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PROLONGED WAITING FOR MEDICAL ASSISTANCE BEFORE NURSING HOME ADMISSION: MANAGEMENT AND ECONOMIC ASPECTS

In the context of global population aging, the issue of effective resource management in the healthcare sector is gaining strategic importance. Delays in providing medical assistance to older adults not only deteriorate their physical condition and increase hospitalization rates but also impose a growing financial burden on households and long-term care systems. Moreover, unpredictable expenses and rising demand for specialized care complicate budget planning at both micro and macro levels.

The purpose of the paper is to analyze the waiting time for medical care among older individuals in Israel and to assess the socio-economic consequences of such delays for the care system. The study also seeks to develop managerial solutions for system optimization, with particular attention to the critical transition from home-based to institutional care, which requires substantial financial and organizational resources.

The paper examines systemic, economic, and administrative factors contributing to delays in care provision – namely, inefficient coordination between services, underfunding of primary healthcare, and the underdevelopment of long-term care infrastructure. A cross-sectional survey of 307 family members of elderly individuals identified key risks: increased caregiving costs, caregiver burnout, and a decline in patients' quality of life.

Involving patients in the decision-making process produced mixed results: while it extended the time required for administrative decisions, it also improved satisfaction with home-based care services. At the same time, individuals with higher education levels demonstrated greater critical attitudes toward the quality of care provided.

The worsening physical condition of older adults increased the need for intensive daily care, directly impacting the financial burden on both the state and individual households. Reduced mobility further elevated the demand for specialized equipment and services, adding pressure to the social welfare system.

The findings highlight the urgent need for the development and implementation of an effective management model to coordinate healthcare and social services. This includes early identification of patient needs, financial support for caregiving families, and flexible budgeting for long-term care programs. The study's recommendations can serve as a valuable resource for policymakers and healthcare managers aiming to improve decision-making efficiency, ensure sustainable funding, and enhance the quality of life for the aging population.

Keywords: elderly, economic burden, decision-making, family involvement, nursing home, management

PROBLEM STATEMENT

As populations worldwide continue to age, ensuring timely access to medical care for elderly individuals has become an increasingly critical public health concern. In many healthcare systems, elderly individuals often experience long waiting periods before receiving professional medical assistance, particularly during the transition to nursing home care. This delay can lead to detrimental effects on their health and quality of life, and it places an enormous burden on families and caregivers. The growing demand for professional medical services combined with systemic barriers creates a situation in which older adults are left vulnerable during one of the most crucial periods of their lives.

The phenomenon of delayed access to medical care for the elderly is multifaceted. It is driven by several factors, including shortages of healthcare professionals, particularly in geriatric medicine, inefficiencies in the referral process, and bureaucratic obstacles in long-term care admissions. According to [10], the increasing complexity of the healthcare needs of older adults often outpaces the capacity of existing systems to provide adequate and timely care. As the population ages, the shortage of skilled geriatric specialists is particularly concerning, exacerbating the problem of delayed care.

The consequences of these delays are profound and far-reaching. Studies have shown that extended waiting times for professional medical assistance can lead to worsened health outcomes for elderly individuals, including increased rates of hospitalization, exacerbation of chronic conditions, and faster cognitive and physical decline [16]. Furthermore,

this period of waiting often places an overwhelming strain on family caregivers, who may be unprepared to manage the complex medical and personal care needs of their elderly loved ones. The prolonged absence of professional intervention not only affects the elderly but also leads to caregiver burnout, further complicating the dynamics of long-term care [11].

When elderly individuals finally gain access to professional medical assistance and are transitioned to nursing homes, they often arrive in a more deteriorated state than if they had received timely care. Mor et al. (2017) highlight how this delay in care exacerbates the difficulties of adjusting to a nursing home environment, making the transition more traumatic and reducing the likelihood of a smooth adaptation. In nursing homes, administrators and healthcare providers are tasked with managing increasingly frail patients who require more intensive interventions due to the delay in earlier stages of care.

Addressing the issue of long waiting periods for professional medical assistance prior to nursing home admission requires a multi-pronged approach. This paper aims to explore the systemic, economic and managerial factors contributing to these delays and analyze their impact on health outcomes, caregiving dynamics, and nursing home care.

Review of recent research and publications

According to the Central Bureau of Statistics, Israel's population is estimated at 9.842 million residents, with Jews comprising 7.208 million (73.2% of the total population) and Arabs numbering 2.080 million (21.1%). Addi-

tionally, 0.554 million residents belong to other groups. In 2023, Israel's population grew by 1.9%, driven by a combination of immigration and natural birth rate increases [13].

A significant concern is the declining dependency ratio – the proportion of working individuals relative to retirees. This imbalance threatens financial sustainability, as a growing elderly population requires increased expenditures in welfare, healthcare, and social insurance. The challenge extends beyond the aging population itself, impacting the nation's capacity to support retirees while maintaining economic growth and public service standards [4].

