THE SUPPORTIVE COMMUNITY

A Program to Enhance the Quality of Life of the Elderly in Israel

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The Supportive Community Program is part of the trend to help elders continue living in their homes while maintaining their quality of life and helping families cope with the burden of care. Among its main contributions are its provision of a sense of security and its meeting needs that are not met by any other service. It creates a neighborhood cooperative structure that provides the elderly with security and facilitates access to health and social services, providing them with a friendly and reliable address for any problem that emerges. The Supportive Community Program developed in Israel, as well as similar programs developed abroad, provides opportunities for mutual learning and innovation in care.

The vast majority of the elderly in Israel live and will continue to live in their homes, and this is what they want. The Supportive Community Program is part of the trend to help elders continue living in their homes while maintaining their quality of life, thus obviating, to the extent possible, the need to move to an institutional setting. The aging of our societies, as well as the concomitant implications for the health and social systems, requires more than ever the need to develop cost-effective community-based programs.

Israel is still one of the youngest of the world's developed countries, primarily because of a relatively high fertility rate: 2.9 children per woman in 2004 (Central Bureau of Statistics, 2005) compared to 2.1 in the United States and 1.5 in Canada in 2003 (World Health Report, 2005). Yet, it has undergone a major increase in its proportion of elderly (65 plus) from less than 4 percent in 1948 to 10 percent in 2004. Within the Jewish population, 11.3 percent are elderly compared to only 3.1 percent in the non-Jewish population, which has an even higher fertility rate. Life expectancy in 2003 reached 77.6 years for men and 81.8 years for women and is among the highest in the developed world, especially for men (Central Bureau of Statistics, 2005).

Israel has experienced an exponential increase in the absolute numbers of its older people because of a combination of both natural growth and immigration. For example, although the general population increased 3.8 times during the past 50 years, the elderly population grew by a factor of 7.9 times – double that of the general population. The rate of increase of the old-old (age 75 and over) has been even more pronounced —11.5 during the past half-century.

Thus, in Israel as elsewhere, not only has the general population been aging but the elderly population itself has been both increasing in numbers and growing older. The number of those aged 65 and older reached 682,000 at the end of 2004. It is projected that the proportion of elderly will remain stable up to 2010, but will rise to 12.7 percent of the total population by 2025, numbering 1,176,000 persons (Central Bureau of Statistics, 2005). This significant absolute increase will continue to strain the capacities of the country's health and social services.

It is of special note that, as a result of the ingathering of the Jewish people from all over the world, Israel is culturally heterogeneous; various waves of immigration have created distinct groups among the aged. All in all, only 16 percent of the elderly (Jews and Arabs) were born in Israel. Actually, there is no other country in the world in which the vast majority of the elders, 84

percent, were born abroad. These elders emigrated to Israel at different stages in their lives and in the life of the country. Many of them came relatively late in life. Thus, the story of aging in Israel is almost equally a story of immigration (Brodsky & Litwin, 2005). This has many implications for the special economic, health, and social needs of the elderly in Israel.

Despite the demands of waves of mass immigration and the pressures of repeated wars and ongoing terrorism, an impressive set of institutions has been built to take care of the country's elders. The majority of elderly people still live or are cared for at home, with only 4.1 percent residing in a long-term care institution (of them, some 3 percent reside in a nursing home); this percentage is lower than in other developed countries, such as the United States and Canada. An Organization for Economic Cooperation and Development (OECD) report found that the proportion of institutionalized elders was 5.7 percent in the United States and 6.8 percent in Canada (this was the midpoint of an estimated range of 6.2 to 7.5 percent; Jacobzone, 1999). In Israel, even among the disabled elderly, 76 percent still live in the community (Brodsky et al., 2004).

