectors? What kinds of services should be developed that are geared to family caregivers rather than to the elderly themselves? What are the issues of equity arising from a pluralistic approach to social security coverage? Is it justified to provide high-cost services for high-risk groups who might be cared for more efficiently in institutions? What are the lines that should be drawn between social security programs and those better implemented by selective welfare programs?

Some of the alternative policy measures which have been put forth especially in a recent OECD report (1988) may undermine some basic social security principles developed in the past:

- restructuring of social expenditures in response to demographic shifts and changing patterns of need, i.e., a diversion of resources from programs serving the young to those serving the elderly;

- reducing the size of populations eligible for social security benefits (e.g., raising retirement age);
- encouraging growth in productivity of the working population;
- increasing labor force participation for some groups, such as women and the elderly themselves;
- moderation of replacement rates of the benefit while raising real earning levels;
- strict eligibility criteria to provide services and benefits on a more selective basis;
- determining a greater role for the private sector in complementing social security schemes in order to relieve some of the pressures on public programs;
- examining possibilities of extending the tax base to include some segments of the elderly population, without harming low-income groups.

In any case, as has been stated by Binstock(1985)and Habib(1985), we should be wary of automatically generating inaccurate estimates of future fiscal burdens and reinforcing anxieties about economic conflicts between old and young generations, between productive and non-productive populations, in the allocation of health and social welfare resources. We should rather be looking at a variety of options that differ from the usual extrapolations of current trends, existing public policies and existing social security programs, searching for a variety of options for policy intervention could ease the problem of coping with population aging.

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Oral Presentation*

* Oral presentation based on background paper prepared for the conference.

As you may have heard and will continue to hear from most reporters at this meeting, one of the most acute and visible problems facing the health and social service sectors today is that of meeting the rapidly increasing needs of the elderly. Per capita expenditures for the very old are already larger than for any other age group in most countries. In terms of resources, as the number of very old increases, proportionally more resources are likely to be used by them than by younger age cohorts.

What we find is that, at the same time that Western industrialized nations are under great pressure to reduce expenditures on income security, health and social welfare programs, the proportion of aged in the population, especially of the very old, has been growing and is predicted to further increase over the next several decades, with parallel increased pressures on providing care to the vulnerable elderly.

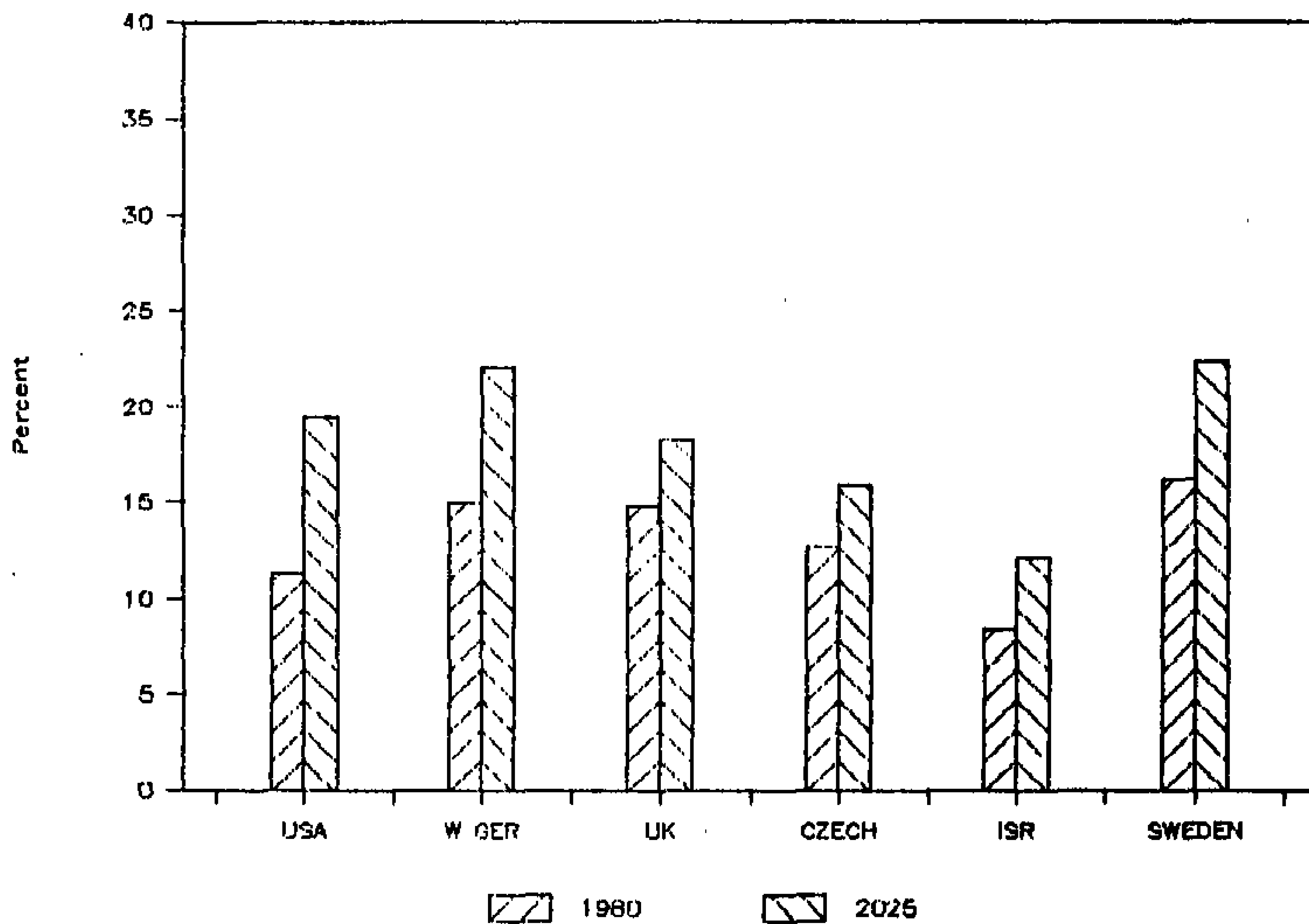
Both developing and developed countries are experiencing population aging. According to data from a 1987 WHO report, in most countries the elderly population is increasing at a faster rate than the population as a whole. The same report predicts that between 1980 and 2020 the total population of the developing world will be increasing by an expected 95%, whereas the aged population will rise by 240%. The period of most rapid growth is expected to be the second and third decades of the next century.

The number of elderly, which has been growing steadily in this century, represented in 1980 an estimated 5.7% of the world population, and by the year 2025 is expected to have reached 9.5%. In more developed regions the proportion of 65+ will constitute an average of 17.3% of the total population, and in some Northern and Western European countries such as Denmark, Netherlands, West Germany and Sweden, it will reach over 22%. Japan, by the way is the most rapidly aging population.

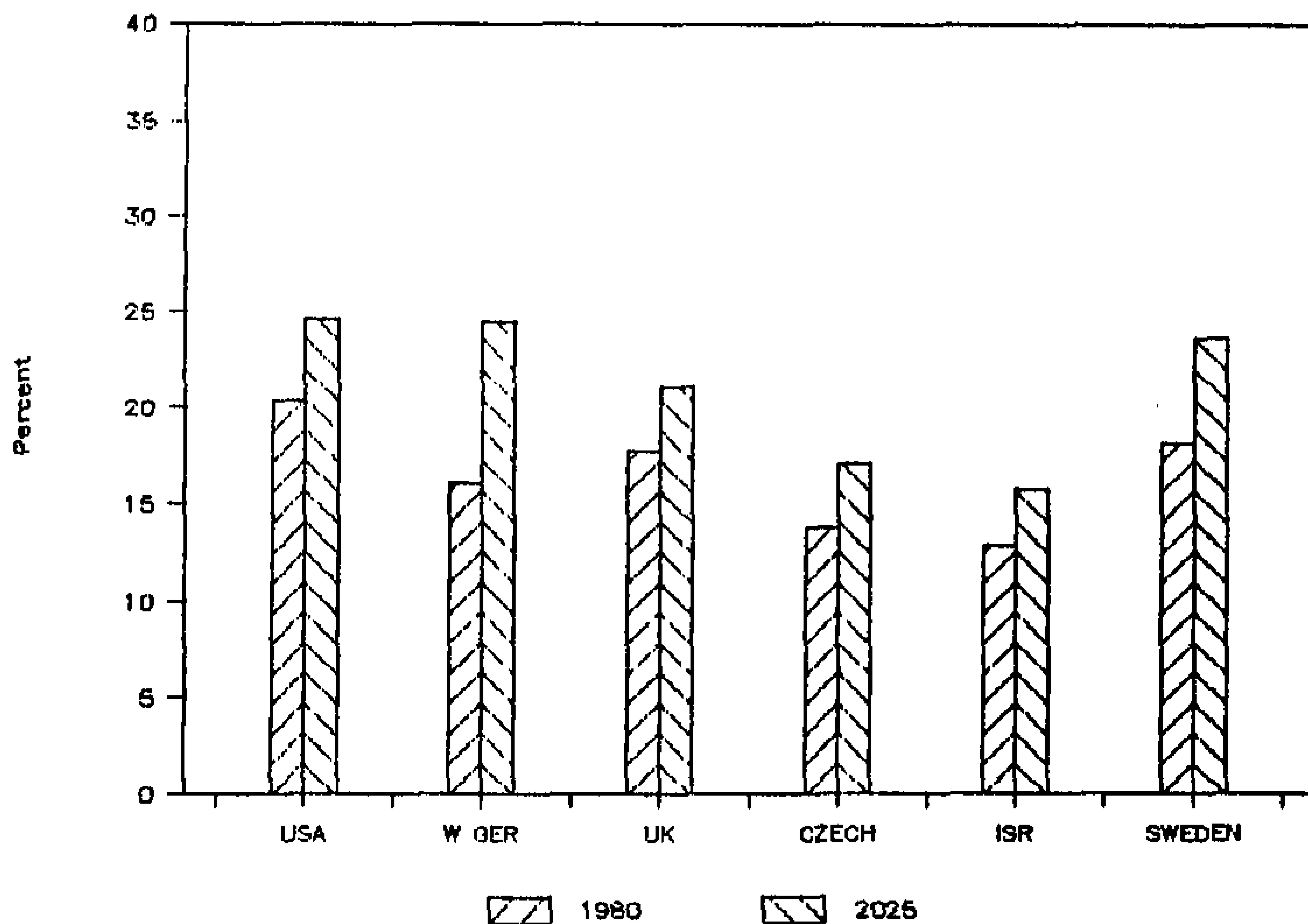
Life expectancy at age 65 is increasing and in the U.S. is expected to be 82 years for men and 87.3 years for women by the year 2035. Literature referring to the oldest old generally include those over 80 or 85. Thus not only is the aged population increasing, but the elderly population is itself getting older as more and more people survive to the highest ages. In fact, most of the growth will occur in the 80 and over group, and in some countries (e.g. Germany, Denmark, Austria, Sweden) will comprise almost one-quarter of the elderly population.

