Aging in Place in Israel

Definition

“Aging in Place”, sometimes called “Aging at home”, means that people continue to live in their own homes in their community and in their natural environment, for as long as they are able and interested in doing so. The assumption is that continued living in the community obviates or postpones their transfer to a residential facility.

Most elderly people prefer to continue living in their homes and in a familiar environment. An institutional framework, mainly because of their fear of losing their independence, (Clarity, 2007) deters them. On the other hand, remaining in the community and in their familiar home surroundings, assures the elderly of their independence, freedom of choice and self-determination in their everyday lives. There are diverse psychological motivations, which influence people’s desire to continue living in their own homes, as they grow old:

- **Independence**: The desire to continue being independent and not dependent on other factors; the ability to control the physical elements that surround a person in his/her close environment.
- **Familiarity**: People wish to continue being in a familiar environment, in which they have a simple and clear orientation, and in which they know their neighbors, the shops, the neighborhood park, and so forth.
- **Home maintenance**: The day-to-day maintenance of the home, arranging belongings, cleaning and cooking - all of these have both a physical and cognitive significance.
- **Hospitality**: The desire to continue the tradition of welcoming friends, family and relatives into one’s home.
- **Historical significance**: The home is a significant place, replete with memories from the past regarding events, celebrations, parties and meetings.
- **Status**: The home is a place which endows its owner with a symbol of status.
- **Support**: The home serves as an incentive to family members and relatives to continue to visit the senior, to support him/her and maintain contact with him/her (Fogel, 1993)
In a well-known research study carried out by the AARP in the U.S., 92% of the 65+ segment answered that they preferred to continue residing in their homes (AARP, 2000). This survey was repeated by AARP and the results remain very similar (AARP, 2010).

There are two aims, which underlie the approach supporting and encouraging aging in place. The first, from the standpoint of the elderly person and his/her family, is that continued residence at home in old age improves the quality of life; the second, from the policymakers’ standpoint, is that aging in place involves lower financial expenditure than residential care.

The Challenge

The increase in age is followed by functional and health problems, such as: declining hearing and sight, problems of mobility and memory decline. At the same time, there is a general decline in health, manifested by higher blood pressure, cholesterol, diabetes, as well as chronic illnesses connected with old age, such as Parkinson’s and Dementia. All of these have an impact on the ability of the elderly to preserve their independence.

What is the attitude to these phenomena within the framework of the “Aging in Place” approach? The institutional framework offers a comprehensive system of services that answers the needs of functioning, health, nursing care and well-being. Does the concept of “Aging in Place” provide an appropriate answer?

The challenge is, therefore, to provide supportive services in the community and at home, that are able to answer the special needs that are likely to develop in the course of the aging process. Presumably, continuing living at home, accompanied by a decline in health and functioning, without an appropriate system of supportive services in the home and community, does not contribute to the well-being of the senior and his/her family. Moreover, this may possibly lead to negative results and the risk of deterioration. It is not sufficient that supportive services exist; several features must characterize these services:

1. **Scope of the services:** The system of services in the home and the community must be broad and comprehensive enough to be able to answer diverse needs.

2. **Quality of care:** The system of services must be professionally based and with high professional standards. It is not enough for these services to exist; they must be effective.

3. **Accessibility:** The services need to be accessible in a number of ways: financial - to enable the senior and his/her family to purchase the services despite their financial cost; physical - to enable elderly who suffer from problems of mobility, to get to the day-care center or any other service in the community which they may require. Without suitable transportation arrangements, the elderly will not able to enjoy available services;

4. **Information:** The existence of an efficient and up-to-date information system, which displays the services, explains the terms of eligibility for them, and the ways of using them, while being intelligible and clear to the senior and his/her caregivers.

To sum up, the challenge facing policymakers and those responsible for the development of services is to provide the elderly with a broad and diversified community services system, on a good and efficient professional level.

The Home and Community Services in Selected Countries

In almost all the developed countries, there is full agreement on the need to enable the elderly to continue living in their own homes, and the need for developing supportive and appropriate services in the community.