It is clear that such a situation would be impossible without a great degree of family involvement, which is quite strong in Israel – an approach fostered by both Judaism and Islam (Clarfield et al., 2003). In addition, during the past decade, a number of formal services have been established, some quite innovative, which are meant to reinforce these social constructs and as such to help families cope with the burden of care and help the elderly remain in the community. Public funds have been increasingly channeled toward care in the community, resulting in a higher proportion of public funds being spent on community and institutional care. In addition to a National Health Insurance Law, which provides for coverage of health services for all elders, Israel has developed a wide range of community-based services.

First, it has implemented a universal home care insurance program for the disabled (the Community Long-Term Care Insurance Law), operated by the social security administration (Brodsky & Clarfield, 2001). The law provides assistance with basic activities of daily living and homemaking services and today covers some 16 percent of the total elderly population. In addition, one of the most significant services developed in Israel is social day care for the disabled. This is based on a cost-effective social, rather than medical, model (Primak, 1992), which has enabled Israel to establish a network of approximately 160 social day care centers. Located throughout the country, these centers serve about 13,000 disabled elderly, providing them with an opportunity to enjoy social contact and to participate in meaningful activities.

An initiative of particular importance has been the development of the Supportive Community Program. The purpose of this article is to describe the implementation of this program and its impact on the quality of life of elders living in the community. Cost issues are addressed as well.

THE SUPPORTIVE COMMUNITY PROGRAM

The Supportive Community Program (SCP) aims to meet the needs of elders that are not met by any other community service. It creates a neighborhood cooperative structure that provides the elderly with security and facilitates access to health and social services, providing them with a friendly and reliable address for any problem that emerges. It thus provides the support and security needed to enable them to live as independently as possible in their homes.

The Supportive Community Program was established 15 years ago by ESHEL: The Association for the Planning and Development of Services for the Aged in Israel and by the Israel Ministry of Social Affairs. It is run by these two agencies in cooperation with the local authorities, the local associations for the elderly (nonprofit organiza-

tions), and for-profit agencies that participate in its operation.

Services and Staffing

The SCP offers a basket of services or benefits package that includes four types of service: medical services (comprising house calls by a physician for the nominal fee of about $5.00 per call and free ambulance service), a 24-hour emergency call service (emergency switchboard), household repairs by a neighborhood facilitator ("neighborhood father"), and social activities. In addition, program staff members are expected to be familiar with other services available to the elderly in the community so that they will be able to refer them to services that meet their needs as they change.

The neighborhood facilitator is usually employed full time and is responsible for all of the households in the program, which typically number about 200 and are distributed within a distinct geographic area of between five and ten kilometers. The neighborhood facilitator helps make small household repairs or procures a repairman; he or she also calls to ask members about their well-being, visits them at home, and may do some errands or deliver medications for a house-bound member. Most of the neighborhood facilitators are aged 50 or over, good with their hands, and personable. All program sites have a male neighborhood facilitator though at some sites, the job is divided between a male and a female facilitator. They receive a monthly salary, which is close to minimum wage.

The social activities offered as part of the program may include lectures and courses given at an existing neighborhood community center, as well as trips; these activities are organized by a part-time social coordinator.

The program is also intended to encourage voluntarism among its members – both to reinforce their sense of involvement and promote closer ties among them, and to provide additional assistance to the neighborhood facilitator.

Funding

The program is funded by ESHEL, the local government authority, and the program members. ESHEL subsidizes the program for three years, during which its participation gradually phases out, as the number of members and the proportion of funding they provide grows. Members pay monthly dues of approximately $22.00; low-income elderly pay only about 40 percent of this sum, and the rest is subsidized by the Ministry of Social Affairs. About 40 percent of the program's elderly members nationwide are eligible for this subsidy. In addition, local governments fund some 10 percent of the program's costs.

Coverage

At present, more than 20,000 elderly people are covered by 120 supportive communities in all sectors and areas of Israel; they constitute about 3 percent of all elderly living in the community in Israel.

Any elderly person who lives in a neighborhood in which the SCP is available may join it. Each specific SCP serves about 200 households and generally reaches full capacity during its first three years (most of them much earlier). New SCPs in the same or other neighborhoods are developed according to a national program that reflects community needs.

