CLIENT SATISFACTION WITH NURSING- HOMES SERVICES IN ISRAEL

https://doi.org/10.47743/jopafl-2023-27-17

Jaudat KHALAILY
Alexandru Ioan Cuza University, Iasi, Romania
jaudatkhalaily@hotmail.com

Abstract: *This article seeks to examine elderlies' satisfaction from their nursing home (NH) based on the type of the NH (governmental, non-profit, or private) and the funding (private or public). Our data confirm that in public NH elderlies feel less satisfied with their care than private NH, perhaps because the former are more functionally impaired and have a greater need for nursing. Another explanation for higher satisfaction with private nursing homes is that elderly people prefer to receive personal attention, a thing that is less prevalent in public NHs, where the ratio of elderlies to one staff is higher than in non-profit and private NHs. Based on sufficient research evidence about public NH services, policymakers need to devise culturally feasible plans to overcome diverse barriers to nursing care and to provide qualified services that meet the needs of elderlies, who prefer public NHs. The data regarding the non-profit NH are found in between the other two. These non-profit NH lead to higher satisfaction than the governmental, but less satisfaction than the private NHs.*
Keywords: *Crisis Management, Covid-19, Nursing Homes for Elderly, Israel.*

Introduction

The nursing care industry has been growing rapidly in OECD countries in general and in Israel in particular in the last few decades, and that is due to the rise in the life expectancy at birth. There is also a high probability that this trend will continue in the coming future (Comondore et al., 2009). The significant increase in healthcare costs has widened the budget deficits in the public sector and led to increased cost and efficiency pressure on hospitals and nursing homes (NHs) in recent years (Zambon et al., 2006; Reibling et al., 2019). Because of the increasing proportion of elderly people in OECD societies and the associated rise in health care and social welfare costs, nursing homes are under even greater pressure to both: improve client satisfaction and seek efficiency (Harrington et al., 2012). This study is solely concerned with an efficiency analysis of Israeli nursing homes and the satisfaction of the elderly from the services they receive. Against this background, the article focuses in particular on the following questions:
How does the type of nursing home, private, non-profit or governmental, affect the satisfaction of seniors in Israel?
Are the Israeli nursing homes characterized by a high level of efficiency and satisfaction, and if yes, which type of nursing homes: private, non-profit or governmental leads to better satisfaction of seniors?
Is the type of nursing home that is more efficient necessarily leads to higher satisfaction of patients?
Which factors that affect satisfaction of seniors in Israeli nursing homes need to be changed?

Does the type of ownership of a nursing home (private / public) and the corporate objective (for-profit / non-profit) of a nursing home play a role in affecting satisfaction (Harrington et al., 2015)?
Hence, the article seeks to explain whether the type of NH plays a role in improving elderlies satisfaction of a NH? With regard to the last point, it can be said that in Israel the long-term care of elderly people is provided by private nursing homes as well as by public and private non-profit nursing homes (Ministry- of-Health-Israel, 2020).

Nursing-homes and Elderlies Satisfaction in Israel:

The number of beds per a nursing home or nursing wards in hospitals in 2014 in the OECD countries averaged around 1,030 beds per 1,000 people aged 80 and over, while Israel was below the average with about 780 beds per 1,000 these people (Kovch et al., 2017). The relatively low ratio of beds per elderlies in Israel corresponds to the relatively low rate of those entitled to assistance in nursing care (about 13% of elderlies in nursing homes), and it reflects a picture according to which many nursing seniors are treated in their homes, especially in the Arab sector (Kovch et al., 2017). OECD countries have on average recorded a slight increase in the number of nursing beds in the last decade and a half, but there is also a difference in this trend (Hillel et al., 2020). At the end of 2019, there were in Israel 25,483 beds in total, most of them 21,348, for long-term geriatrics, nursing geriatrics and the mentally debilitated, and 4,135 for active geriatrics, rehabilitation, complex nursing, supportive care, acute geriatrics, prolonged respiration and tuberculosis. The rate of beds has been declining since the mid- 2000s (Hillel et al., 2020).
In Israel, there are about 73,000 elderly people living in institutions, of which about 22,000 are in inpatient institutions for nursing and the mentally debilitated (long-term geriatrics) and about 4,300 are in active geriatric wards, under the responsibility of the Ministry of Health. In addition there are 5,500 elderly people staying in nursing homes for the debilitated and 16,000 in sheltered housing under the responsibility of the Ministry of Welfare; and the rest - about 26,500 – are in nursing houses of the Ministry of Housing and the Ministry of Absorption (Cohen- Mansfield, 2020; The-Association-of-Elderlies'-Families-in-Nursing-Houses, 2020). These people are scattered in 113 nursing homes that already signed a contract with the Ministry of Welfare, based on which they can receive welfare subsidies for their tenants.
It can be difficult to make a general comparison between private, non-profit, and public NHs based on customer satisfaction, given that such satisfaction can vary depending on several factors such as location of the NH, facilities provided, staff quality, and care provided. However, in general, customer satisfaction surveys can provide a useful benchmark for comparing the quality of care and services offered by different types of NHs.
It is important to note that non-profit nursing homes are usually mission-driven and may prioritize providing quality care over maximizing profits, which may result in higher customer satisfaction (Lusky et al., 2005). On the other hand, private nursing homes may have more resources and offer more luxurious facilities, leading to higher customer satisfaction. Public nursing homes, however which are funded by tax revenues, may have lower budgets and fewer resources, potentially leading to lower customer satisfaction.