Reductions in mortality due to possible technological and medical advances may have an additional effect on the size of the very old population. If there are further increases in life expectancy due to major breakthroughs in treating such diseases as cancer and heart disease, current projections in the growth of the elderly population may in fact be understated, and more and more people will be living into their very old age.

Graph no. 1



Graph no. 2



In fact, our health care system is becoming increasingly capable of sustaining the survival of sick people at enormous costs. These costs may not be able to be borne by individuals living on post-retirement income and assets, and are therefore viewed more and more the responsibility of government. Is this a financially realistic aproach? Can governments design policy and plan programs which are predicated primarily on increasing costs without seriously considering alternative options, some of which may undermine previously held principles of social security?[1]

Estimates of per capita public health expenditures for the elderly in 1984 ranged from $1200 in the U.S. to over $2,000 in the Scandinavian countries. As you can see, public health expenditures for the elderly as a proportion of the GNP varies and is as high as 3% in Norway. Total per capita public expenditure for the elderly ranges from 5.4% in Canada to a high 14.5% in Sweden. In the U.S., for example, since 1960 the proportion of the federal budget on programs for the elderly has doubled. The oldest old, who are the subject of this meeting, have the highest health costs.

The key policy concerns for this meeting, arising out of current and predicted demographic trends are:

a. Whether the aging of populations will automatically lead to a major increase in the cost of public health and social programs, especially for the very old. Are expected growths in public costs direct extrapolations of magnitude of population increases, of current rates and current patterns in service utilization, or can we meet needs but control costs by policy decisions restricting parameters such as coverage, benefit levels, control of supply of institutional beds, and expanding the role of the private sector?

b. What type of services or programs will be required by which groups of the very old? Will programs be aimed at meeting in-depth service needs of residual groups such as the severely disabled, the cognitively impaired, the poor, and those without family support, or will programs aim at providing a basic level of care to a broader group of the very old?

c. Which of the required services can or should be provided under the umbrella of social security entitlement programs, and which would better remain the responsibility of non-entitlement welfare programs, informal care, or the private market? What is the desired mix of formal and informal, private and public care? What economic and social constraints will affect the optimal balance between these sectors?

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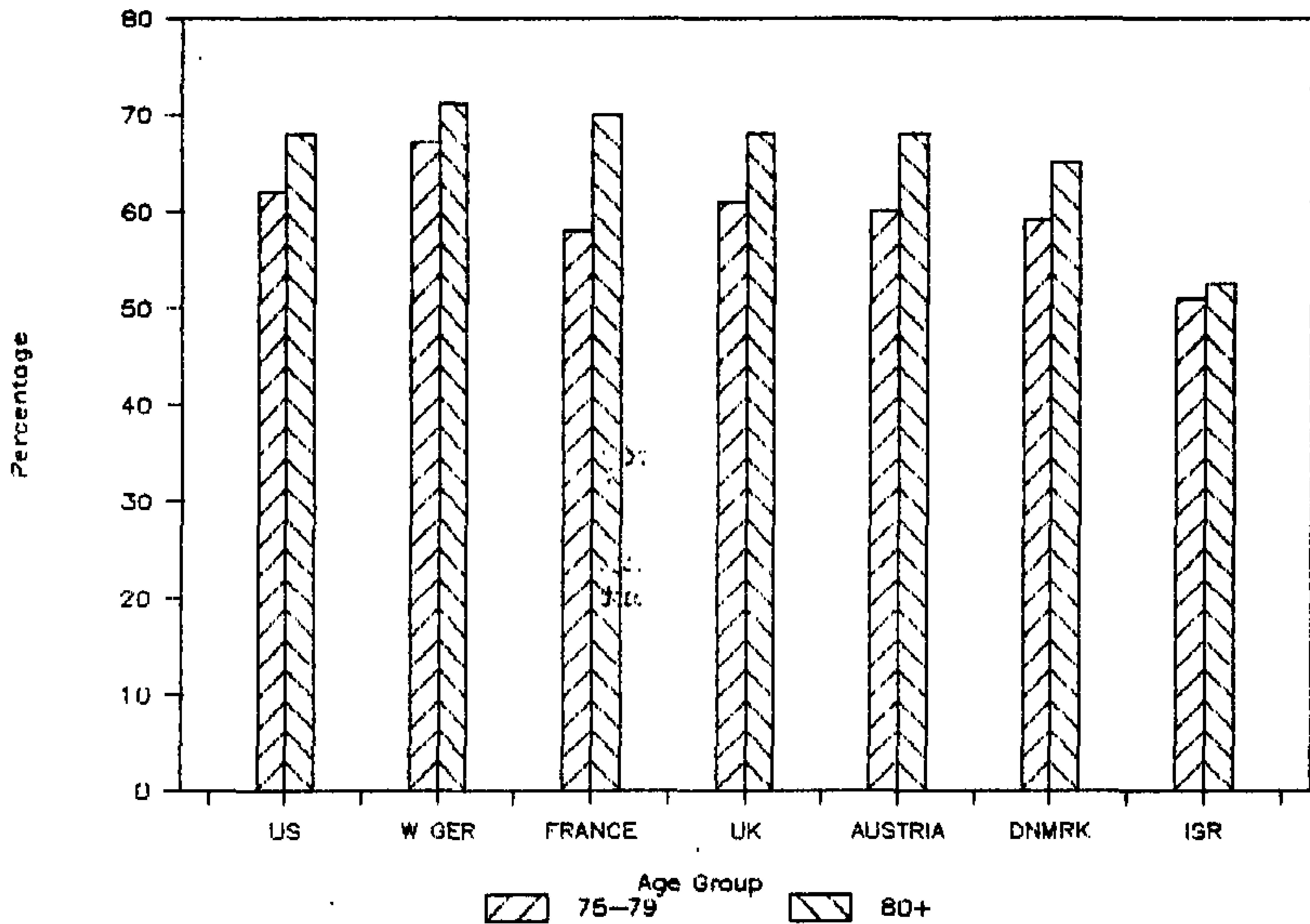
1. See Table 4 in Background Paper.

d. Similarly, what is the desired balance between community and institutional care, and how can this balance be achieved through incentives inherent in publicly financed programs?

e. The question which will have to be answered by each country is whether expected increases in health and long-term care expenditures will outstrip real economic growth. Will society, and in particular, the working population, be willing or able to bear the additional financial burden? Which economic policies should be pursued so as to achieve economic growth as well as cost-containment goals?

I am certain that reports heard in the next few days will address several of these issues.