SELECTED EVALUATION FINDINGS

The Myers-JDC-Brookdale Institute, which is Israel's national center for applied research and provides the planning and evaluation needed to develop Israel's policies and programs for the elderly, has been involved in the evaluation of the SCP since 1997 (Berg-Warman, 2001; Mizrahi & Himmelblau, 1999). Descriptive studies have examined the achievements of the supportive community in light of its goals, the program's target population and who it actually serves, service utilization patterns, whether clients are satisfied with the program, and what they perceive as the program's contri-

bution to their quality of life. These studies have used both quantitative and qualitative methods, including in-depth interviews with program implementers and staff and face-to-face interviews with members of supportive communities.

The results presented in this article are based primarily on findings from a study conducted in 2001, which included interviews with 200 members of four supportive communities (who were sampled randomly from a total of about 1,000 members of these communities), as well as interviews with 15 program directors and operators. Information was also gathered from 46 SCPs (all programs that had been operating for at least six months at the time of the study), which provided a more general picture of the population served and the services provided.

The Target Population

The SCP is serving a wide variety of groups with respect to age, marital status, functional status, and income levels; it also serves both non-immigrants and new immigrants. However, the program has particularly attracted elderly at risk: The proportion of women who are 80+, widowed, and disabled is higher among SCP members than among the general elderly population in Israel.

Awareness of Services Offered through the Supportive Community Program

One of the study's goals was to examine the extent to which members were familiar with the services to which they are entitled as part of the program. The findings reveal that not all had that familiarity. Eighty-three percent knew they could call for a physician through the program; of them, 83 percent were aware that a physician house call incurred a fee. Seventy-five percent of the respondents knew that physician house calls were available 24 hours a day, seven days a week. Only 26 percent of them knew they would be reimbursed for ambulance service.

Use of the Program's Services

Use of the services provided through the program is primarily a function of members' needs. However, it is also affected by such factors as their awareness of the availability of services and their satisfaction with the services actually provided.

Household Repairs

Sixty-eight percent of the households had a need for home repairs during the year preceding the interview. Of them, 36 percent (24 percent of all members) sought help from the SCP. Those who did not do so primarily preferred to receive help from other sources, such as relatives, friends, and professionals. In addition, about one-quarter of those members who needed the repair service were not aware it existed. An even smaller proportion of them did not use the service because they were disappointed with past repairs made in their home through the program. Among those who did ask the neighborhood facilitator to make home repairs, 79 percent – or 19 percent of the members – received his help; the rest did not receive the service, although they were waiting to receive it when the study was conducted.

The data reveal that requests for assistance, the help actually provided by the neighborhood facilitator, and satisfaction with the service were greater in for-profit programs than in those run by a nonprofit agency.

Medical Services

Two main types of medical service—physician house calls and ambulance service—are provided through the SCP. To receive either of these services, the member usually first calls the emergency switchboard.

Close to half (46 percent) of the members noted that, during the past year, they had felt ill and urgently needed a physician to make a house call. Eighty-seven percent of them (40 percent of all members) sought assistance from the program, and 88 percent of those individuals (35 percent of all members) had a

physician sent to their home. In other words, a physician was sent to the homes of most (76 percent) of those who needed such a service. Of the remaining 24 percent who reported asking for a physician to make a house call but not receiving one, most reported that this was because their problem had resolved itself and they no longer needed the service. A few of those who needed the service never asked for it, mostly because they did not know it was available. It should be noted that the program promises to send a physician within 90 minutes of the request; however, in rural areas, it may take longer for a physician to come. Compared to the previous evaluation study (Mizrahi & Himmelblau, 1999), an increase was noted in the need for physician house calls and in the use of this service, perhaps because the percentage of members who were disabled in functioning had increased due to the aging of the elderly population.