The United States

In 1965, the United States enforced a major law concerning old age, called the Older American Act. Since its enactment, the Administration has been working to promote a policy of “Aging in Place.” This policy was carried out via the AOA (Administration on Aging). Over the years, the trend of “Aging in Place” has intensified, as has been evident by the changes introduced in the law in the years 2000 and 2006.

Beginning in the year 2002, a comprehensive national program was initiated, specifically directed and focused on achieving the goal of aging in place – NORC (Naturally Occurring Retirement Community). (Hunt, 1985, 1990, 2001). This assistance program of the Welfare and Health Services is designed either for seniors living in a geographic locality, a large apartment building or within a single neighborhood. The declared aim of the program is to encourage independent seniors to continue living in their homes. (Black, 2008). Another
program is PACE (Program of All-Inclusive Care for the Elderly). In 2010, there were already 75 programs in 29 different states. The program is based on the perception that it is desirable and preferable for the disabled senior and his/her family to continue living at home to the extent that this is possible.

The U.S. Administration on Aging published, in 2009, a call for proposals (AOA, 2009) for the funding of innovative programs geared to aging in place (CIAP - Community Innovations for Aging in Place). Fourteen organizations won grants within the framework of this program (AOA, 2010).

Canada
A parallel program to the American PACE program was developed at the end of the 1990s in Canada. The program, called SIPA (System of Integrated Services for Older Persons). The aim of the program is to care for elderly people aged 65+, with a high disability level and who are living in the community. SIPA was responsible for the provision of all the health and welfare services aside from institutional services found in this model (Beland, et al, 2006; Kodner, 2006).

Another model which was developed in Canada at the beginning of the year 2000, and was similar to the SIPA program, was PRISMA. This program covered the 65+ segment of elderly with disabilities living in the community, with the aim, among other things, of reducing the rate of institutionalization in that segment, as well as expanding the services in the home and the community (Herbert, Durand, Dubac et al., 2005).

Japan
The Japanese government developed a national policy aimed at enabling old people to live happily and honorably with government aid. In April 2000, a national program called “Long Term Care Insurance” was inaugurated in Japan. It was designed to help seniors and their families continue living in their homes and in the community with maximum independence.

As in Israel, the proportion of those benefiting from various services has grown rapidly. Since its initiation in 2000, and until the end of 2008 and thereafter, the number of those benefiting from the program has grown threefold (Simizutani & Inakura, 2007). There is a comprehensive description of the programs in Japan later in this issue.

Sweden
The government in Sweden has adopted the “Aging in Place” policy. Since 1994, the responsibility for the care of the elderly has fallen to the local authorities, which serve mainly as a coordinating and overseeing body, while the services themselves are provided by commercial and non-profit organizations. With the aim of implementing the “Aging in Place” policy, a special program was developed for adapting the elderly housing (Ministry of Health & Social Affairs, 1992) (Cecilia, Ulla & Stefan, 2009).

Denmark
In 1998, a change in policy occurred in Denmark, when a decision was made to stop building old-age institutions, and instead build residential units for the elderly. In Denmark, 5.5% of the elderly live in institutional frameworks. The new legislation decreed that the apartments for the elderly should be up to 67 square meters in size, without steps, with suitable accessibility and the possibility of receiving round-the-clock services. Research studies found that there was a high level of satisfaction with these conditions on the part of the elderly. The main reason for this is that health and welfare services are available to them in the community, 24 hours a day (Matsuoka, 2007).

Spain
Satisfaction with living in the community was also examined in Spain (Madrid). Over 95% of the elderly in Madrid live in their communities, in their own homes or in their children’s homes. According to the research conducted on 65-to-84-year-olds in Madrid, a high level of satisfaction was found from the very fact that they could continue to live at home, as opposed to moving to an institutional framework. The factors which particularly influenced this trend were the residential environment of the occupants, the housing itself (size of the apartment, ventilation, noise, lighting and so forth), and aspects connected with the physical details of the apartment (Perez, Fernandez, Rivera et al., 2001).
United Kingdom (Darlington)
The program related to elderly people who had been released from hospital to a community in which they were provided with community services including a care manager and an interdisciplinary team. The care manager had a budget for two-thirds of the cost of an institution, and made sure to provide each person with the services he/she required for his/her condition. The result was that the institutional expenditure decreased, the elderly enjoyed an improved quality of life, people remained living at home for longer periods, and there was general satisfaction.