Ultimately, the best way to determine the quality of care and services offered by an NH is to research and visit the facility in person, talk to residents and their families, and review relevant information such as inspection reports and survey results.
Comparing private, non-profit, and public nursing homes based on customer satisfaction can be done through surveys, questionnaires, or focus groups where residents and their families are asked to rate their experiences with the facilities (Clarfield et al., 2009). This study is based on collecting data through questionnaires that were filled out by elderlies and interviews with managers of NHs in Israel. The data collected from these methods was then analyzed to determine the level of satisfaction with each type of NH. It is important to note that the comparison of customer satisfaction between these three types of nursing homes should be done with caution, as factors such as location, staff training, and resident demographics can greatly influence the results. A more comprehensive and in-depth study would be necessary to accurately compare and determine the level of customer satisfaction between these types of nursing homes.

Test Default

Nursing homes provide long-term residential nursing care for elderlies. The findings below are based on a sample that included 576 participants in Israel from three types of nursing homes (NHs): Governmental, Non-profit and Private, where the proportionate allocation is: 26 participants from Government nursing houses, 170 participants from Non-Profit Organizations, and 380 participants from Private ones. These results and the statistics on the dependent variables are presented from the perspectives of the residents of the participating NHs. The satisfaction was measured based on the categories mentioned in Table 1 that include elements such as Tangibility, Responsiveness, Reliability, Empathy, cleanliness, Private room, Dining room etc.

Findings

Table 1 shows the ranking of the mean of those who had code from the Ministry of Health and those who went private. Among those who had did not have code from the Ministry of Health (private), the lowest and highest mean score were for Professional Treatment and Cleanliness, respectively (4.51 and 4.78), while among those who did have code, the lowest and highest mean score were for Private Room and external Structure, respectively (3.25 and 4.12) (It should be noted that the mean score for the Covid-19 among these who had code was 3.15).

Table 1: Mean of Satisfaction, private vs. Ministry of Health Code

Mean of Satisfaction: 1 Strongly Dissatisfied, 5=Strongly Satisfied		
	Private	Ministry of Health Code
NH Infrastructure	4.68	4.12
Professional Treatment	4.51	3.83
Tangibility	4.63	3.69
Responsiveness	4.59	3.51
Assurance and Security	4.66	3.59

Reliability	4.57	3.38
Empathy and Autonomy	4.48	3.39
Cleanliness and Hygiene	4.78	3.41
Private Room	4.58	3.25
Dining Room	4.49	3.53
Community and Religion	4.56	3.69
Covid-19 Satisfaction	3.92	3.15

Users of long-term NH services evaluated their care positively. Table 2 ranks the mean value of each of the three types of NH. In the private NH group, the highest mean score was for Cleanliness and Hygiene domain (4.78). In the non-profit NH group, the highest mean score was for Exterior and Architecture (4.19). In the Government NH group, the highest mean was for Exterior and Architecture too (3.65). However, those elderly resident of government NH were least satisfied with daily activities provided in the nursing home and with their treatment during the Covid-19 crisis and their Private Room (2.89 and 3.92, respectively). In non-profit NH, the lowest mean score was for Covid-19 and Responsiveness (3.19 and 3.46, respectively). In the private sector, however, the lowest mean score was for Covid- 19 and Empathy (3.92 and 4.48, respectively).