Twenty-two percent of the respondents reported needing to reach a hospital urgently at least once during the past year; 41 percent of them (9 percent of all members) called the program's emergency switchboard for an ambulance. However, most of the members who needed an ambulance called one themselves or reached the hospital on their own. It is important to note that about one-fifth of the members who needed this service did not know it was available through the program. It is also worth noting that there was an increase in the need for an ambulance compared to the previous study (Mizrahi & Himmelblau, 1999) – here, too, most likely because of an increase in the percentage of members disabled in functioning, an outgrowth of the aging of the population.

Social Activities

Various social activities are offered through the SCP: regular classes, lectures, and the like, as well as some occasional trips and special events. Efforts are made to plan activities that will be to the members' liking; at the time of the study, the most common activity was lectures. Members are informed of social activities either by telephone or through flyers distributed to their home. Thirty percent of the respondents reported that they usually or sometimes participate in the social activities. Larger percentages of women, elderly who live alone, and semi-independent elderly participate in the social activities offered through the program. The main reasons cited for not participating were health problems, difficulty getting to the activity (45 percent), or a lack of time or inconvenient activity times (30 percent). Larger rates of participation in social activities were found in programs run by nonprofit organizations than by for-profit programs.

About one-quarter of the members reported often feeling lonely, and about 40 percent of them reported being dissatisfied or not so satisfied with how they spend their time. These responses signal the existence of unmet social needs.

Unmet Needs

An additional goal of the study was to identify unmet needs among program members, with the intention of considering how to meet them. To this end, we examined the need for services not currently included in the core basket of services. One of the most significant was the need for an escort to medical examinations or treatments, which was cited by 61 percent of the members. One percent of those who needed this service received it from their neighborhood facilitator, even though he was not obligated to provide it.

About half (49 percent) of the respondents reported that, during the past year, they had needed help obtaining medications, shopping, or arranging for laboratory tests when they were ill. Five percent of them (or 3 percent of all members) asked the neighborhood facilitator for help, and half of them received it, even though he was not obligated to provide it (this service is not in the core basket). Most of the members asked a relative for help, and 3 percent of those who needed assistance did not ask anyone for help. Four percent reported having forfeited

taking medication because no one could bring it to them.

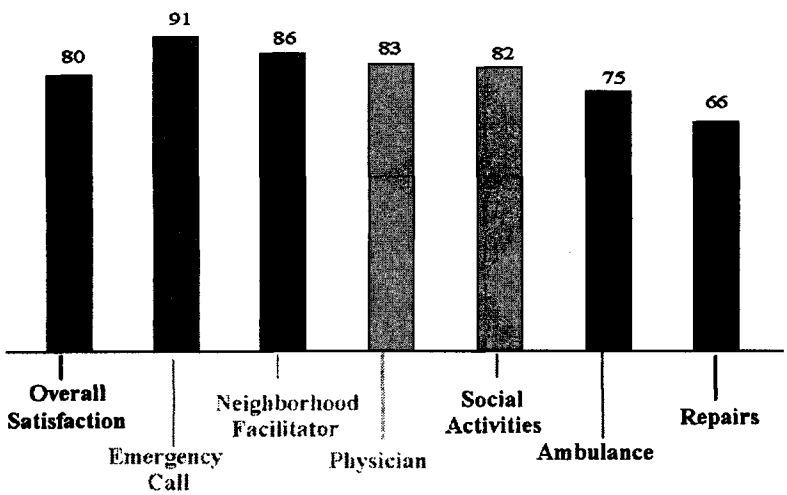
Satisfaction with the Program and Its Perceived Contribution

The generally high satisfaction with the SCP is reflected in the minimal number of members who leave it. During the period of study, an average of 11 people dropped out of each program – mainly because they either moved to assisted living or an institution, (an average of four people per program) moved to another neighborhood in which the program was not offered, or died. A very few (about one elder in each program) left the program because they were dissatisfied with it.