Italy (Rovereto and Vittorio Veneto demonstration)
These two programs were based on a broad and comprehensive provision of services, given based on geriatric evaluation performed by an inter-disciplinary team and care manager. The results of this experiment were extremely positive: the rate of institutionalization declined, and institutional expenditure was reduced by 29%. Correspondingly, there was a marked improvement in the health of the elderly in the community.

In conclusion, the above examples indicate that there is widespread development and research activity in the field of aging in place in almost every country in the world - both on the national level and that of individual organizations and the community. Their activities are geared to ensure a system of supportive and available services in the community, housing adaptation and the development of technological systems. The combination of these three elements gives the elderly an opportunity to continue living at home with advancing age, while ensuring a comfortable quality of life in accordance with their desires and that of their families, on the one hand, and the aim of the policymakers on the other. From the general survey, it emerges that in recent years, a large number of experimental models have been developed, whose main purpose is to enable the elderly to continue living in their own homes. At the same time, it is important to note that in Israel, as in most countries in the world, the main burden of caring for the elderly still falls to the family, relatives and friends.

The following is a review of the programs and services developed in Israel in recent years for the elderly at home and in the community, and an examination of the impact of their development on the “Aging in Place” trend.

Aging in Place in Israel
The “Aging in Place” policy has also been adopted in Israel. The first signs of this policy can be found in a report from an inter-ministerial committee, which submitted its recommendations to the Minister of Welfare in 1967. The main recommendations were to develop community services for the elderly, and to see institutional care as a last resort and a complementary solution only to the community services. (Golander and Brick, 2003). In spite of the report and its recommendations, neither a national master plan nor a declared formal government policy emerged. During the past three decades, many services and action programs have been developed, whose main purpose is to enable the elderly to continue living in their own homes. At the same time, it is important to note that in Israel, as in most countries in the world, the main burden of caring for the elderly still falls to the family, relatives and friends.

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The Long Term Care Law
The first national program, in which the Israeli Government gave formal expression to a policy of aging in place, was within the framework of the Nursing Care Law. The Long Term Care Law is part of the general National Insurance Law, and was implemented in April 1988.

The benefits for those eligible were given as services in kind and not in cash. Receiving the services outlined within the law is conditional on an income test, which is based on the elderly person’s income and that of the spouse. The basket of services would also include visits to the day-care center, purchase of disposable absorbent products, laundry services and distress call buttons. Those eligible for the nursing care benefits are elderly people who are significantly handicapped in their everyday activities, as has been defined by the law: “An insured person who, as a result of disability, has become to a large degree dependent on the help of his fellow men to perform the bulk of his everyday actions, or who requires supervision... an insured person who, as a result of disability has become totally dependent on the help of his fellow men to carry out all of his every day actions, or is in need of permanent supervision...”
Caregivers employed by private firms or non-profit organizations provide home care. Initially, two levels of aid were established. However, since January 2007, three levels of aid are available according to the degree of disability of the eligible person – 9.75, 16.0 and 18.0 hours a week. (The National Insurance Institute, 2008). The number of recipients grew rapidly from 27,685 in 1990 to 143,000 in 2010.

Within the framework and outline of the law, funds have also been designated for the development of services and infrastructures in the field of aging.

The Long Term Care Law represents a significant breakthrough in the attitude of the State towards the elderly, and it gives both formal and practical expression to the Israeli government’s commitment to this population. This benefit is given to the elderly by right, and is not considered charity. All those who meet the conditions of eligibility receive the services outlined within the law; the services are intended as support for the family caring for the senior person (and not to replace it). The subsequent result is that the law enables the elderly to continue to live in their own homes for as long as possible (Katan and Lewenstein, 1999; Shtassman, 2001).