Table 2

Category	Type of NH		
	Government	Non-profit	Private
NH Infrastructure	3.65	4.19	4.68
Professional Treatment	3.61	3.86	4.51
Tangibility	3.26	3.76	4.63
Responsiveness	3.02	3.46	4.59
Assurance and Security	3.33	3.63	4.66
Reliability	3.12	3.42	4.57
Empathy and Autonomy	3.17	3.43	4.48
Cleanliness and Hygiene	3.15	3.45	4.78
Private Room	2.92	3.30	4.58
Dining Room	3.14	3.59	4.49
Community and Religion	3.32	3.75	4.56
Covid-19 Satisfaction	2.89	3.19	3.92

This study examined several factors related to overall satisfaction in nursing home care. In the multiple correlation analysis, the models including age, sex, duration in months at the NH, exterior structure and architecture were used. From our calculations, we only noticed that only the variables of the Ministry of Health Code, and the Type of NH significantly predicted overall satisfaction in nursing home care.

Our findings showed that senior citizens receiving public funding (code from the Ministry of Health) in nursing home had lowest care satisfaction. These results were consistent with previous studies (Comondore et al., 2009). Earlier studies conducted in Israel also showed similar results to ours (Clarfield et al., 2009). This low satisfaction could be attributed to the fact that private NHs seek to outperform public and non-profit NHs in the services they provide to their elderly residents. Although users reported that they currently felt satisfied

with the care provided, it is important to show which factors should improve or retained in order to provide high-quality care. Our data confirm prior findings that public NH care elderlies feel less satisfied with their care than private NH (Jester et al., 2019), perhaps because the former are more functionally impaired and have a greater need for nursing. Another explanation for higher satisfaction with private nursing homes is that elderly people prefer to receive personal attention, a thing that is less prevalent in public NHs, where the ratio of elderlies to one staff is higher than in non-profit and private NHs (Dov Chernihovsky et al., 2017). Based on sufficient research evidence about public NH services, policymakers need to devise culturally feasible plans to overcome diverse barriers to nursing care and to provide qualified services that meet the needs of elderlies, who prefer public NHs. In this study, the quality of caregivers who provided care services in person was an important factor that augmented care satisfaction. These results are supported by prior studies that caregivers' abilities and sympathy had an important role in care satisfaction (Ministry-of-Health-Israel, 2019).

Medical or nursing services need to be increased because low-income senior citizens have high care needs due to their medical problems and most of them cannot pay for private medical or nursing home service (Kojima, 2018). It is particularly difficult to monitor their health status because many of them are unable to visit hospitals due to mobility problems or because of a lack of family members who can care for them. Yet, private NHs are highly expensive. To establish the use of NH for better care services, the costs should be balanced with those of other services. In this study, NH elderlies in private and non-profit NHs were ordinarily satisfied with their living conditions, whereas they were relatively less satisfied with knowledge about what services were promised in the NH on admission. In addition, their scores concerning autonomy regarding care decisions and daily activities were smaller than those of the other indicators. In our regression analysis, quality of care facilities, including service information and contact availability, exerted important effects on care satisfaction among these elderlies.

Moreover, NHs should provide adequate information about what elderlies would go through to assist them in their decisions. In addition, elderlies reported lower satisfaction with the activities available in their public nursing homes, compared to the other two types of NHs in our study. Group activities reduce feelings of loneliness and increase feelings of wellbeing among the elderlies, thus influencing their emotional health. Therefore, diverse programs promote physical and emotional health and such activities and programs were more available in private and non-profit NHs.

Although variables such as age, sex, and duration at an NH could be related to satisfaction, existing evidence on these relationships is insignificant (Kajonius et al., 2016). There was no significant association between personal data and overall care satisfaction in our regression models.