In response to a direct question about satisfaction with the program, 80 percent of the members reported being satisfied with it overall, 15 percent reported being only somewhat satisfied, and 5 percent reported being dissatisfied. Examination of satisfaction with each of the services provided by the program (using the same three-point scale) revealed that members were most satisfied with the emergency switchboard (91 percent of those who used this service were satisfied with it). Moreover, this was found to have the strongest correlation with satisfaction with the SCP in general. Satisfaction with the neighborhood facilitator, which was 86 percent, also had a strong correlation with overall satisfaction. High levels of satisfaction were also recorded among those who used the services of a physician (83 percent) and those who participated in social activities (82 percent). Relatively lower levels of satisfaction were found among those who used ambulance services (75 percent) or needed household repairs (66 percent; Figure 1).

Using open-ended questions to examine the reasons underlying the satisfaction or dissatisfaction with these services, we found that satisfaction with the emergency switchboard was due primarily to the rapid response of its operators. Satisfaction with the neighborhood facilitator was ascribed primarily to his courtesy and willingness to help. It is important for members to feel comfortable asking the neighborhood facilitator for help, that he be easy to contact, that he visit the homes of members (especially those who are disabled), and that he be both courteous and willing to help. There seems

Figure 1. Percentage of Members Reporting Satisfaction with Program Overall (n=205) and with Its Components, 2001.*



* Among those who received the service

to be room for improvement in the household repairs service. Twenty-eight percent of those members who needed this service were not aware it was offered. Others who needed repairs felt that the neighborhood facilitator was not sufficiently helpful. It appears that a clearer definition of the service, the time frame within which it is to be provided, and the nature of the repairs that the program will cover—that is, what type of repairs will be made (e.g., changing light bulbs, but not painting the elderly person's apartment)—could improve the functioning of the neighborhood facilitator and ensure that members' expectations of the neighborhood facilitator and of the repair service are realistic and can be met.

Satisfaction with social activities was derived from their being interesting and providing an opportunity to meet new people. Dissatisfaction with social activities primarily focused on their quantity – that is, there were not enough activities (especially trips, 12 percent). The lack of transportation services was also mentioned by some as being problematic (5 percent). However, this percentage may actually be higher, as members who did not respond to this question may not participate in activities simply because they have difficulty getting to them.

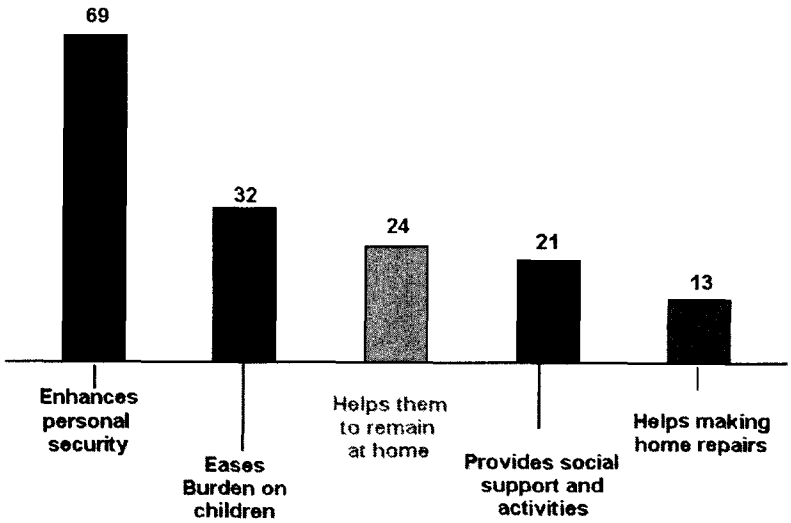
Members were more satisfied with the medical care than with the time it took a physician to arrive at their home. Those who called an ambulance through the SCP were satisfied with both the time it took to arrive and the medical care provided.

Using a checklist of items, we also asked the members what the program contributed to their quality of life: 69 percent said it gave them a sense of personal security, 32 percent reported that it eased the burden on their children, and 24 percent reported that it enabled them to continue living in their home (Figure 2).