Day-Care Centers
The day-care center for the elderly is a community service designed mainly for disabled elderly living in the community. It is a service which is provided on a group basis, and it offers a wide range of services and activities. The basket of services provided in the day-care centers includes breakfast and lunch, social activities, occupational therapy, physical activities, physiotherapy and personal care. The activities provided relate to the disabilities of the elderly, which gives them the opportunity for social and communal interaction. Furthermore, the activities at the center give the elderly opportunities to cope with their disabilities and their personal and social needs (Korazim, 1997). Most centers have a special wing devoted to those suffering from dementia, but there are also a number of day-care centers designed exclusively for the mentally frail.

The day-care center operates 5-6 days a week, and at least 6 hours each day. About 10% of the day-care centers have an activity, which runs until 7 p.m. Almost all the elderly attending day-care centers arrive from their homes in the morning by organized transportation, and are returned home in the afternoon. On average, the day-care centers cater to about 90 participants, while the average daily attendance is 51 people. On average, each client attends the center 2.9 days a week (Resnizky, Be’er, Nir and others, not yet published).

The first day-care centers were established in the beginning of the 1980s. The accelerated development of the day-care centers occurred mainly in the 1990s. 14 centers had been established by 1984, it had gone up to 53 in 1990 and by the year 2009 there were 172 day centers with 15,000 visitors (2.2% of the elderly population).

Funding for the operation of the day-care center comes from two sources: the National Insurance Institute - for a person entitled under the Long Term Care Law; and the Ministry of Welfare and the local authority - for frail elderly who are not eligible for nursing care benefits. The elderly and their families participate in the cost of service up to about $4.00 per day.

The attendance of the disabled elderly at a center plays an important role supporting the elderly person's families. It alleviates the burden of care of the disabled elderly in the community, helps achieve the aim of aging in place, and obviates or delays institutionalization. (Resnizky, Be’er, Nir and others, not yet published).

Ministry of Welfare and the Municipal Social Services Departments
The direct care of the elderly on the local level is undertaken by the departments of social services in the municipalities, under the direction of the Service for the Aged in the Ministry of Welfare and Social Services. The Ministry sets the policy, the principles of care and how to provide the services for the elderly. The Ministry participates in the funding and supervises the implementation of their provisions by the workers of the social services departments. The main part of the work is carried out by social workers – about 700 throughout Israel - for the care of the elderly. In most departments of social services in the local authorities, there are special units dealing with care for the elderly.

In 2008, 242,850 elderly were looked after by the social services departments, constituting about a third of the general elderly population. Two-thirds of the total of the elderly cared for are over the age of 75, most of them from a low socioeconomic strata. 57% of them live alone, and 44% of them are widows or widowers.
The official policy of the Ministry of Welfare and Social Services is to leave the elderly at home and prevent the transfer to an institutional framework. Consequently, most of the services provided by the social services departments in the municipalities, under the guidance of the Ministry of Welfare, are services at home and in the community. The services include the assistance of the social workers for counseling, care, support and individual or group guidance; help in running the household, help with personal care for those who are not eligible under the Nursing Care Insurance Law; subsidizing the low-income elderly in the supportive communities; help in operating social and occupational clubs; transportation for medical treatment; assistance in providing home equipment; special additional services, such as programs for Holocaust survivors, help with dental treatment, etc. In addition, the Service for the Aged helps to place frail elderly in institutions. Table 3 shows the various kinds of services available and the number of elderly benefiting from them.

In 2010, the budget of the Service for the Aged amounted to 392 million NIS, of which 159 million NIS was earmarked for services in the community (40.6%). This budget also includes the share of the local authority, which generally totals 25% of the overall budget.


<table>
<thead>
<tr>
<th>Year</th>
<th>Total Budget</th>
<th>Community Services</th>
<th>Percent of Community Budget out of Total Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>393,397</td>
<td>122,123</td>
<td>31.0</td>
</tr>
<tr>
<td>2008</td>
<td>398,559</td>
<td>131,273</td>
<td>32.9</td>
</tr>
<tr>
<td>2010</td>
<td>392,102</td>
<td>159,216</td>
<td>40.6</td>
</tr>
</tbody>
</table>


As reflected in Table 1, the allocations of the Ministry of Social Affairs in the recent years consistent with the policy of Aging in Place. The budget for community services has increased every year since 2006 and constituted 40.6% of the total budget of the ministry to its Services for the Elderly Unit in 2010.