It is important to recognize the limitations of this study. Our study can be considered a preliminary step to continuously monitor NHs quality and customer satisfaction with NH services in Israel. To achieve these goals, new studies are necessary to implement more effective ways to preserve qualified staff at NHs and to provide social and nursing services that meet elderlies' needs. Overall, elderlies from low-income households who stayed in a private NH were more satisfied with the care provided than were those who stayed in government or even non-profit NH. We showed that elderlies satisfaction with NH care was strongly impacted by the quality of care facilities and staff members. Our findings

suggest that to increase elderlies satisfaction, NH facilities should provide more flavorful meals, interesting activities, and better info about their care options. In addition to social services at the NH, the use of NH services needs to be facilitated by adjusting the high-priced of private NHs for low- income elderly adults. Monitoring care satisfaction and public dissemination of such information would promote customer-centered NH services, and ultimately increase the quality of life of its elderlies.

Impact of Dining Room and Private Room on Elderly Satisfaction

All NHs in Israel are characterized by an extensive full supply of food, because their elderly residents do not have the opportunity to prepare their own food. With central kitchen equipment, these NH institutions can rationalize essential work processes and thus save costs (Abbott et al., 2013). Eating meals together is also well organized, allowing meals to be shared by a large number of people at a minimum time and effort. The elderlies, who are often housed separately, are brought together during mealtimes. A measure that, depending on the institution, may in turn necessitate special control measures. However, the dining rooms are always also a social place where elderlies meet and there is an opportunity for communication, albeit to a very limited extent in some of the establishments.

Like every old people's home, the three types of an NH examined have a dining room where the main meals are served to all residents. This is a large room with a large number of tables at which the residents meet to eat without a fixed seating order. In contrast to the cafeteria, the dining room is not open to strangers, but due to the large community and the presence of the kitchen staff, it cannot be assigned to the private sphere either (Rijnaard et al., 2016). It is also not defined that way by most residents. The food is served in the pure care and mixed areas. Only the residents from one living area and, if desired, a few others, use the large dining room. These small dining rooms are also available to the residents as all-day lounges.

Eating meals together in the large dining room is quite popular with the residents of the NHs. Above all, the aspect of the community as positive or even very positive is cited as the most important by seven of the respondents. From Table 3.20 it is clear that the best meals of all the three types of NHs are provided by private ones, followed by non-profit NHs. The fact that residents who have major difficulties in eating due to physical handicaps prefer to eat alone can be seen as a further indication of the definition of the dining room as at least a partially public area.

The observation carried out confirms the assessment that the large dining rooms of the three NHs are no longer part of the private sphere; the users always enter this room in a complete wardrobe, as is customary in the public areas (Naja et al., 2017). In these cases, the quasi-familiar atmosphere of these rooms and the proximity to the individual rooms should lead to different satisfaction by the residents. What can be said is that the social contacts institutionalized by the fixed mealtimes are quite popular with the residents of the three NHs. This applies in particular to the lunchtime meal.

The communicative aspect of eating meals together is important for a large proportion of the residents. The fact that the dining room is seen as a more public sphere does not affect this social component. Rather, it seems to be the case that this promotes the impression of a normal visit to a restaurant, i.e. an event with a consistently positive connotation. The

division of the actually large dining room into small, manageable seating areas underlines this impression. There is no question of the atmosphere with its long tables that is typical of the traditional NHs. As shown in the Tables 3.19 and 3.20 above, the quality of the food served in the homes examined apparently plays a significant impact on the satisfaction of the elderlies.

According to the described criteria for NHs, the most complete possible control of the entire space by the employees is typical for this type of institution (Rijnaard et al., 2016). Therefore, there must be no possibility for the members to evade it, i.e. no private sphere is provided for them, or at most a very small one. The dormitories of these facilities are usually equipped with shared rooms. This allows a few employees to monitor many members. When single rooms are available, they have minimal amenities and serve as a room for serving sentences. In these cases, accommodation is in such a room should by no means be regarded as a special privilege.

As already explained, it is characteristic of NHs that the separation between the places of work, home and play, which is usual in Western societies, has been abolished. For further analysis of everyday life in NHs, it is important that these individual places are further differentiated. Depending on the resources of the person or family, other specific rooms can be added for work, for children, for guests and many more. This classification is of course only to be understood as an example, individual variations are not uncommon and are often caused by architectural specifications.

In principle, however, the tendency towards the separation of more public and predominantly private areas can also be stated for the interior layout of an apartment (Mahieu et al., 2015). Because depending on the degree of familiarity, different rooms are made accessible to outsiders. The side open to general visitors is usually much better equipped and maintained than the rear regions.

