Geriatrics in the New Millenium, Israel

Beni Habot[1] MD and Shmuel Tsin[2]

[1] Shmuel Harofeh Hospital, Geriatric Medical Center, Beer Yaakov, and Geriatric Center, Rishon LeZion, Israel
Affiliated with Sackler Faculty of Medicine, Tel Aviv University, Ramat Aviv, Israel
[2] Former Administrative Director of the Geriatric Division of the Ministry of Health, Israel

Key words: geriatrics, geriatric services, elderly in Israel, mentally frail

Abstract

Since the early 1980s demographic changes compelled Israel's health system to dedicate efforts to establish modern geriatric services. This task was performed with the help of governmental and non-governmental institutions and was coordinated by the Division of Geriatrics and Long-Term Care Diseases of the Ministry of Health. Today, 20 years later, as a result of those efforts, geriatrics and geriatric services in Israel are thriving. Qualified staff, including physicians who specialized in geriatrics, are working to maintain a high quality of care in various geriatric settings. However, more resources should be allocated for research in order to maintain and to continue to develop geriatric medicine in Israel.

IMAJ 2003;5:319–321

In the early 1980s the *Israel Journal of Medical Sciences* published a special issue on Geriatric Medicine [1] on the initiative of the late Prof. Margulec, who headed the medical side of the Association for the Planning and Development of Services for the Aged in Israel (known by the Hebrew acronym ESHEL), and Prof. Beni Habot, Director of the Geriatric Division of the Israel Ministry of Health. Previous publications by Margulec and Habot on healthcare for the elderly in Israel [2,3] and the needs of Geriatric Medicine convinced the editorial board of that Journal of the necessity for such a publication. We are pleased that now, some 20 years later, the editorial board of *IMAJ* decided to publish a special issue devoted to geriatrics in Israel.

The last two decades witnessed considerable demographic changes, including a large increase in the number of elderly requiring highly trained staff; this increase called for research in geriatrics and geriatric services. New health regulations that specifically concern the aging population were issued. The Nursing Law, issued in 1988, offers up to 16 hours a week for assistance in activities of daily living. By the end of the year 2000 more than 100,000 citizens aged 65 years and over (16% of the elderly in Israel) had benefited from this law. In addition, an interministerial committee for the improvement and construction of nursing institutional beds was established, funded by the Ministry of Health, the Ministry of Welfare, the National Insurance Institute (social security), the Claims Conference (i.e., the German Foundation for Financial Compensation for Holocaust Survivors), and ESHEL.

A new concept in long-term care is reflected in the creation of a complex nursing system. The Porat-Habot Agreement (approved by the Ministry of Health and the Clalit Health Services) made a clear distinction between simple nursing and the complex nursing of the late 1980s. Rules of the complex nursing system and staffing rates are described elsewhere [4]. This became part of the basket of services provided by the new National Health Insurance Law of 1995.

Since the 1950s the aging population has grown at an unpredictable rate – 7.3 times the rate of the general population, compared to 3.6 in the 1950s. This rapid increase in the rate of elderly people is unique among western countries. The total number of people aged over 65 in Israel at the end of 2000 was 623,000. Among them, 276,000 were over 75 (41%) and 139,000 were over 80 (22%). The population of 65+ is expected to reach 723,000 in 2010 and 1,026,000 in 2020 [5]. Life expectancy at birth in Israel for men is 76.6 years and 80.4 for women [5]. Women represent 57% of the aged in Israel [5].

The wave of Russian emigration in the early 1990s added 20% to the aging population in Israel. They are older than the average Israeli. Numbering 124,000 at the end of 2000, these elderly immigrants constitute 16% of the newcomers as compared to 10% among the Israeli aging population.

The care for the elderly in Israel is differential and is based on functional status: independent, frail (partially dependent), mentally frail (all kinds of cognitive decline), requiring nursing or complex nursing [4]. The Ministry of Welfare takes care of the independent and frail elderly, and the Ministry of Health for the mentally frail (cognitively impaired) and those requiring nursing. The complex nursing patients are the responsibility of the health maintenance organizations (health insurance funds).