**Foreign Caregivers**

One of the unique solutions developed in Israel, to fulfill the desire of the elderly to continue living at home, even when their health and functioning decline, is the service provided by foreign workers. This phenomenon also exists in other countries, but in Israel, it has assumed a particularly large dimension and constitutes an important part of system of support services required in order to enable aging in place. These caregivers generally live with the elderly person and assist in the day-to-day household chores, provide personal home care and 24 hours-a-day supervision, thereby also relieving the sense of loneliness which a large part of the elderly experience. The widespread use of foreign workers living at home with the elderly relieves the primary caregivers from having to deal with the elderly disabled (Iecovich, 2010). This service is far cheaper than the home services provided by local caregivers. The senior and his family employ the foreign workers. Part of the payment for this is provided for within the framework of the Long-Term Care Insurance Law. Most of the foreign caregivers are from the Philippines, but there are also workers who come from other countries, such as Eastern Europe, Sri Lanka, India, etc.

The foreign workers began arriving in Israel at the end of the 1980s. The consumer public welcomed the service, and the number of foreign caregivers grew at a rapid pace. In 2008 there were approximately 54,000 foreign caregivers in Israel (Nathan, 2008), and this number is expected to increase in the future.

It is important to stress that this procedure of employing foreign workers as caregivers for the elderly has developed naturally, without any planned government intervention. There is no doubt that these arrangements have had an additional impact on the overall system of supportive services that enable the elderly with disabilities to continue living in their homes. It may be assumed that, in many cases, these arrangements also delay institutionalization.

**Supportive Communities**

The Supportive Community is an additional program that enables the elderly to continue living in their homes. The program provides the elderly with a basket of services that meet the basic requirements of whoever wishes to continue living in his/her home despite aging. The basket of services includes four basic components:

- **Community Mother/Father:** A salaried professional worker who is permanently located in the community’s geographical area, is in contact with its members,
and provides them with services that enable them to lead their everyday lives normatively, such as helping with minor repairs in the home, bringing medicines when necessary, or summoning skilled workers.

• **Emergency Call System:** A system installed in the senior’s home enables him to communicate with the call center when necessary. The call center operator can contact the “Magen David Adom” (Israel Red Cross) ambulance service, police, community Father or a family member, depending on the problem and the specific need.

• **Medical Services:** In special cases, doctors will make home visits to the senior following a distress call. The visit takes place almost immediately and carries a minimum fee. In addition, an ambulance can be summoned when necessary. The cost of the ambulance is included in the program’s budget, in the event that Kupat Cholim (the medical care system) does not cover it.

• **Social activities:** The program enables social activities for all members of the supportive community, generally within the framework of a neighborhood club. These activities include discussions, lectures, outings, festival parties, etc.

A group of residents together with JDC-Eshel developed the first Supportive Community in 1989 in the Kiryat Moshe neighborhood in Jerusalem. Since then, supportive communities have been established at an accelerating rate throughout Israel, and in 2010 they numbered 250 and were serving an elderly population of about 50,000.

The program is based on an economical model, which in turn is based on monthly payments by the members of the program (about 30 USD per month), while those living solely on social security are subsidized by the Ministry of Social Welfare. JDC-Eshel subsidizes the program during the first three years until it reaches 200 households.

Over the years, three research evaluation studies of the program were conducted in order to examine its effectiveness.

The first study was published in 1999 and found that most of the members had joined the program because it gave them self-confidence (78%) (Mizrahi and Himmelblau, 1999). The second study was published in 2003, and its findings testified to a high level of satisfaction. About 80% of those questioned attested to the fact that they were “happy” or “very happy” with the program. More than a third of the members of the Supportive Community felt that the program gave them confidence, and a quarter of them explicitly declared that thanks to the program they were able to continue living in their homes (Berg-Werman, 2003). The third evaluation study, which was conducted by the Meyers-JDC-Brookdale Institute, was published in 2010. Here, too, a high level of satisfaction was noted, and the significant help given to the elderly in the framework of the program was reported.