Graph no. 3



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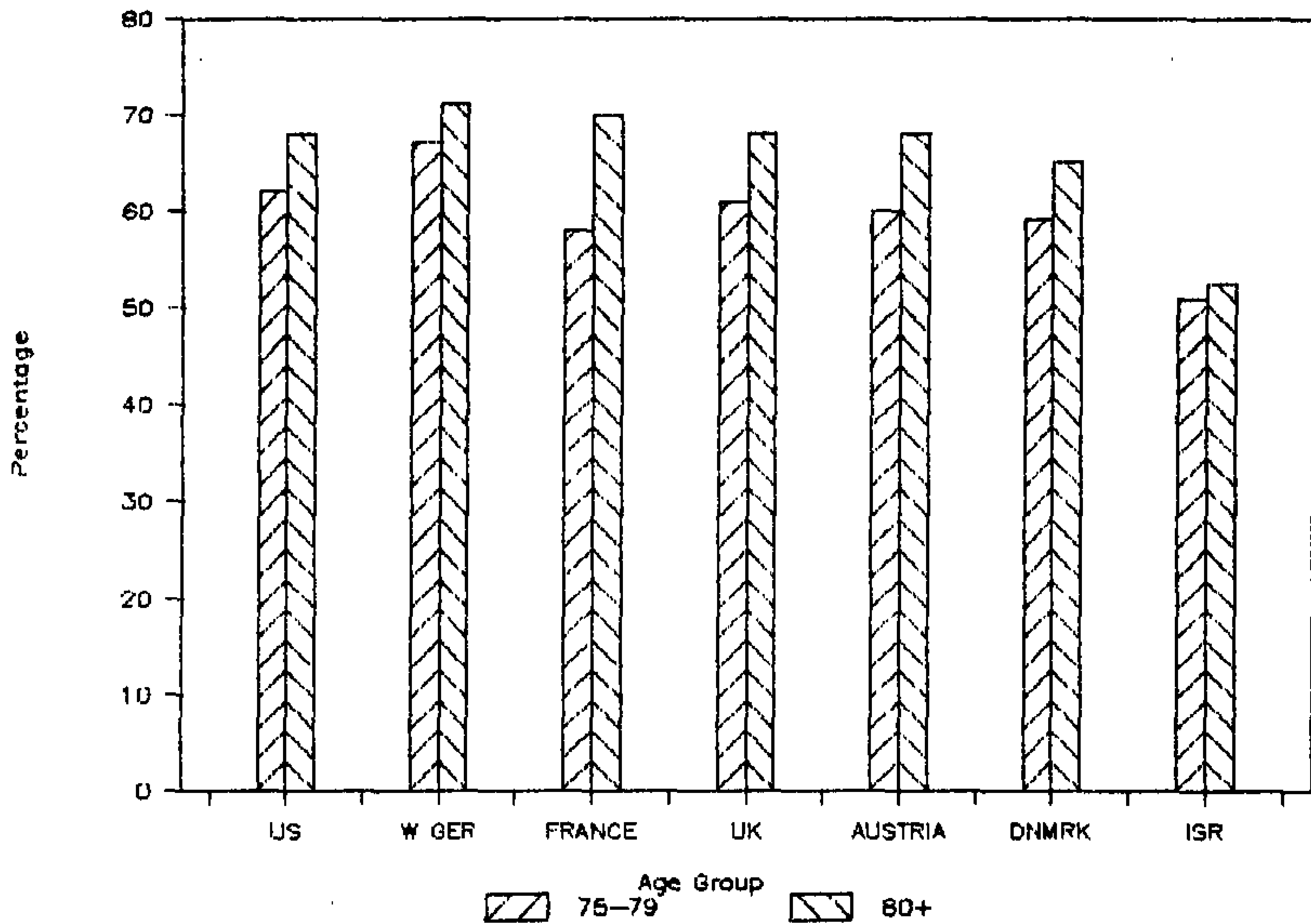
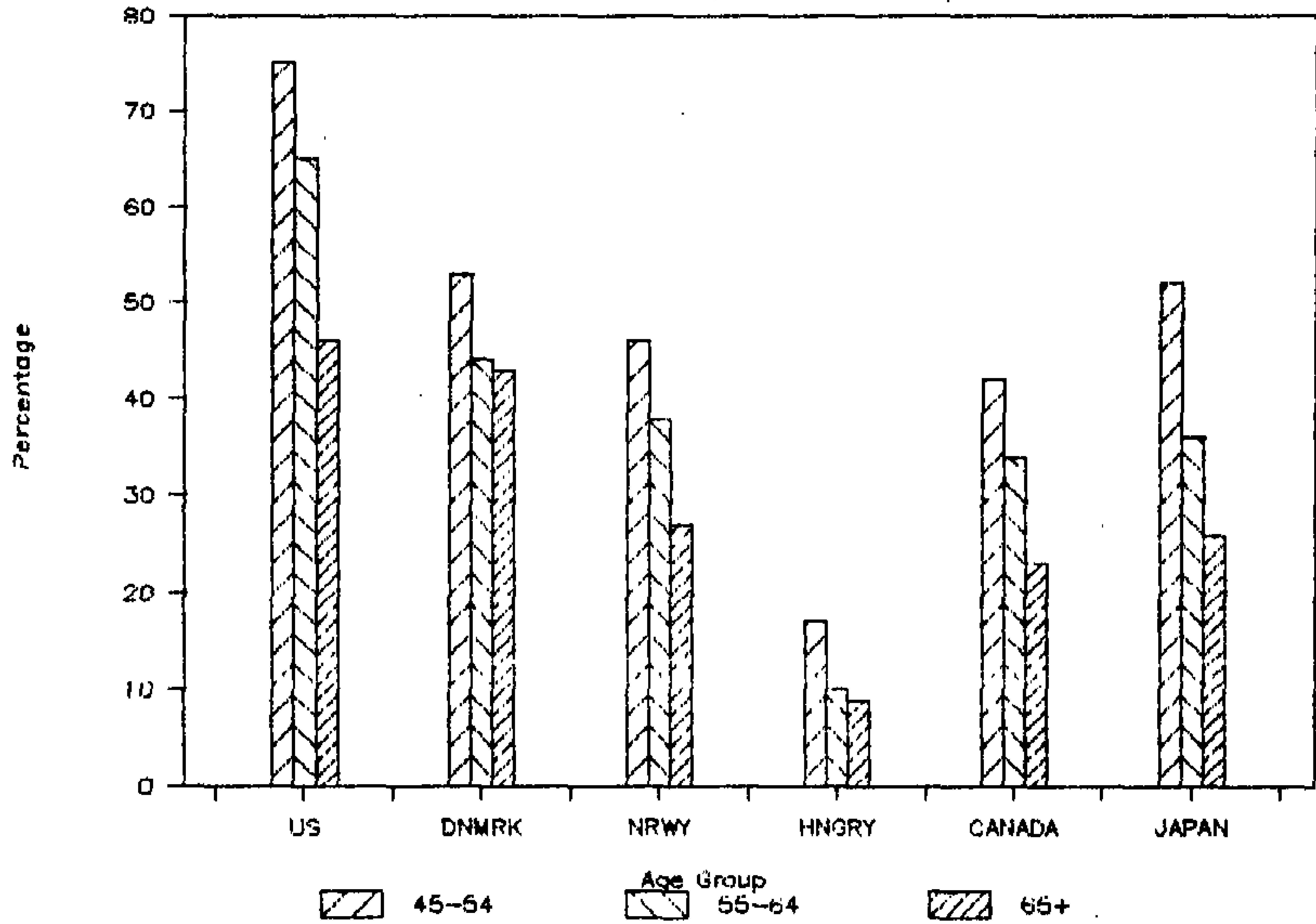


However we decide to define what specific ages we will be referring to during this meeting, as a group, the oldest old today are distinguished from younger elderly in a number of ways. I would like to briefly mention several:

a) As expected, there is a higher incidence of morbidity and mortality. Moreover, mortality rates for elderly men are more than 40% higher than for women in countries such as Germany and Japan.
b) As you can see from the graph, we therefore have a unique sex ratio among the oldest old, with a predominance of females as compared to males. Elderly women greatly outnumber elderly men in most countries of the world, with the percentage of women steadily increasing with each age cohort, especially in urban areas. In developed countries, the proportion of women among the oldest old reaches as high as 70%. Thus the social, economic and health problems of the over 80's are largely those of older women.
c) As a result, among the oldest old there is a greater probability of widowhood and living alone, resulting in higher incidence of isolation and loneliness.
d) We find among the oldest old lower educational attainment levels
e) and lower income levels.
f) We also find an extensive use of high-cost services, especially diagnostic medical services, acute hospital and long-term institutional care. For example, the rate of hospital days per 1,000 for those aged 85 and over is twice that of the younger old. The rate of nursing home residents is 11 times higher for men and 16 times higher higher for women.
g) A higher proportion of dependency in activities of daily living such as mobility, dressing, washing, grooming. Although varying definitions make it difficult to compare, studies in Israel and the US have shown that of the elderly living at home, approximately 7-8% require the significant assistance of others in performing such daily activities (ADL). These dependency rates increase sharply with age, reaching about 25% requiring some help in ADL among the 85 and over age group.
h) A heavy reliance on family for providing personal care in this area and homemaking services.

However, in spite of these general characteristics, one of the best reasons for holding a special meeting on the subject of the very old is that this is not a homogeneous or static population. We have been traditionally studying and providing data for the elderly as a single group spanning some 35 years, whereas in fact there is a great deal of diversity among this group, diversity which should be addressed in planning social security policy.

Graph no. 4



a) One is adopting a more pluralistic approach in examining the interrelationship between the basic demographic, social and economic variables, rather than using summary data for the elderly, in this way looking at the needs of diverse groups of elderly, not all of whom will require similar levels of publicly funded care. This approach will facilitate identifying the nature of heterogeneity within the older population as well as target groups with specific acute needs;

b) Secondly, rather than rigid adherence to existing structures, each society should be examining possibilities for modifying current patterns of meeting needs, such as the balance between institutional and non-institutional care, the role of the private and informal sectors. The feasibility of change in current patterns will, in each society, be a function of policy objectives reflecting social and political systems, division of responsibility among government bodies, traditions, cultures and priorities, as well as concern with costs, funding structures, and the role of the private market.

c) Thirdly, we ought to begin to examine a variety of options and objectives for funding and program development, some of which may clash with some traditions of social security policy development. Options should outline alternatives in at least four basic, interrelated areas that form a continuum of care, rather than focus on saving or spending in one area, without considering trade-offs in another area. These areas include economic and housing security, prevention and health promotion, curative care including rehabilitation, and maintenance or long-term care.

d) It will be essential to set priorities in resource allocation among these areas of intervention. For social security this especially means finding a balance between income maintenance programs and service delivery programs, as well as drawing boundaries between entitlement and non-entitlement programs.