The entire population in Israel, including the elderly, are insured by the Israel Health Law and receive care from the traditional health funds (HMOs). The percentage of the elderly in the four HMOs are as follows: Clalit 74%, Maccabi 13%, Leumit 7%, and Meuhedet 5%.

HMO = health maintenance organizations

Table 1. Comparison of hospitalization data in different healthcare settings: 1975 and 2000

	Total	General hospitalization	Psychiatry	Long-term care	Rehabilitation
No. of institutions					
2000	343	48	21	272	2
1975	125	47+2%	39	36	3
% change	+174%		-46%	+655%	-33%
No. of beds					
2000	38,613	14,165	5,589	18,220	639
1975	23,682	11,309	8,220	3,624	529
% change	+63%	+25%	-32%	+403%	+21%
Rate of beds per 1,000 population					
2000	6.07	2.23	0.88	2.86	0.10
1975	6.82	3.27	2.35	1.04	0.16
% change	-11%	-32%	-63%	+189%	-38%
Discharge rate per 1,000 population					
2000	183.6	175.1	3.5	5.2	0.8
1975	136.6	130.3	4.0	1.8	0.5
% change	+34%	+34%	-12%	+189%	+48%
Hospitalization day rate					
per 1,000 population	2,040	764	294	946	36
2000	2,299	1,037	851	363	51
1975	-11%	-26%	-65%	+160%	-29%
% change					
Average length of stay					
2000	13.2	4.3	233.2	160.0	40.3
1975	16.4	8.0	166.4	230.0	109.4
% change	-20%	-46%	+40%	-30%	-63%
Occupancy rates					
2000	92.2	93.1	88.0	92.7	97.2
1975	92.7	86.9	99.0	99.3	87.8

These provide primary care to the elderly in the community. Elderly patients visit the HMO clinics twice as much as does the general population [5].

In 1996, the Scientific Council of the Israel Medical Association and the Family Physicians Association published guidelines on prevention and care for the medical needs of the elderly population [6]. At the end of 2000 there were 92,300 elderly who needed help with at least one ADL function. Constituting 12% of the aged population, these 72,000 elderly were living in the community. By 2010 we expect this number to increase to 120,000. The number of elderly in need of assistance is twice that of the younger population [5].

The National Insurance Institute provides home help to 27,300 males and 72,800 females aged over 60; 26% of them are over the age of 75. Care in the community also includes day care, and at the end of 2000 about 10,000 elderly received day care in 125 day care centers throughout the country. A new kind of community care is "The Supporting Community." This special and innovative project provides assistance in instrumental activities of daily living to the elderly in the community. Approximately 8,800 elderly in 50 communities benefit from this kind of help [5].

By the end of 2000, the number of beds in long-term care institutions totaled more than 28,000, including independent (19%), frail (25%), nursing (47%), and cognitively impaired patients (10%)[5]. By contrast, in the early 1980s, about 5,300 elderly were institutionalized in long-term care settings [2]. In the late 1970s and early 1980s, the long-term care beds (geriatrics beds) constituted 18% of the total beds, as compared to 47% today. Since 1975 the number of long-term care beds increased 2.5 times, reaching 2.86 per 1,000 population or 66.5 per 1,000 aged over 75 [7]. Of these, 9.8% of beds belong to the government, 3.5% to Clalit Health Services, 1.6% to Maccabi, 1.4% to Meuhedet, 0.1% to the Hadassah Medical Organization, 0.6% to the Christian missions, while 36.7% are non-profit (public) and 46.3% are private [7]. Table 1 presents a comparison of the different kinds of beds between 1975 and 2000 [7].

Hospitalization of the elderly in general hospitals increased from 30% to 35% between 1994 and 2000 [7]. The rate of psychiatric hospitalizations of elderly per 1,000 population was 1.402 for males and 1.524 for women. Thirty-two percent were hospitalized for less than 1 year and 68% for more than 1 year [7].