**Non-profit Organizations**

**Local Associations for the Elderly**

In Israel, there are 124 such organizations, engaged in developing and operating services for the elderly in the community. These organizations were established, for the most part, at the initiative of Eshel, the Association for Planning and Developing Services for the Elderly in Israel (Brick and Clarfield, 2007).

These organizations were established in the 1970s and mostly during the 1980s. They operate a wide range of services, including day-care centers, supportive communities, home care, health promotion programs, etc. Over 50% of the organizations’ budget comes from government sources. An additional part comes from JDC-Eshel for developing new services, and the rest from revenues and donations.

**Yad Sarah:**

At the heart of Yad Sarah’s activity is the loaning of medical, rehabilitative and technological equipment, which assist the handicapped and the elderly. In addition, Yad Sarah operates a range of services that help the elderly to age in their homes, such as distress call buttons, occupational therapy for the housebound, transportation for the disabled, etc. The main strength of the organization lies in recruiting and activating volunteers in the community. More than 6000 volunteers engage in loaning equipment, home visits to the housebound elderly, and other services.

**Matav:**

Matav is the largest organization, which provides home care for the elderly and disabled in their homes. Their
main activity was to provide home care services. Over the years, Matav has expanded its range of activities, and today it operates 12 day-care centers for the elderly, sheltered housing, a number of supportive communities, custodianship services, etc. Matav provides services to about 25,000 needy persons in the community.

**Ezer Mitzion:**
This non-profit organization was established in 1979 with the aim of providing food for the needy. Over the years, the services rendered by the organization have expanded and now concentrate on providing paramedical support services for the sick and the handicapped - mainly for the elderly. Today, Ezer Mitzion has about 11,000 volunteers. The organization operates a number of programs that contribute to aging in place, such as loaning of medical rehabilitation equipment, 20 ambulances that take the disabled elderly for medical treatment.

Aside from the large national organizations, there are also a number of smaller active organizations which target specific populations. Among them, Melabev in Jerusalem, a noteworthy organization, operates clubs and day-care centers for the mentally frail; Misgav Lakashish, which also operates in Jerusalem, provides support services for the elderly in the ultra-Orthodox community; the Emda organization operates support groups and provides various services to the mentally frail; Milbat engages in adapting aid accessories for the handicapped, and Yad Riva provides legal aid. In addition to these, many other organizations are also active.

This comprehensive review of the activities of the public organizations, which provide supportive services to the elderly at home and in the community, indicates an extensive additional contribution to the public and government effort aimed at maintaining the “Aging in Place” trend.

**Community Health Services**
With increasing age, there is a rise in illnesses - mainly chronic illnesses, such as high blood pressure, heart attacks, diabetes, Alzheimer’s, Parkinson’s, strokes and malignant illnesses. As a result, there is an increasing need for health services. Health services play an important role in achieving the goal of aging in place. This is true for primary medicine, and perhaps even more so for the health promotion and illness prevention programs (Mashav, 2009).

Health services for the elderly in the community are provided within the framework of the Sick Funds community primary medical care clinics, in professional medical clinics, in rehabilitation centers, and in home care and day hospitalization units. The General Sick Fund initially developed home care units as early as the 1970s. Since then, this service has gradually been extended to all the Sick Funds and in different parts of Israel. Substantial differences exist in the extent and intensiveness of this service among the Sick Funds as well as in the various regions of Israel. The underlying premise of the home hospitalization service is that the housebound patient may be provided with essential medical services as an alternative to hospitalization. This service includes visits by qualified doctors, physiotherapy, occupational therapy and nursing services. Among the treatments given to the housebound patient, are blood pressure tests, treating bedsores, inserting/removing catheters, giving antibiotics and chemotherapy, and stabilizing symptoms (pain, anxiety, shortness of breath, constipation and vomiting).