The residents of single rooms, as in the homes examined here, do not have the option of dividing up the space. Only the bathroom remains closed to visitors. Otherwise, the bedroom and living room, which at least partially has to be used for eating, are identical. This puts them in the dilemma of either keeping their private room up to the standard of a front stage, which means a not inconsiderable amount of daily work, or presenting potential visitors with a view typical of the backstage. Although the single rooms, which are currently regarded as the standard in some private NHs, represent an immense improvement over shared rooms, for most residents they mean a considerable reduction in the space available compared to the living situation before moving into the NH (Jing et al., 2016).

The decisive criterion when defining a space as a private sphere is the question of the conditions of its access and the possibility of disposal. This means that a room can only really be described as private if the occupant decides for himself or herself who is to be granted access. In addition, s/he should at least mostly have the opportunity to design his/her room as s/he sees fit. This is the most important external demarcation from the previously discussed rooms in a nursing home. So if the individual rooms in a home can be correctly described as the private sphere of the residents, corresponding signs in subjective perception and behavior must also be able to be proven.

The three nursing homes examined had almost no single rooms for the residents in the living area, with the exception of a few special cases in private NHs. Therefore, at this

point, the certainly interesting consideration of life in double or multi-bed rooms must be considered as the mainstream option.

The side of the room door facing the corridor forms the beginning of the private sphere of the room. Many homes make frequent use of the option of labeling them individually (Makimoto et al., 2015). The labeling refers to self-made name tags and, depending on taste, the attachment of small floral decorations or the like. In many cases, however, the suggestion for such changes probably comes from the staff, as this makes it much easier for the residents to find their own rooms on the otherwise uniformly furnished corridors. Two features that are technically clearly part of the exterior door of a ward and convey this impression to both residents and visitors. They also offer practical advantages in that they meet the security needs of many residents, as was explicitly emphasized by some during the survey.

Almost all rooms in the NHs are essentially identical. From a narrow hallway behind the front door, a door leads to the toilet room and straight ahead into the roughly square room, the outside of which is completely occupied by a window front with a glass door leading to the balcony (Joseph et al., 2016). While there are built-in cupboards installed in the small hallway of the home, the furnishing of the actual room in the private NHs is up to the taste of the respective resident.

Most of the rooms in the comparable non-profit and government NHs are identical in construction; however, they are a bit smaller and usually two residents share a bathroom. Some of these rooms do not have their own balcony and it is only possible to take one's own furniture with her/him to a very limited extent. Due to the small size of the rooms and the fact that most of them are furnished with furniture from the NH, there are hardly any individual design options for the residents in these types of NHs. The rule is a wardrobe, a bed, an armchair and a rather small table by the window. In addition, however, all rooms have personal items such as pictures, photos or souvenirs, albeit to a varying extent. In the double rooms of private NHs, which are more common in this type of NHs, the possibilities for the residents are considerably greater, because the rooms are large.

The side of the room door facing the corridor forms the beginning of the private sphere of the room. Many homes make frequent use of the option of labeling them individually. The labeling refers to self-made name tags and, depending on taste, the attachment of small floral decorations or the like. In many cases, however, the suggestion for such changes probably comes from the staff, as this makes it much easier for the residents to find their own rooms on the otherwise uniformly furnished corridors.

The result is clear, in this point there is indeed a big difference between the three types of NHs. It should be emphasized that for the residents of private NHs, this aspect has the greatest influence on their well-being in their own room. Finally, questions no. 36 about the autonomy of the residents of these NHs are important for assessing the room as a private sphere. These answers also clearly show a trend among the residents of the private NHs towards activities outside their room. This trend, which continues across several questions, not only confirms the validity of the results in general, but it clearly shows that in this type of NH some of the elderlies show different space-use behavior. With very few exceptions, most residents spend the evening and of course the night alone in their rooms. This is confirmed by the fact that the residents spend most of the day in their own rooms.

The main problem is control of access. Although all residents have the key and the room doors are in fact almost always locked when they are absent, sometimes also when they are

present, but in practice this conflicted with the interest of the staff. Because, as was already registered when the survey was conducted, the prevailing habit here is to enter the residents' rooms immediately after knocking, without waiting for an entry request. On the one hand, this handling makes the work of the employees who are under time pressure easier, but on the other hand, it represents an intrusion into the private sphere of the residents that should not be underestimated; a practice that is even more widespread in the care areas of homes. However, the employees can refer to their duty of supervision with some justification.