One variable inevitably determining the size of the population requring care funded by the public sector, is income. Comparisons show that the risk of poverty is generally higher among those aged 75 and over than for younger groups.[3] Significant differences exist between countries, with Sweden having virtually no poverty for these groups. Studies such as the LIS which collects data over time, according to uniform definitions, will enable us to monitor changes in the income status of the elderly cross-nationally. As social security and work-related pensions mature, each successive cohort of elderly may have higher income due to accumulated assets and higher retirement benefits.

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3. See Table 8 in Background Paper.

We do, however, require better income data for future generations of elderly. In order to project the economic circumstances of people aged 85 in 2020, we should be looking at those aged 50 now, examining how they are being affected by improved pension availability, earning histories, changes in women's labor force participation, etc. In countries such as England and the United States, the financial position of the elderly as reflected by income and assets (primarily home equity) is predicted to improve markedly by the year 2020.

This would probably be true however about income status on the eve of retirement. From data based on cross-sectional analysis only, we know little about important income changes and expenditure patterns associated with the aging process itself, and especially about resource depletion over time, which requires longitudinal research. Whereas we do know that there are age-related reductions in major basic acquisitions, we don't know, nor is it easy to predict, the nature of expenditures on health, medical care, etc. From a policy perspective, the question is whether future generations of very old will have the resources to pay a greater share of their high health costs, or whether they will have depleted their resources by the time they reach advanced age.

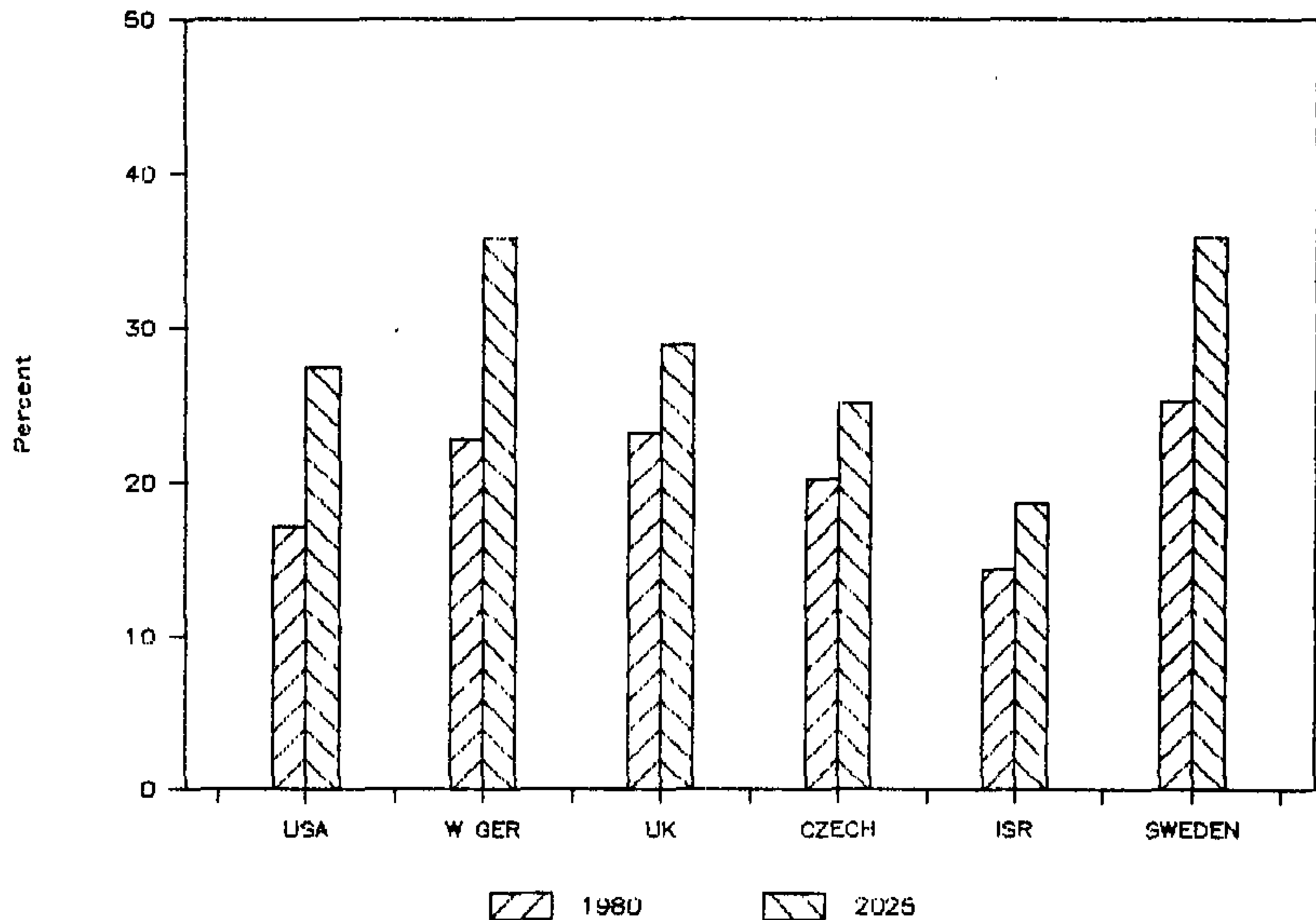
Longitudinal data about income depletion over time are therefore of special salience, if we want to look carefully and realistically at cost-sharing and other possible alternatives for providing health and maintenance care for the very old, since cost-sharing programs will be unviable if the resources of those expected to share costs will have already been depleted.

Let us take a quick look at one economic constraint related to population aging and productivity, which affects how we define needs and our ability to bear the cost of meeting needs: old-age dependency ratios.

Population aging has important implications for the size and age structure of the working population and the ratio of the population aged 65 and over to the population aged 15-64.

According to a recent OECD report, by the second decade of the next century the numbers of working age people are projected to be falling in almost all industrialized nations.

Graph no. 5



As can be seen in the graph, which shows only selected countries, the old age dependency ratio is expected to increase in every major world region. The most dramatic increases are occuring among the more developed countries (and in East Asia). As people live longer, as mortality decreases, as demands for income support and for a range of social services increase, the difficulties of supporting comprehensive social security schemes will be felt. Countries will face growing fiscal burdens as expenditures increase and the working age population shrinks.

However, these numbers in and of themselves do not give the complete picture about economic productivity of the two age groups, about the degree to which the economy can support expected costs of support. In fact, these trends may be even more serious if we take into consideration already high levels of unemployment in some countries which are difficult to predict for the future.

On the other hand, we should remember, however, old age dependency ratios reflect the burden of supporting the care of the non-working, but not necessarily non-productive part of society, since not all productivity can or should be measured in quantitative terms.

The way in which society and individuals deal with the burden of caring is related to other factors than just population and expenditure data, not in the least the way in which society views its elderly, and the value it attaches to their roles as consumers, contributing family members, volunteers, etc.

Another facet of the burden of providing care to the elderly, not in economic terms or demographic dependency ratios, is the actual, *immediate burden to the family. In planning the* comprehensive care of the elderly, each society will have to decide what will be the continued expected role of the family in providing care, for that proportion of the elderly requiring care, since this type of decision has operative, practical implications for the kinds of programs to be developed.

Several conditions that may affect patterns of informal care, family expectations and service utilization, have been identified in the literature as influencing the types of programs which have evolved in various societies, especially the balance of formal and informal care and community vs. institutional care. These include: differential fertility rates among age cohorts, divorce rates (affecting the availability of children to provide informal care), marital status of the elderly (availability of spouse caregiver, spouses being by the way the silent "unsung" majority carrying the burden of care), and female labor force *participation (availability of women to provide informal care* at home). To these should be added patterns in living arrangement trends, such as proportions living alone, as well as economic status and level of education, all of which would influence not only emerging patterns of formal and informal care but also expectations as to kinds of programs which might be made available, and the ability to pay for services.

In estimating future needs for public services, it remains a question, however, whether it is desirable and realistic that the burden of coverage for these groups be largely assumed by the public, at public cost, thus substituting for informal care. At most, the formal sector can only reduce some of the burden associated with caring functions.

In planning programs for the elderly and their families at home, it is necessary to define carefully our concept of social policy *in a way that closely reflects actual patterns of informal* care, expectations and preferences of the older person and his family, and expected family behavior in the future as influenced by current programs, and changing social and economic trends among successive age cohorts which will constitute future generations of elderly and their caregivers.

Research as well as experience continue to affirm that the family is and will continue to be the major provider of care for the elderly. Studies have shown that at least 80% of the elderly, dependent in functional activities of daily living, are receiving care from family members. In fact, if we look at <u>who</u> is eligible

today for services under Israel's LTCI program, or receiving care in a program as comprehensive as Manitoba's continuing care program, we would realize that the formal sector is effectively utilized only if some relative in the community is in the picture, responsible for service coordination.