In recent years, health promotion programs have been developed, mainly in the sphere of physical activity and correct nutrition. In addition, eyesight and hearing screenings are held as well as actions to prevent and treat incontinence. Other educational programs exist which enhance a healthy lifestyle. According to a health survey conducted by the Central Bureau of Statistics and the Ministry of Health in the years 2003-2004, 41.3% of those aged 65 and above engage in physical activity (at least three times a week, for a minimum of 20 minutes). In general, it can be said that there has been a growing awareness regarding healthy lifestyle, the importance of physical activity and wise nutrition. All of these directly affect the ability of the elderly to continue living in the community.

**The Impact of the Development of Services in the Community on Aging in Place**
The past two decades have witnessed an accelerated development of the supportive services in the community. Whereas the number of elderly in this period increased 1.6-fold, the various supportive services in the community during the same period have grown many
times over. As we have mentioned, a basic condition for aging in place is the existence of community supportive services that provide help and support to whomever desires to continue living at home. The accelerated development of the various services in the community constitutes a significant factor in the overall support for the “Aging in Place” trend.

From Table 2 we can learn about the development of the community services between the years 1990 to 2008. In that period the number of those benefiting from day-care centers grew approximately fourfold, whereas the number of elderly at that time rose only 1.6-fold. In addition, those benefiting from home care in the framework of the Long-Term Care Law increased 4.7-fold during the same period. The growth of supportive communities is much greater and forms part of the overall picture of accelerated development on the scale of the community services and their number of beneficiaries.

We should contrast the development of the services for the elderly in the community with the proportion of the elderly in institutions. It emerges that during this entire period, the proportion of elderly in institutions did not increase despite the significant growth in the absolute number of elderly during the same period. Hence, it may be assumed, that the extensive development of the services in the community had a significant impact on the rates of institutionalization, that is – more old people continued to grow old in the community.

From Table 3 we can see that the rates of institutionalization have remained almost stable, around 40 beds per one thousands elderly, despite the 1.6-fold rise in the elderly population.

### Table 2. Development of the Services in the Community in the Years 1990 to 2008

<table>
<thead>
<tr>
<th>Service</th>
<th>Programs</th>
<th>% of Change</th>
<th>Rate of Growth</th>
<th>Participants</th>
<th>% of Change</th>
<th>Rate of Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1990</td>
<td>2008</td>
<td>Rate of Growth</td>
<td>1990</td>
<td>2008</td>
<td>Rate of Growth</td>
</tr>
<tr>
<td>Day-care Centers</td>
<td>53</td>
<td>172</td>
<td>224</td>
<td>3.2</td>
<td>3,875</td>
<td>299</td>
</tr>
<tr>
<td>Benefits</td>
<td>27,684</td>
<td>131,266</td>
<td>374</td>
<td>3.9</td>
<td>15,500</td>
<td>3.9</td>
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<tr>
<td>Supportive Communities</td>
<td>4</td>
<td>223</td>
<td>547</td>
<td>55.7</td>
<td>210</td>
<td>2,007</td>
</tr>
<tr>
<td>Institutions</td>
<td>192</td>
<td>403</td>
<td>109</td>
<td>2.1</td>
<td>19,041</td>
<td>59</td>
</tr>
<tr>
<td>Eldery in Institutions</td>
<td>117</td>
<td>2,507</td>
<td>12,507</td>
<td>37</td>
<td>19,041</td>
<td>43</td>
</tr>
<tr>
<td>Sheltered Housing</td>
<td>70</td>
<td>165</td>
<td>135</td>
<td>2.4</td>
<td>21,315</td>
<td>245</td>
</tr>
<tr>
<td>Institutions</td>
<td>192</td>
<td>392</td>
<td>900</td>
<td>101,000</td>
<td>30,233</td>
<td>59</td>
</tr>
<tr>
<td>Elderly Population</td>
<td>442,200</td>
<td>708,000</td>
<td>60</td>
<td>1.6</td>
<td>39</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3. The Rate of Beds per Thousand in Given Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Institutions</th>
<th>Beds</th>
<th>Rate per Thousand</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>117</td>
<td>12,507</td>
<td>37</td>
</tr>
<tr>
<td>1990</td>
<td>192</td>
<td>19,041</td>
<td>43</td>
</tr>
<tr>
<td>2009</td>
<td>392</td>
<td>29,281</td>
<td>39</td>
</tr>
</tbody>
</table>

In conclusion, against the background of the accelerated and wide-ranging development of services for the elderly in the community on the one hand, the proportion of the elderly in institutions remained stable. On the other hand, it may be assumed that the development of services in the community has had an impact on the level of institutionalization, and that, equally, this has had a positive effect on the “Aging in Place” trend.