In principle, however, it can be said that the power to dispose of keys is always an expression of the social relationship. Locks are not only mechanical locks, they also have a symbolic character (Even-Zohar, 2014). The power to dispose of the key is also an expression of power. The sometimes observed behavior of the staff is therefore a sign of an unequal relationship and can also give the residents a feeling of control in their own private sphere, which is a serious difference to 'normal' tenancies.

Therefore, this imbalance can be seen as an indication of the dominance of the staff. People who feel dominant often claim the right to move about as they please (Halperin, 2013). Even if it could not be determined during the investigation, it can be assumed that there is friction between staff and residents on this point.

Private or Ministry of Health Code

Everyone thinks that looking for nursing homes or sheltered housing is long, tedious and involves a lot of expenses, but they don't know that there is a way to ease these expenses and procedures in a simple process called "obtaining the Ministry of Health code" or sometimes also called "participating in nursing hospitalization". Israeli elderlies have reached the moment when they have decided to look for a nursing home for themselves, and they certainly have heard the term "Ministry of Health Code" that can ease the expensive financial expenses.

What is the Ministry of Health code?

The Ministry of Health code is a special document that an elderly receives from the Ministry of Health, with the help of which s/he can receive partial or full funding whether the elderly person needs a long-term nursing home, or a nursing home for the mentally debilitated or only for the debilitated.

There are many people who, during the search for a suitable nursing home for their spouse or parents, encounter multiple difficulties, all of this mainly because the elderlies or their children do not have the financial capability that involves registering and financing a nursing home independently. In these cases, the Ministry of Health gives an option of help in financing a nursing home, the help is conditional on meeting various criteria, and is given by receiving a "code from the Ministry of Health".

The Ministry of Health, by virtue of its position, assists in financing, and supplements the participation fee for the price of a code. But in cases where the income is higher than NIS 9,500, it is important to know that the code will be accompanied by a deduction in the amount of funding. But despite this, there are many who are interested in receiving this code, even with full deduction, because this code gives an elderly significant protection against future price increases, and it also allows him/her to enter nursing homes, which exceed their financial capacity for self-registration.

When an elderly person received a "Ministry of Health code" and is hospitalized through the Ministry of Health in a nursing home, the ministry pays the cost of hospitalization to the institution in full, and collects the costs that are deductible from the family members. The family members of the hospitalized person do not have to pay an additional fee to the institution itself, and the institution is prohibited from demanding that they pay him any amount and/or request that they purchase themselves and/or bring equipment, medicines, etc., with the exception of medicines that are not in the health basket that require the approval of the family or the guardian.
The Ministry of Health provides assistance in financing nursing hospitalization according to the State Health Insurance Law. The assistance is conditional upon formal recognition by the Ministry of Health of the elderly's status as "nursing", and upon the payment of a deductible cost by the elderly or members of his immediate family (his wife and children) according to the income of each family member. The financing of hospitalization is called the "nursing code" of the Ministry of Health. It is important to know that not every nursing home has a license for the Ministry of Health code.

Satisfaction from the Nursing Homes during the Covid-19 Pandemic

The performance of nursing homes during the Corona period can severely affect the satisfaction of elderly residents (Verbeek et al., 2020). Due to the pandemic that erupted in early 2020, nursing homes have had to change their policies and procedures to ensure the health and safety of its highly vulnerable elderly residents. These changes may include imposing restrictions on the visitor, changes in daily routines and activities, and additional personal protection measures for staff (Khalaily, 2022).
While these measures are necessary to prevent the spread of the virus, they can also impact the quality of life and overall happiness of elderly residents. For example, the restrictions on visitors can lead to feelings of isolation and loneliness, and changes in daily routines can disrupt the sense of stability and comfort residents may have previously experienced (Cohen-Mansfield, 2020).
However, satisfaction with these changes will depend on how well the nursing home adapts to the new circumstances and how well it is able to respond to residents' needs and concerns. A nursing home that takes a compassionate and communicative approach, providing residents with clear information and support, can help mitigate the negative impact of change and maintain high levels of resident satisfaction. In short, a nursing home performance during the Corona period can have a significant impact on senior resident happiness, but it is possible to maintain high levels of happiness through effective communication and adaptation. Similar to the previous variables above, the coefficient of Ministry of Health Code is significant and negative, while the coefficient of the Type of NH is significant and positive.