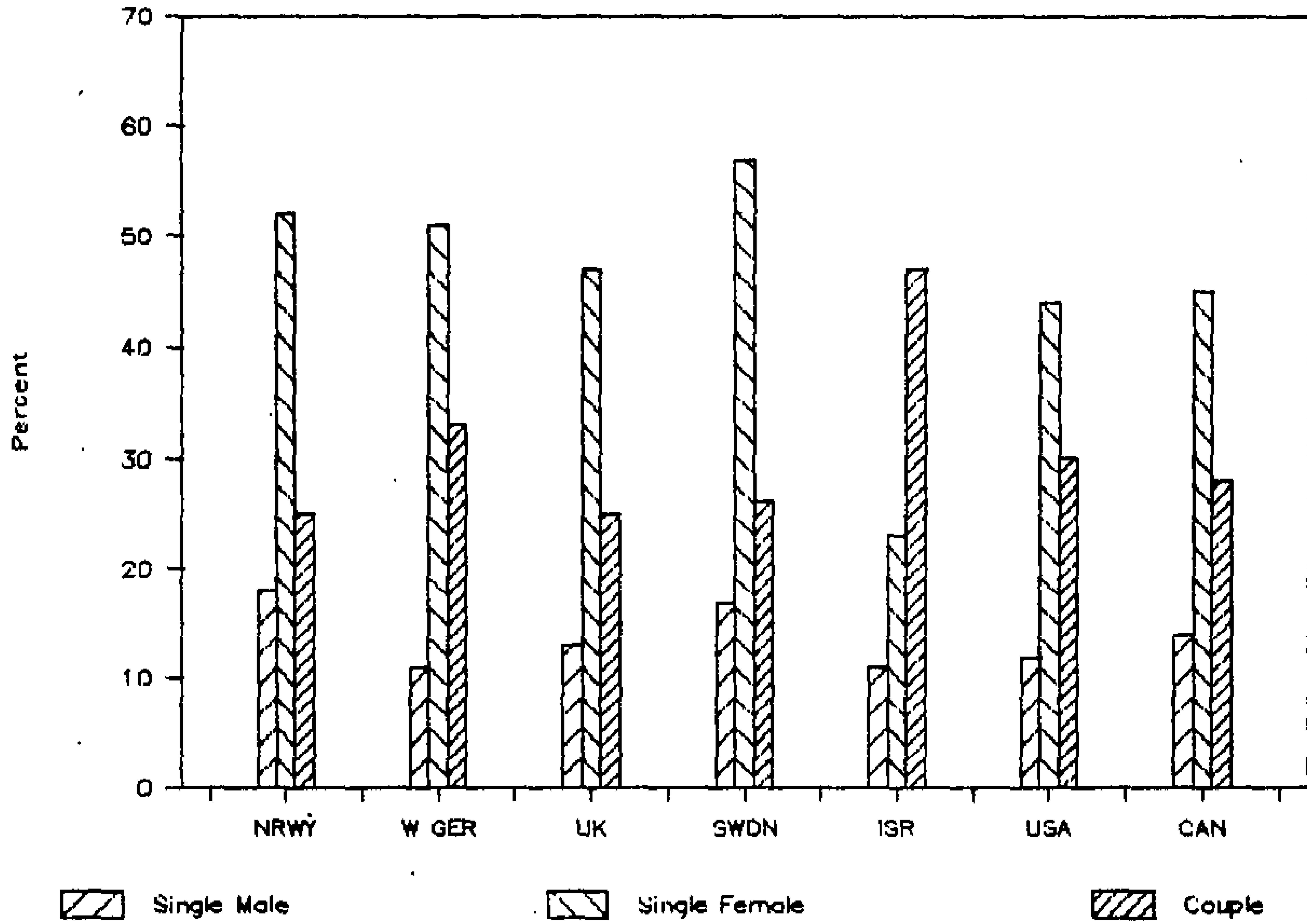
While, as I have often emphasized, the family cannot continue to be viewed as a free resource, and Israel has recognized the importance of reducing the burden of care on families in its LTCI law, forecasts of the magnitude of public burden and costs, must be based on policy decisions in regard to what part of the burden will remain the responsibility of informal as well as private market sectors.

It is clear, however, that given the recognition of the increasing burden on families and the need to provide assistance early enough to prevent crisis, exhaustion, breakdown and inevitable institutionalization, a broadened view of the target population is required, one in which both the dependent elderly and his family are targets of any planned program. This approach has in fact been adopted in Israel's LTCI law which is designed to participate in the burden of caring via a joint program of shared responsibility between the elderly and the public.

An expanded view of the target population should be accompanied by a flexible approach in designing the kinds of benefits and services which will be included in a comprehensive program, some of which might be made available to family caregivers themselves. If we are to respond adequately to family needs and expectations, concern with the family should become an integral aspect of planning, as in fact is the case in implementation of Israel's Long Term Care Insurance.

As mentioned, the degree to which relatives are able to provide care is related to a number of factors: demographic, economic and social. For example, caregivers of the very old are primarily the old themselves: spouses and elderly children who are themselves often close to retirement age. Thus the very existence of spouses and children, their age and proximity to the very old will largely determine how feasible it is for family to fulfill responsibilities in the future.

Graph no. 6



Household composition of the elderly is thus one important factor and one which may explain cross-national differences in proportions of individuals requiring and receiving care at home and proportions receiving care in institutions. Throughout the developed world, except for Japan, living alone in old age is becoming a social norm. This trend is a result of the high proportion of widowhood among the elderly, especially among women, and increasing rates of divorce and separation.

Israel is distinguished from European countries by its much lower proportion of people living alone and a higher proportion of couples, which may explain its low 4.5% rate of institutionalization, and high rate of family support.

It ought to be pointed out, however, that living alone does not in and of itself consitute a high risk factor for the elderly unless accompanied by other economic, social, health, psychological and support risks. In fact most old people value their independence and, far from being a risk factor, living alone would indicate personal decision and choice on their part. Moreover, although more and more older people are living alone, there seems to be little evidence that they are not receiving support from children and other relatives when this is required.

The changing role of women has been pointed out in several studies as having an effect on informal caring patterns, and the response of the public sector to needs. An increasing proportion of women are entering the labor force and are unable to fill the traditional role of caregiver on a full-time basis. Labor force participation rates are interesting for age groups that are particularly vulnerable as potential caregivers. In the U.S., Israel, Sweden and Canada, for example, the proportion of working women aged 55-64 has increased significantly, as opposed to increasingly early retirement patterns for men, as signified by what you see in the slide as steep reductions in labor force participation rates for men.[4]

Increased labor force participation rates for women may have a dual effect: while the time available for caring may be reduced, the improved economic situation of women, accrued pension rights, savings, etc., may enhance their position as consumers of services. Data soon to be published from a recent Israeli national survey of the aged suggests that whereas earnings-related pension coverage rates for men may be reaching a saturation point, cohorts of elderly women on the eve of retirement have accrued a greater proportion of pension rights. If it is true that families in which the wife works are more likely to purchase care, the tendency to acquire services from the formal sector may increase as a result of women's increasing participation in the labor force.

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4. See Table 6 in Background Paper.

In view of studies that, despite predictions to the contrary, families are not relinquishing their responsibility as caregivers, the implication of this trend is twofold: a greater proportion of families will expect to exercise greater independence in the way in which they manage care and in their choice of services; and as their earning power increases, women, who are traditionally the managers of care, may be able to purchase more services. Cost-sharing in several forms is in fact becoming a central aspect of some governmental programs for long-term care being sponsored in the U.S.

In fact, part of the alarm raised at growing public expenditures for the care of the elderly are being replaced by willingness to examine cost-sharing and other options in covering the expenses involved in providing care for specifically identified high-risk groups. In addition to the elderly themselves, cost-sharing might more actively include today's younger working population, which is already becoming more cognizant of the importance of investing a part of their current income in protecting against future risks of catastrophic medical treatment and may be willing to insure against the risk of long-term care at home and in institutions.

Additional alternative policy measures which have been put forth in the literature and might be discussed during the course of this meeting, include:

- restructuring of social expenditures in response to demographic shifts and changing patterns of need, i.e., a diversion of resources from programs serving the young to those serving the elderly;

- reducing the size of populations eligible for social security benefits (e.g., raising retirement age);

- encouraging growth in productivity of the working population;

- increasing labor force participation for some groups, such as women and the elderly themselves;

- moderation of replacement rates of the benefit while raising real earning levels;

- strict eligibility criteria to provide services and benefits only to specifically targeted groups.

- determining a greater role for the private sector in complementing social security schemes in some countries in order to relieve some of the pressures on basic public programs;

- examining possibilities of extending the tax base to include some segments of the elderly population, without harming low-income groups.

- and finally, biases toward high-cost institutional care could be balanced by community-based programs of housing and personal care.