The Ministry of Health through its Geriatric Division takes care of the nursing elderly patients. The budget for nursing institutionalization is 5–7% of the Ministry's budget. The rules and the process of nursing home licensing and supervision are described elsewhere [4]. The institutionalization of almost 11,000 elderly nursing patients was subsidized in 2002. The Ministry of Health controls institutionalization through the "Code" system. Each nursing home

ADL = activities of daily living

is assigned a code at the time of entry of each subsidized patient. The same code cannot be used for more than one patient during the same period. Despite the increased number of individuals subsidized (codes), the waiting list contains around 2,500 nursing elderly patients [8]. Each year an average number of 300 beds become available in nursing homes due to deaths or change in functional status; these are then reusable codes [8].

The quality of care is one of the most important issues for the Geriatric Division of the Ministry of Health and is based on regular visits by professionals at the nursing homes and according to strict criteria [4]. Concern for the quality of care is a major issue for caregivers abroad too, including the United States [9–11].

With regard to training, education and research, this is dealt with in detail in another article in this special *IMAJ* publication. Today in Israel there are between 120 and 150 board-certified specialists in Geriatric Medicine. This is a big step forward when compared to the 1980s, and we are gratified that our vision, then, of the development of geriatrics in Israel has largely been accomplished. Geriatrics and geriatric services in Israel today are well developed and offer many models of care. However, there is room for improvement. One weak area concerns the dispersal and division of responsibilities, but a recent initiative has been taken to bring together the various responsible parties into one unit. Other countries are also dealing with this problem [12].

On the assumption that the demographic developments for the next 20 years meet the projections, and that the institutionalization trends do not change, there will be a need for an additional 15,000–20,000 geriatric beds, an additional 250 board-certified geriatricians to provide institutional and community care, as well as funding for teaching and research. Indeed, research in geriatrics should be fostered and proper funds should be allocated. This is the key for further advance and for maintaining the quality of care. Based on the achievements of the last 20 years we trust that geriatric medicine and geriatric services will continue to thrive.

References

1. Aging and the Health Care of the Elderly. *Isr J Med Sci* 1985;21(3).
2. Habot B. Geriatric medicine of the eighties, reality and challenges. *Harefuah* 1983;95(1-2):33–5 (Hebrew).
3. Habot B, Margulec I. Geriatrics – policy issues and models of care in Israel. *Isr J Med Sci* 1985;21:203–4.
4. Habot B, Tsin S. The Compendium of Rules. Jerusalem: Division of Chronic Diseases and Aging, Ministry of Health, 1994 (Hebrew).
5. The 65+, Numbers and Facts. Jerusalem: Mashav, Eshel, Joint-Brookdale Institute for Gerontology and Development of Man and Society, 2002 (Hebrew).
6. Tabenkin H. Preventive medicine action and health community promotion. Clinical guidelines 1996. The Israel Medical Union, the Family Physician Association, the Educational Council, the Division of Quality Assurance, 1996 (Hebrew).
7. Haklai T. Institutions for Hospitalization and Day Care Units. Jerusalem: Ministry of Health, 2001 (Hebrew).
8. Monthly report. Jerusalem: Geriatric Division, Ministry of Health, 2002 (Hebrew).
9. Mueller C. Quality care in nursing homes: when the resources aren't there. *J Am Geriatr Soc* 2002;50(8):1458–9.
10. Saliba D, Schnelle JF. Indicators of the quality of nursing home residential care. *J Am Geriatr Soc* 2002;50:1421–30.
11. Simmons SF, Babineau S, Garcia E, Schnelle JF. Quality assessment in nursing homes by systematic direct observation: feeding assistance. *J Gerontol Med Sci* 2002;57A(10):M665–71.
12. Sundstrom G, Johansson L, Hassing LB. The shifting balance of long term-care in Sweden. *Gerontologist* 2002;42(3):350–3.

Correspondence: Dr. B. Habot, Director, Shmuel Harofeh Hospital, Geriatric Medical Center, P.O. Box 2, Beer Yaakov 70350, Israel.
Phone: (972-8) 922-1673
Fax: (972-8) 922-0672
email: shmuelh@netvision.net.il