Conclusions

This article provides a review regarding government policy in relation to the non-profit, private and governmental nursing homes in Israel in particular and the service provided to nursing patients in particular, and the standards according to which the institutions are run

and are responsible for their licensing and control over the quality of care provided to patients.

In recent years we have witnessed a growing perception that private facilities are efficient, while non-profit organizations and governmental institutions, which do not operate according to private business principles, are extravagant and inefficient. This approach has led to attempts to force non-profit and governmental organizations through more "business" management. In this review, there are studies that found no difference between the economic efficiency of non-profit organizations and that of business firms. Moreover, some studies' findings indicated that non-profit organizations operating in the nursing home industry contribute to public welfare by raising quality or lowering the price. Thus, it is not clear whether forcing a "business" way of managing them would improve the situation of the public. Some studies indicated that the government significantly influences the quality of service in the nursing home industry through the price that it sets for institutions. It would have been appropriate for the government prices to be determined according to the quality of the institution, but in Israel this is not done in this way. The Ministry of Health has initiated a plan for reform in the industry, according to which the rates paid to institutions are to be determined according to the quality of the institutions. The plan also sets uniform labor standards and prices for non-profit organizations and business institutions, which will eliminate the existing discrimination between the three types of institutions.

References

1. Abbott, R. A., Whear, R., Thompson-Coon, J., Ukoumunne, O. C., Rogers, M., Bethel, A., . . . Stein, K. (2013). Effectiveness of mealtime interventions on nutritional outcomes for the elderly living in residential care: a systematic review and meta-analysis. Ageing research reviews, 12(4), 967-981. https://doi.org/10.1016/j.arr.2013.06.002

2. Clarfield, A. M., Ginsberg, G., Rasooly, I., Levi, S., Gindin, J., & Dwolatzky, T. (2009). For-profit and not-for-profit nursing homes in Israel: Do they differ with respect to quality of care? Archives of gerontology and geriatrics, 48(2), 167-172. https://doi.org/10.1016/j.archger.2008.01.001

3. Cohen-Mansfield, J. (2020). COVID-19 and older adults in Israel–common challenges and recommendations. Quality in Ageing and Older Adults.

4. Comondore, V. R., Devereaux, P., Zhou, Q., Stone, S. B., Busse, J. W., Ravindran, N. C., . . . Cook, D. J. (2009). Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. BMJ, 339, 1-15. https://doi.org/10.1136/bmj.b2732 Retrieved from https://www.bmj.com/content/339/bmj.b2732.long

5. Dov Chernihovsky, Avigdor Kaplan, Regev, E., & Shatsman, Y. (2017). Nursing care in Israel: Financing and organization issues. Taub Center for Social Plicy Research in Israel. Retrieved from http://taubcenter.org.il/wp- content/files_mf/longtermcareheb.pdf

6. Even-Zohar, A. (2014). Quality of life of older people in Israel: a comparison between older people living at home who are members of a 'supportive community'and nursing home residents. European Journal of Social Work, 17(5), 737-753. https://doi.org/10.1080/13691457.2014.930731

7. Halperin, D. (2013). Aging, family, and preferences for care among older Jews and Arabs. Israel Studies Review, 28(2), 102-121.

8. Harrington, C., Olney, B., Carrillo, H., & Kang, T. (2012). Nurse staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies. Health services research, 47(1pt1), 106-128. https://doi.org/10.1111/j.1475-6773.2011.01311.x

9. Harrington, C., Ross, L., & Kang, T. (2015). Hidden owners, hidden profits, and poor nursing home care: a case study. International Journal of Health Services, 45(4), 779-800. https://doi.org/0.1177/0020731415594772