A few words about home care and community care as opposed to institutional care. A cross-national study by ISSA in 1986 pointed out clearly that factors other than extrapolated population data are responsible for institutional rates and should be considered in forecasting the number of required beds. Most industrialized countries perceive their rate of institutionalization as higher than necessary or desirable. Most are currently pursuing deliberate policies to expand home and community-based long-term care services. Whether there is in fact a trade-off between the two sectors, and whether home care is less expensive than institutional care, is still a subject of controversy, although several studies in Israel seem to support this view at least for the less severely dependent. At present, Israel's Brookdale Institute together with the NII is conducting a study examining the effect of our community LTC program on the rates and patterns of institutionalization. Still, based on the axiom that if there is a bed available, whether in a long-term care ward or an acute hospital bed, it will be filled, I maintain that reducing institutionalized rates, enabling the deferal of entering a nursing home, is actually a question of policy in controlling the supply of beds, and not only of providing home care.

Only if we make a decision to put severe limits on the number of beds will there be a significant reduction in institutionalization, and for this reason, I do not believe it is justified to base long-term planning for building and expanding institutions on the sole basis of current utilization rates and population growth.

The emphasis should be both on keeping a limit on beds, and at the same time providing an alternative to institutionalization in the community, even for a short period. LTCI in Israel has at least expanded these options, making it possible to suggest defering institutionalization by offering services at home to those on waiting lists, so that the transition from home to institution is becoming a more flexible one.

LTCI in Israel should be viewed as a logical continuation and expansion of social policy for the aged under social insurance. Whereas for the past 15-20 years comprehensive measures for income maintenance for the elderly have been developed and refined, this next step in social policy reflects a shift in focus toward a statutory allocation of resources for the functionally dependent elderly, within a social insurance entitlement program.

In effect, the primary aim of the law is to formally define the State's statutory obligation to provide a basic level of long-term care services to the seriously disabled among the

elderly, on the basis of personal entitlement and clearly defined eligibility criteria, thus meeting individual needs of the eligible elderly and enhancing the family's role as a primary caregiver. LTCI therefore has two target populations, as I mentioned: severely dependent elderly and their families, where such exist.

LICI is innovative not because it provides services to the elderly but because it is part of Israel's social security system and operates according to insurance principles, paid for by contributions from the working population. The aim of the law is to enable dependent persons to remain at home for as long as possible, and to strengthen family caregivers by providing services. The emphasis is on providing home and community services, not institutional care. Under the law, an individual is eligible for services only if he or she does not reside in a nursing home. However, it should be emphasized that the role of the law is not to replace family functions and responsibilities. The family will continue to have primary responsibility for the care and welfare of the individual, since as I have already mentioned, the benefit covers only part of the basic costs incurred in caring.

Another basic principle is the continued expansion of the network of available services and manpower, through the benefits themselves, and by allocating special funds for service development in the community and institutions. In fact one of the important achievements of LTCI has been the rapid increase in services over the past year, in response to a tripling in the number of elderly eligible for and receiving home care.

Israel has developed an interesting mix of centralized and decentralized functions in implementation of LTCI. There is a clear division between assessment for eligibility on the one hand, and service provision on the other. Service provision and case coordination are decentralized functions, while eligibility determination and monitoring based on uniform guidelines and instruments, is a centralized responsibility of the NII, so as to assure responsibility, maximum equity under law and, it should be emphasized, maximum control over targeting and costs. This measure of centralized control over who will be eligible, the size of the eligible population, and the corresponding cost of the program is an essential, innovative element of LTCI.

On the other hand, decentralization in service provision is based on the important principle that on the most basic level the family is an active partner, together with local social workers and nurses, in determining what kinds of services the elderly person most requires and when to provide these services, and has an active role in coordinating services. This in fact reflects an approach not of external intervention in individual choice and perogative but the development of a model in which family needs and choices are respected and in fact are major determinants in the provision of services.

I would like to expand on some of these principles and provisions of LTCI.

1. Who is eligible under this Law? Men over age 65 and women over age 60 who are severely functionally disabled in activities of daily living or require constant attendance due to danger of harming themselves or their environment, are eligible for services. Eligibility level is defined primarily on the basis of functional dependency, i.e., the degree to which the individual is dependent on the help of others in basic daily functions including mobility in the home, eating, dressing, washing, continence control, and the need for personal attendance or supervision.

   There are two levels of eligibility, according to the degree of dependency, as assessed by a public health nurse from the Ministry of Health, who uses an uniform, objective assessment instrument for measuring ADL. Each person receives a score based on a home visit. Under certain conditions, additional points are awarded to persons living alone and to those requiring constant personal attendance.

2. As mentioned, the benefit is intended for elderly living at home, in the community. Thus, only persons living outside of nursing homes and nursing wards may apply for a benefit. However, persons residing in sheltered housing or old-age homes that are not publicly financed may also apply. For those elderly receiving a benefit while living at home, if a decision is made to enter a nursing home, the benefit will be halted upon institutionalization.

3. Eligibility for benefits is income-tested, based on income of the elderly and his spouse. The income test is quite liberal. Data for 1988 shows that very few applicants were ineligible due to income levels.

4. As I mentioned, benefits provide only a basic level of care. The lower benefit level can be used to provide 11-12 hours per week of personal care and the higher provides up to 17-18 hours per week. The emphasis is on in-kind services, not cash benefits. Only in specifically-defined instances where services are unavailable, and the eligible person is being cared for by a relative living with him or her, is it possible to receive a cash benefit, until services become available.

5. The kinds of services which can be provided under LTCI are defined in a proscribed basket of services, and include personal assistance in the home or in organized community facilities (such as day care centers), home help (with basic household chores), personal attendance, laundry, meal preparation and delivery, and supply of absorbent under-garments for the incontinent. Medical, paramedical and social support services, such as home nursing and physiotherapy, are not covered under LTCI, and continue to

remain the sole responsibility of health and welfare bodies.

6. The National Insurance Institute has overall responsibility for the law's operation and its monitoring. However, there is a sharing of responsibility in implementation between branches of the National Insurance Institute, the Ministry of Health, the Ministry of Social Affairs and our major Histadrut sick fund. Local and professional committees, which are defined by law, have responsibility for determining care plans, providing services, monitoring changes and reporting.

   These local committees are staffed by a senior social worker from the municipal authority welfare department, a nurse from the sick fund and a clerk from the National Insurance Institute.

   As mentioned, this arrangement decentralizes the most important professional functions at the level of case management and service provision, recognizing that these are best understood and dealt with at the local professional level by social workers and nurses who represent the responsible welfare and health agencies.

7. In addition to stipulating which services will be provided, the care plan developed by the local committee indicates which agencies will provide services. The program operates strictly on a sub-contracting basis, raising important requirements of licensing, monitoring, quality assurance and control. Only certified agencies, private and non-profit, having legal status and approved by the Ministry of Labor and Social Affairs can be contracted with to provide services. Benefits cannot be transferred to private persons providing care.

The emphasis, then, is on the words eligibility and services, a combination which does not exist in other countries in the same way as in Israel. What I mean is a combination of a largely universal approach in determining eligibility with a differential approach in service provision according to individual and family requirements.

An important contribution to LTCI in Israel is that it brought to public debate and resolution, in the form of legislation, many issues that had previously remained solely in the province of professional literature - substitution issues regarding the role of the family in providing care and dangers of over-dependency in public programs; links between informal care provision and formal service structures; public incentives for community versus institutional care; cash versus in-kind benefits; centralization versus decentralization in implementation; roles of private and public agencies in service development and provision; and, in Israel, the drawbacks, benefits and cost considerations of a social insurance-entitlement program, versus existing public programs based on general revenues as well as more selective and discretionary

modes of resource allocation. Some of these issues have now been resolved in the law; others are still undergoing debate and will, I hope, be raised here during the next few days.

LTCI has already had a major impact on the system of LTC in Israel. To a great extent, the success of LTCI in meeting social goals and needs depends on the degree of coordination and cooperation between the various agencies and organizations. We already have some indications that benefits do not constitute a separate system but are slowly becoming an integral part of an improved program, with potential for even greater coordination between LTCI and other frameworks.

Through the local professional committees we have in fact created a unique opportunity for reducing fragmentation and improving inter-agency cooperation, which it is hoped will enable a more comprehensive approach to the assessment and care of the elderly, in a model of case management, or coordination, we have developed as a result of this law throughout the country including urban and rural areas.

If utilized properly, the local committees have the potential in the future of becoming a single-entry point into the system of care and services for the elderly, which would provide assessment and referral for other required services and, perhaps at some later stage, for initial screening for institutionalization, thereby assuring a continuum of care, a more rationalization of resources, as well as reducing the often informidable and insurmountable burden of turning from organization to organization for an already overburdened and exhausted population.

Moreover, the very fact that LTCI is an insurance-based, statutory program, has introduced a large measure of uniformity in tools and procedures for assessment which have become widely accepted by professionals in other related areas, in a greatly expanded network of home visits by social workers and nurses, uniformity in determining treatment plans, in the certification and contracting with private service agencies, and in working within limited periods and deadlines. Because of LTCI, today dependent elderly who in the past may have had little contact with professionals are being visited at home on a regular basis by local professionals.

A year after its inception, we have already tripled our coverage and almost 5% of the elderly population will be receiving services, when we complete processing all the expected applications. If we add to this the 4.5% of the elderly population in institutions, it is safe to say that Israel is approaching an acceptable level of coverage of long-term care needs, and provides, through LTCI, a viable option for care in the community.