### Future Challenges

Together with the accelerated development of the community services and the success of aging in place in Israel, there remain important challenges. Coping with them might help to increase the number of elderly who will be able to continue living at home.

**Integration and coordinating the services:** There is a great fragmentation among the various community services; each of the health and welfare services is provided in a different location, according to different conditions of eligibility, and operated by a separate organizational system. Incorporating, or at least intensifying the coordination between the various services, would significantly reduce the need of the elderly and their families to run around among the various agencies. Thus, it would also save large numbers of resources for the government,
the local authorities and the rest of the organizations engaged in providing services to the elderly in the community (Shtessman, Maaravi and Cohen, 2000).

Adjust housing conditions to growing needs: Although there have been a number of limited attempts in this area, a need exists to develop a comprehensive program, geared to adapting the residential apartments of the elderly to the special needs which accompany the aging process, and the development of illness and decline in everyday functioning. This includes modifying the structure of the shower and toilets, installing handles and ramps, automatic opening of doors, etc.

Modern Technology: Modern technology is advancing at a rapid pace and affects the improved life quality of human beings as a whole. The advances in technology should be used for the benefit of the elderly and aging in place. The care and medical supervision of the housebound elderly can be upgraded by remote-controlled electronic systems (Tele-medicine); sensors can be installed in the homes of the elderly, which will report their physical state and everyday functioning, as well as give a warning about irregular and potentially dangerous symptoms. The new electronic systems can also help the elderly to develop social contacts to help them cope with loneliness and feelings of isolation from society and the community.

Day rehabilitation: Elderly people who have suffered a stroke, had an orthopedic injury, or other illnesses, are entitled through the Insurance Health Law to health services for a proper rehabilitation process. The possibility of receiving rehabilitative help in the communities, and still remaining at home, depends on the availability of rehabilitation centers geared to this purpose. In reality, there are only a limited number of such centers. It is necessary to develop a national system of daily rehabilitation centers, which will meet the current needs.

Loneliness: As was mentioned above, even though continued living at home may meet the elderly’s desire to maintain a connection with his close and familiar environment, this still does not ensure that such an arrangement will provide a complete solution to the problem of loneliness. Seniors can be happy about continuing to reside in their homes, but are also liable to suffer from a sense of loneliness. This phenomenon must be dealt with in all to do with the continued residence in the home and the community.

Conclusion
In this paper, we have given a broad description of the development of the health and welfare services for the elderly at home and in the community. As has been pointed out, this development has occurred at a very rapid pace, mainly in the past 20 years. This overview of the situation clearly proves that the State of Israel has adopted the policy of “Aging in Place”.

Concerning the question of whether this major effort has in fact led to the realization of the goal of aging in place, it may be said with relative certainty that the goal has, largely, been achieved. The comprehensive and varied development of health and welfare services in the community, as opposed to the fact that the rates of nursing care hospitalization in Israel are so low, indicates that the goal of aging in place has largely been achieved. This assessment is not meant to replace a thorough research study that will scientifically establish the connection between the broad and accelerated development of the services in the community, and the fact that such a large number of elderly are aging in the community.

The policy of “Aging in Place” is based on two basic premises. The first - that it contributes to the improved quality of life of the elderly; and the second - that continued living at home is less expensive than hospitalization. These premises require a more exhaustive and thorough investigation in the Israeli reality. Moreover, it is important to bear in mind that, despite the accelerated development of the supportive services in the community, the policymakers and those responsible for developing services for the elderly still must confront and deal with important challenges, and that this is likely to intensify and reinforce the “Aging in Place” trend.

Prof. Yitzhak Brick
Director General - JDC-ESHEL
brick@jdc.org.il
REFERENCES