10. Hillel, S., & Haklai, Z. (2020). Hospital beds and licensed stations. Retrieved from https://www.health.gov.il/PublicationsFiles/beds2020.pdf
11. Jester, D. J., Hyer, K., & Bowblis, J. R. (2019). High on SMI: quality concerns about nursing homes serving high proportions of seriously mentally ill residents. Innovation in Aging, 3(Supplement_1), 510- 511. https://doi.org/10.1093/geroni/igz038.1885
12. Jing, W., Willis, R., & Feng, Z. (2016). Factors influencing quality of life of elderly people with dementia and care implications: A systematic review. Archives of gerontology and geriatrics, 66, 23-41. https://doi.org/10.1016/j.archger.2016.04.009
13. Joseph, A., Choi, Y.-S., & Quan, X. (2016). Impact of the physical environment of residential health, care, and support facilities (RHCSF) on staff and residents: A systematic review of the literature. Environment and Behavior, 48(10), 1203-1241. https://doi.org/0.1177/0013916515597027
14. Kajonius, P. J., & Kazemi, A. (2016). Structure and process quality as predictors of satisfaction with elderly care. Health & social care in the community, 24(6), 699-707. https://doi.org/10.1111/hsc.12230
15. Khalaily, J. (2022). Crisis management: the case of managing the corona crisis in nursing homes for elderly people in Israel. European Administrative Area–Integration and resilience dynamics, 287.
16. Kojima, G. (2018). Frailty as a predictor of nursing home placement among community-dwelling older adults: a systematic review and meta-analysis. Journal of geriatric physical therapy, 41(1), 42-48. https://doi.org/10.1519/JPT.0000000000000097
17. Kovch, G., Niska, T., & Rosen, M. (2017). Long-term care insurance in Israel. Retrieved from https://www.boi.org.il/he/Research/Pages/pp201801h.aspx website: https://www.boi.org.il/he/Research/Pages/pp201801h.aspx
18. Lusky, I., & Givon, Y. (2005). Efficiency and quality in nursing homes: non-profit organizations versus business institutions. Retrieved from Taub Center: http://taubcenter.org.il/wp-content/files_mf/h2005_nursing_homes.pdf
19. Mahieu, L., & Gastmans, C. (2015). Older residents' perspectives on aged sexuality in institutionalized elderly care: A systematic literature review. International journal of nursing studies, 52(12), 1891-1905. https://doi.org/10.1016/j.ijnurstu.2015.07.007
20. Makimoto, K., Kang, H. S., Yamakawa, M., & Konno, R. (2015). An integrated literature review on sexuality of elderly nursing home residents with dementia. International Journal of Nursing Practice, 21, 80-90. https://doi.org/10.1111/ijn.12317
21. Ministry-of-Health-Israel. (2019). Survey of Patients Experience in Nursing Homes. Retrieved from Jerusalem: https://www.health.gov.il/publicationsfiles/satisfaction-patients-hosp- ger-2019.pdf
22. Ministry-of-Health-Israel. (2020). Geriatrics Division and Geriatric Hospital Procedures. Retrieved from https://www.health.gov.il/download/ng/0_5_10.pdf
23. Naja, S., Makhlouf, M., & Chehab, M. A. H. (2017). An ageing world of the 21st century: a literature review. Int J Community Med Public Health, 4(12), 4363-4369. http://dx.doi.org/10.18203/2394-6040.ijcmph20175306
24. Reibling, N., Ariaans, M., & Wendt, C. (2019). Worlds of healthcare: a healthcare system typology of OECD countries. Health Policy, 123(7), 611-620. https://doi.org/10.1016/j.healthpol.2019.05.001
25. Rijnaard, M., van Hoof, J., Janssen, B., Verbeek, H., Pocornie, W., Eijkelenboom, A.,. . . Wouters, E. (2016). The factors influencing the sense of home in nursing homes: a systematic review from the perspective of residents. Journal of Aging Research, 2016. https://doi.org/10.1155/2016/6143645
26. Verbeek, H., Gerritsen, D. L., Backhaus, R., de Boer, B. S., Koopmans, R. T., & Hamers, J. P. (2020). Allowing visitors back in the nursing home during the COVID-19 crisis: A Dutch national study into first experiences and impact on well-being. Journal of the American Medical Directors Association, 21(7), 900-904. https://doi.org/10.1016/j.jamda.2020.06.020
27. Zambon, A., Boyce, W., Cois, E., Currie, C., Lemma, P., Dalmasso, P., . . . Cavallo, F. (2006). Do welfare regimes mediate the effect of socioeconomic position on health in adolescence? A cross-national comparison in Europe, North America, and Israel. International Journal of Health Services, 36(2), 309- 329.