Of course a program of this type, especially during this period of transition from one system to another, has its problems, and

sometimes I still think that we have more questions than answers. Because it is a statutory program, covering only a basic level of needs, there are elderly who require more hours of care than is provided. The danger of cutbacks in other sources of revenue and essential services for the elderly still exists and must be prevented. Moreover, because of the huge administrative and professional efforts expanded on absorbing and processing the large numbers of applications - about 8% of our potentially eligible elderly population has applied over the past year - there may be a tendency to neglect other services required, other populations of elderly having different needs. We do not know, for example, what is happening with those who are ineligible for LTCI but who do require supportive services, or to those who require the immediate response of short-term post-hospital care at home. This has traditionally been and should continue to be the responsibility of our sick funds. It is thus important to make certain that other responsible public organizations do not relinquish their responsibility for providing health, home care, housing, physiotherapy and social support services for the elderly groups on a selective basis, and do not cut back their budgets, but rather reallign their programs to complement LTCI.

One of the law's major achievements, belying much of the scepticism that existed prior to implementation that there would be sufficient services, is that there has been a geometric growth in services and in manpower. Whereas prior to the law it was predicted that a sizeable proportion of the elderly population would receive cash benefits due to our inability to provide services, today only 150 out of some 17,000 recipients receive a cash benefit. Services have developed sufficiently to provide care even to the large number of eligible in our age-concentrated urban areas.

As part of this growth in services, since the inception of LTCI the number of private, for-profit agencies has mushroomed. It is clear that an immediate major concern to the National Insurance Institute will be that of quality assurance: the development of a program to closely monitor the operation of private as well as non-profit agencies, to assure the quality of care provided, the efficient use of funds for services, in short - to ascertain that agencies are providing services in accordance with the decision of the local committees, via competent home care attendants, in terms of both hours and quality of care.

Finally, if I had to choose the most significant impact of LTCI, I would say that it has brought about a most basic change in the attention paid to what was an overly neglected population in the past. The dependent elderly are being given the weight they deserve and require in terms of social programs, resource allocation and professional involvement, and this I believe to be the real implication and benefit of incorporating a program of this type under social insurance.

Summary

Introduction

Mr. President, Mr. Secretary, Mr. Chairman and Fellow Colleagues,

By necessity, this summary presentation will have to be short and quite general and therefore cannot do full justice to all the excellent papers and level of discussions we have heard during the course of this meeting. I therefore apologize in advance if I do not adequately cover all the details and issues raised in the last few days. Any omission on my part will most certainly be included in the published proceedings of these meetings.

After three intensive days of hearing reports, participating in discussions, exchanging views and information, I believe we are all approaching the culmination of this conference with a clear sense of having raised some of the most salient issues in an area of common concern to all of us here involved, in various ways, with developing social security policy, each in his own country. The title of this meeting, "The Role of Social Security in Providing Social Protection to the Very Old", included several terms which, significantly, did not elicit discussion or disagreement about basic definitions regarding what and who were the focus of concern, as often occurs during opening sessions of meetings of this kind: whether we ought to define the group of very old according to age categories or variables characterizing specific need situations, or to what kinds of social protection we are referring. This suggests to me that there is already largely a feeling of consensus about who our target population includes, and that by the term social protection we are referring primarily to issues and challenges to society with regard to caring for dependency and alleviating conditions of social isolation.

Demographic Trends

All presentations described similar demographic trends of aging in the various countries, as well as related social developments affecting patterns of formal and informal caring, developments which make imperative that each society consider alternative solutions and move toward decisive policy, as difficult as this progress may be. Several reports indicate that in some countries legislative action is well under way.

I should like to point out, however, that with regard to demographic and economic data, discussions at this meeting have supported suggestions made during the opening session, that the very old are a heterogeneous and changing population, and that program planning and legislation ought to consider the requirements of specifically defined sub-groups. This approach was reiterated today by participants who pointed out the undesirability of basing planning on general demographic trends

rather than on specific data regarding acute-need groups. We also heard several comments by our colleagues over the past few days, which suggest that demographic trends are not absolutes. It was proposed that we ought to remain closely attuned to re-estimating figures and trends so that the implications of demographics be carefully monitored in a rapidly changing society, from the viewpoint of changing medical technology, social trends and especially cohort changes. Based on the position that we are relating to a changing, heterogeneous group, it was pointed out that there is not necessarily a direct correlation between the evident increase in numbers and a growth in incapacity and dependency. We may, in fact, find improvement in the health and economic independence of some groups among future cohorts as people enter into old age. The data brought by several participants, although not definitive, hint at some improvement in the overall economy of aging, in terms of reductions in rates of increase in medical and social expenditures, especially as compared to increases in the GNP. This would support the view that each of us, in his own country, closely monitor national trends related to population aging, social and health expenditures, and the ability of the economy to support these expenditures.

Along these same lines, it was interesting and gratifying that in several reports we heard echoes of our first discussant's opening comments that we should during the conference, as well as in our own work at home, avoid alarmist predictions about the spectre of aging populations and impending fiscal crises, while remaining aware of pressures and needs. This welcome point of view was manifested again in yesterday's presentations, which outlined a specific pragmatic program for service development, and which emphasized two related and important points.

The first is the avoidance of placing the onus of guilt on our elder population, avoiding the danger of blaming the elderly for their growing numbers and needs and thereby creating unfavorable political climates in regard to the financial implications and burden of meeting these needs. At the same time, however, that we seek to avoid placing blame on a population group, it is incumbent upon us to encourage and increase each individual's sense of responsibility for his own aging, especially among today's younger population, by actively promoting and pursuing preventative measures, by educating younger society towards healthier life styles that will extend the period of functional independence, and by not neglecting those who are less dependent, thus preventing and reducing the need for high-cost services later on in life.

The emphasis during our conference, then, was also on prevention and not only on curative or ameliorative care, rehabilitation, and maintenance services, important as these are. Prevention was underscored by several reporters as constituting a subject for

further ISSA discussions as well as a priority in planning during upcoming years.

<u>Cash Benefits and In-Kind Services: Mixed Economies of Care</u>

The informative and excellent reports and discussions we had yesterday added another dimension to several very important, basic approaches first raised in Tuesday afternoon's session by our reporter from the Federal Republic of Germany, a country which seems to be considering an alternative model to the one adopted in Israel's Long Term Care Insurance Law. This report emphasized that social rights of the elderly be protected by legislation under which the eligible person's autonomy, personal choice, preferences and self-determination are overriding considerations in planning the form of resource allocation. The eligible person's exercise of choice and personal priorities for services at home or in an institution, for example, must be enabled in a mixed program offering a broad spectrum of alternatives and service agencies, based primarily on an approach in which cash grants are provided to eligible individuals who could use them to acquire services according to their personal preferences.

The issue of cash grants versus in-kind services is really one of emphasis, as seems to have emerged in discussions here, rather than one of mutually exclusive approaches. The focus of emphasis is actually a question of where each society is in terms of its development. According to one participant, each society is facing the problem of aging at a different stage in development from the point of view of its social goals, means of implementing and achieving these goals, and its economic situation.

Given these various stages at which our societies find themselves, the reports during the first two days of our meeting brought to focus the point that in protection to the very old, we have two basic, distinct systems for providing care, which are again subdivided by two different modes of provision: The two distinct systems described were our familiar social assistance and social insurance systems, while the two modes of provision which emerged in discussions were service-oriented systems for providing specific care packages versus cash benefits based on some form of income assurance measures. In practical terms, the choice for each society between these various elements depends on its stage of development as well as a decision how, within limited funds, it can best <u>achieve its social goals</u>, and not whether it values the independence of its citizens.

In fact, we will find that there is and probably will continue to be a <u>mixed economy of care</u> in most societies, which includes elements of both systems and both approaches for providing services, and we are each today faced with deciding, for each society, which system and mode of provision will receive emphasis in the future through some form of legislation for the elderly.

Several countries, such as England and Austria, already have attendance allowances or supplements for dependent elderly, recognizing the need to cover additional costs related to the care of dependency. Others provide relatively high income assurance levels, as in the Netherlands and West Germany, which enable the elderly to meet costs of care and institutionalization without additional allowances. These mixed economies are generally the result of programs having been built in stages, using an incremental approach, as explained by our discussant today, an approach which may not be ideal in all cases but which enables us to gradually improve our systems within political and economic exigencies. In Israel, even with Long-Term Care Insurance, a mixed economy still exists, sometimes resulting in some inequities for small groups. Even in terms of cash and kind services, we have a mix, due, again to incremental stages of developing our social security and social assistance systems. Thus, for example, dependent elderly persons who received attendance allowances under General Disability Insurance can opt to continue receiving these cash allowances in lieu of in-kind services under Long-Term Care Insurance. We also, as I mentioned, still have important selective measures for providing personal home care and home help services through our welfare and health services and our sick funds. As a result we in fact have different forms and levels of coverage for some small groups eligible under various programs. However, while it is important to remain aware of problems and irrationalities in a system, these should be weighed against the vast improvements which have resulted from Long-Term Care Insurance.