CONCLUSION

Most elders prefer aging in their own home, in familiar surroundings and living in proximity to family. The SCP is one of a range of community services aimed at enabling the elderly to remain in the community for as long as possible. Among its main contributions are its provision of a sense of security and its meeting needs that are not met by any other service. Although no major differences were found between the SCPs run by for-profit agencies and those run by nonprofit agencies, the former seemed to be better at providing home repairs, whereas the

Figure 2. Sense of Contribution of the Program (in percentages), 2001 (n=205).



latter provided more ample recreational services.

From the perspective of service providers and policymakers, this SCP is also unique in its flexibility. As it evolves, we learn what elders need, and as their needs change, adaptations are considered accordingly.

Some issues should be considered in further developing SCPs. As noted, study findings show that some members of supportive communities are not fully aware of the services available to them through the program. It is therefore important both to ensure that members receive sufficient information about the services to which they are entitled and are reminded of them.

Studies have also identified unmet needs among the members. For example, there seems to be a significant need for an escort to medical tests and for the delivery of medications to house-bound members. We may expect this need to increase as the population ages. At present, most elders are assisted by their children. Although the neighborhood facilitator helps to the extent he can, a great need remains for escorts for the elderly. It is important to examine how the supportive community, in particular, and the system of community services for the elderly, in general, might effectively respond to this and other needs that may arise with the aging of the population.

When the SCP was first implemented in Israel, most of those who joined it were relatively young and independent. Over the years, as the elderly population has aged, the needs of members and their patterns of service utilization have changed. These changes necessitate rethinking the composition of the basket of services. For example, it may be wise to increase the medical services provided, add the services of a nurse to help manage the elderly person's medical care, offer social support services in the homes of the house-bound, or provide assistance with shopping and errands.

The SCP has been economically viable since its inception, and the principle underlying continued development of this program is that it remains economically sustainable. This means that any service for which a need arises is analyzed carefully before being added to the basket of services. The trend is to have those running the programs organize the provision of a given service, but ask that members who are interested in that service pay for it out-of-pocket. An example of this is transportation services: Although program providers may organize their provision, only those elderly members who wish to use the service pay for it. In this way, the cost of optional services is not added to the monthly dues nor to the burden of the Ministry of Social Affairs, which subsidizes the program for low-income elders.

Another way of keeping the program economically viable while addressing currently unmet needs is to further develop the provision of services by volunteers. Moreover, it should be remembered that the SCP is an addition to the existing system of services for the frail and disabled elderly in Israel, which is relatively generous. It is meant to meet those needs that are not met by home care programs, such as the Community Long-term Care Insurance Law and Israel's extensive network of social day care centers. The role of the staff of SCPs is to remain sensitive to the changing needs of members and to ensure that they take advantage of the other services available to them in the community.

Yet, it is important to recognize that Israel has entered a new era in its social and economic policies; whereas in the past government budgets were increased as needs expanded, Israel now faces a period of severe economic restraint and of declining government budgets, which is expected to continue over the next 10 years. In this context, it is important to note that despite the cutbacks in the system of services, the government has decided to expand the SCP very significantly because it is viewed as highly cost effective. Furthermore, a new service for nonelderly disabled persons has been initiated based on the model developed for the elderly population. The Supportive Community Program for Disabled Persons is being developed by

JDC-Israel's Unit for Disabilities and Rehabilitation, in cooperation with local authorities, the Ministry of Social Affairs, and the National Insurance Institute. This pilot program is also being evaluated by the Myers-JDC-Brookdale Institute, providing the planners with feedback from professionals and participants to further develop the model.

Concern for ensuring the quality of life in old age is very much shared by Israel and Jewish communities throughout the world, which have made special efforts to provide for the elderly well beyond what is publicly available. This concern has been and continues to be an important force for developing new approaches. The Supportive Community Program developed in Israel, as well as similar programs developed abroad, provides opportunities for mutual learning and innovation in care.

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