Most countries we have heard from during this meeting have not achieved a completely unified, rational, efficient and effective system for resource allocation in assessing and meeting needs of the elderly, but rather continue to have mixed economies they are trying to improve on an incremental basis. For all countries, however, because of these mixed economies, the issues of inequalities, irrationality, waste, fragmentation and coordination between various components of the system are very current, immediate problems to which we must stay attuned. How these inevitable and sometimes overwhelming issues of coordination are being practically addressed have perhaps not been sufficiently emphasized during this meeting and might be the subject for future discussions.

I would like to say, however, that mixed systems do not have to be the result only of development of social policy by stages, but can be planned as desirable, and even optimal solutions, as suggested by several reporters and discussants. One might say that from the point of view of individual needs and differences there is even some advantage to diversity. A mixed system would take the form of both cash benefits and in-kind services, a mix of alternatives, from which the eligible and his family can chose. But this is based on a strong assumption that elderly dependent people and their families, finding themselves in the

highly tense, emotional, difficult situation of requiring personal care services, will make the "proper" choices for the welfare and benefit of the elderly and themselves, and that they are aware of the implications of these choices. Moreover, we assume that social objectives of reducing the burden on the family and of increasing the provision of care, will in fact be achieved through the individual's exerting independent choices in service acquisition. That, for example, if the choice is made for a cash benefit, the individual will in fact acquire services and will not demand, in addition to the cash benefit, publicly-funded services to meet the same needs. Experience with attendance allowances to disabled populations indicates that they are what they perhaps were intended to be: income supplements rather than means for service acquisition. Since cash benefits are not generally utilized to obtain services, the direct impacts of attendance allowances cannot be expected to include a reduction in the burden of caring in the practical terms of service provision, improval in the quality of care, or service development. In contrast, these outcomes are emerging as the desired impacts of Long-Term Care Insurance, providing services in kind. The question is then whether non-earmarked income supplements improve the condition of the elderly recipients, which is, of course, societies' ultimate goal. However, as came out clearly from one report, even earmarked funds may be utilized incorrectly, inadvertently running out of control, with the effect perhaps of undesirable impacts on the utilization of services, from a societal point of view. In fact, the report from one participant described an experience of how potentially beneficial legislation may be acting as an incentive to undesirable institutionalization rates, something it wishes to avoid. Of course additional research is necessary to examine this issue at greater depth.

There is perhaps one point, however, which should be made, and with which there has been overall agreement during the course of this meeting, that whichever system is chosen, it has to be evaluated by the same outcome measures: the improved situation of the elderly and their family caregivers, the reduced burden of caring, the increased range of choices, the enabling of individuals to remain in their homes if they so choose, the respect of the elderly by themselves and the society's younger generation. In this context, as was pointed out by one participant, there is an obligation on the part of those committed to research to develop meaningful and systematic outcome measures, a task not easily accomplished in the area of community long-term care, especially if outcome is to be assessed in terms of effectiveness and quality, and not only efficiency.

Having said that, an important criterion which in each country should be utilized when monitoring program outcomes is that of cost-effectiveness. An important question to which we have to be attuned is: how much of the resources spent in Long Term Care Insurance does in fact reach the eligible elderly in terms of

quality, net service hours and what proportion is going for labor-related and administrative costs inherent in a service system. Future research will inevitably be examining questions of this type very closely.

The Role of the Family

This brings me back to a subject already raised during our first day's discussions: the different ways in which each country represented here views the role of the family, and its expectations from the family in providing care for its dependent elderly members. Without launching into economic and social theories and formulations regarding the nature of intergenerational contracts and transfers of services and money at different times of the life cycle, a point was made at this conference, as previously mentioned, was that each society today is dealing with the problem of aging populations at a different stage of its social and economic development, in terms of standards of living on the one hand and important social parameters such as living arrangement patterns, the traditional role of females as caregivers, etc. Perhaps Israel constitutes an exceptional situation, for example, with its unusually high proportion of elderly living with spouses, as opposed to European countries and the United States which are characterized by a high rate of elderly living alone, thus resulting in different patterns of informal care and a different approach regarding what families can realistically be expected to contribute to the care requirements of the elderly.

But, in general, I wonder if you would agree with my conclusions from the remarks made by participants, that whatever the level and expected role of the family in each society in providing care for its elderly, no society wishes to evolve the kind of formal system of care that would create an incentive for reducing family responsibility. The question is therefore not necessarily one of "forcing" or imposing on relatives to provide care, against their wishes, but rather to offer families the kinds of viable alternatives that will enable them to continue to provide care, to be involved in executing responsibility, in whatever form and level they consider appropriate - whether this means performing direct, practical caring functions, managing and coordinating services, or providing important social supports both at home and in institutional settings. In this context, a point made by one participant seems extremely valuable: relatives are looking for a way of sharing the burden of care. They want some form of entitlement, a contract between themselves, the older person and society, in which the limits of informal care are recognized. Most family caregivers report in surveys that they have chosen to provide care out of a sense of love and duty, but that they do require the assistance and support of the formal service sector. This type of support is what I hope we are providing in our various different programs. However, as was suggested by the

comments of several discussants, we urgently require more research examining the roles of family caregivers, their attitudes and expectations, and the limits of care.

In any case, whatever system is chosen, cash benefits or services or a mixture of the two, each society will have to deal with the problem of supply of quality services and manpower; assuring that there is a clear policy aimed at developing a broad network of accessible service alternatives which are capable of offering attainable quality care and which are cost-effective.

In fact, a country such as West Germany can realistically consider adopting a program of long-term care based primarily on cash benefits only because it has an extremely well-developed network of services operated by non-profit, voluntary organizations which employ a large number of trained, experienced personnel, so that benefits can easily be utilized by the eligible to obtain services in the community.

Issues for Future Research and Discussion

Several other issues were raised during the course of this meeting, such as the balance between different kinds of required services along the continuum of needs and the interrelationships among these services. For example, several discussants emphasized that we should be careful not to over-emphasize high-cost medical care at the expense of social services; we ought to develop more rehabilitative care; to improve the health care of the elderly in order to prevent deterioration and alleviate dependency; and finally, a point repeated in several reports, the urgent need to develop independent, but sheltered housing arrangements for the elderly as alternatives to choices which would otherwise mean either remaining a burden on families or entering an institutional facility.

Given the various models described here as to modes of service development, it was suggested by participants that one means of examining the viability and effectiveness of alternatives is the controlled demonstration project - a worthwhile investment geared to practically experiencing and learning about alternatives as part of policy development prior to introduction of a specific program on a nationwide scale. Also, the use of research tools for problem-solving and for examining new sources of social and health revenues for social security funding was strongly suggested.

Several additional areas which we raised during our conference and which might be the subjects of future in-depth research and discussion are:

a. **The Desired Mix of Private and Public Service Programs**

Perhaps we would have liked to hear more about the experience in various countries with the private sector, each country having a different economic, social and political approach. For example, it would be useful to learn more about the effectiveness of private complementary insurance programs and their possible application in different societies.

b. **The Mix and Balance between Non-Institutional and Institutional Care**

This subject deserves further attention. Beyond the fact that we agree that institutional care is inevitable and necessary at some point, for a certain proportion of the population, several issues were raised in discussions which could not be elaborated due to time constraints - issues related to comparing quality and costs of home versus institutional care and the effectiveness of planned interventions to reduce institutionalization rates.

c. **Elderly having Acute Needs**

We touched upon but were unable to allocate discussion time to the requirements of small groups of elderly having in-depth needs and requiring high-cost care, such as elderly suffering from dementia and, especially, Alzheimer Disease. Other related issues raised by our representatives were the high cost of medical technology and medical diagnosis in the case of illness in old age. To this I would add the importance of expanding the state of the art in regard to managing disease and disability in old-age in geriatric education and medicine and their application in practical health care.

d. **Cost-Effectiveness Issues**

A subject calling for more in-depth research and discussion has as its objective improving the overall interrelated cost-effectiveness of social, medical, health, rehabilitative and maintenance care, and preventing the misuse of expensive services which sometimes occur, due to what might be termed the automatic shifting of responsibility for what could be low-cost care to nationally-funded services, in spite of the high costs of the latter. These issues include some examples heard here of the misuse of nationally-funded acute hospital beds for long-term care which could be provided at lower cost within other maintenance service models funded by local governments.

e. **Role of Women**

The role of women as caregivers in modern societies, the difficulties to women in reconciling and reconstructuring their responsibilities as worker, homemaker, professional, spouse and parent, was discussed by several of our colleagues, who also suggested that we consider possibilities for compensating income losses of female caregivers, especially in light of the danger to women, who are currently providing care, of improvishment in their own old age due to lost income and pension rights.

f. **Quality of Care**

How can we better measure the quality of services? There is an urgent need in research to develop meaningful criteria and outcome measures for evaluating the impact of care and instruments for quality assurance and monitoring. This is an area in which little progress has been made but which is of urgent theoretical and practical importance to those responsible for program effectiveness monitoring.

g. **Prevention**

Finally, there is an immediate need to learn more from each other about prevention measures; the reduction of risk factors in young and old age; the cost trade-offs between prevention and care provision programs; possibilities for more wide-scale and efficient utilization of appropriate medical diagnosis and treatment, including medication and rehabilitation to reduce what might today be improperly classified as irreversible dependency, thus perhaps reducing the need for and cost of long-term services. Research in this area is called for and perhaps, by reducing needs and dependency, future professional groups will be able to make decisions more easily than we have been required to do, about how to plan for the protection of the elderly under social security.