Israel, like many developed nations, must deliver efficient, high-quality, and sustainable services to its aging population, particularly those remaining at home. These individuals often need assistance with daily activities due to physical disabilities or cognitive decline. The state, in collaboration with family caregivers, must provide adequate support to help elderly individuals maintain independence and delay or prevent transition to nursing homes. Family caregivers play a crucial role, but state services and funding are equally critical. Adequate home care services, medical support, and financial assistance can significantly enhance the quality of life for the elderly, allowing them to remain in their communities longer [5].

The State Health Insurance Law of 1994 (hereinafter: "the law") establishes that every resident of Israel is entitled to health services. According to the law, the state is responsible for financing the health service basket, while the health funds (Kupot Holim) are responsible for providing the full spectrum of health services to which the insured are entitled. Section 3(d) of the law stipulates that "the health services included in the health services basket will be provided in Israel, at a reasonable distance from the insured's place of residence, and all within the framework of a medical opinion, of reasonable quality, and within a reasonable time, according to the funding sources available to the health funds as per section 13."

This section outlines the guiding principles for the provision of medical care by the health funds, including the obligation to provide services to the insured within a "reasonable time". However, the law, as it currently stands, does not specify what constitutes a "reasonable waiting time" for appointments with specialized medical professionals. The absence of clear regulations or guidelines on this matter has significant implications for the oversight and regulation of health services.

The lack of clarity on reasonable waiting times undermines the Ministry of Health's ability to effectively control and supervise the services provided by health funds. Without formal regulations or ministry guidelines defining acceptable waiting periods for specialist care, the Ministry of Health faces significant challenges in fulfilling its regulatory responsibilities. Consequently, the Ministry is often forced to rely on the health funds' willingness to cooperate in the monitoring and supervision of service provision, leading to a lack of transparency and accountability [19].

According to a survey conducted by the Brookdale Institute in 2018, there was an increase in the number of Israelis reporting long waiting times for consultations with specialists compared to 2016. The percentage of those who reported waiting between one and two months rose from 13% to 18%, while the percentage of those waiting more than two months increased from 12% to 15%. This means that one in

three Israelis had to wait more than a month to see a specialist. Furthermore, long waiting times have become the primary reason why 29% of Israelis forgo medical treatment [24]. A follow-up study conducted in 2021 by the Joint Distribution Committee revealed that although health funds manage appointments with doctors as part of their routine operations, they do not report this data to the Ministry of Health, nor is it made accessible to the public. Given that patient perception of waiting times is a key factor in determining whether they choose to wait, seek private care, or forgo treatment entirely, the absence of transparency in this data is a significant oversight in Israel's healthcare system.

There are also substantial disparities in the availability of medical personnel between Israel's central and peripheral regions. The number of doctors per capita in the Tel Aviv district is 2.3 times higher than in the northern district, which has the lowest rate of doctors per capita. Similarly, the number of nurses per capita in the Haifa district is 2.05 times higher than in the southern district, where the rate is lowest. This inequality significantly affects access to health services, and addressing these disparities remains crucial [8].

The period preceding admission to a nursing home is often marked by increasing frailty, chronic conditions, and deteriorating health among elderly individuals. Timely access to professional medical assistance is crucial during this phase to manage health conditions effectively and improve the quality of life. However, prolonged waiting times for medical care can have severe consequences on both the health of elderly individuals and the overall efficiency of long-term care systems. Several studies underscore the negative impact of delayed medical intervention on the health outcomes of elderly individuals awaiting nursing home admission. Prolonged waiting periods often lead to the worsening of existing conditions, increasing the likelihood of complications and hospitalizations [22].

One of the critical consequences of delayed medical assistance is the increased use of emergency services and hospitalizations. When elderly individuals do not receive the appropriate care in time, their conditions often escalate to emergencies that require urgent hospital admission. These hospitalizations are not only costly for healthcare systems but also place additional strain on patients, who often face longer recovery times and a higher risk of readmission due to the progression of their conditions during the waiting period [17].

The burden of prolonged waiting times for medical assistance is not borne solely by the elderly patients; it also significantly impacts their caregivers. Family members often step in to fill the gaps in care during these waiting periods, taking on the role of primary caregivers despite lacking the necessary medical expertise. This can lead to heightened levels of stress, anxiety, and burnout among caregivers, particularly as the elderly individual's condition worsens [11]. Caregivers may find themselves managing complex medical tasks, such as administering medication or monitoring symptoms, which can be overwhelming without professional support.

The strain on caregivers during this time also affects the decision-making process regarding nursing home transitions. Prolonged waiting times for medical assistance can delay the transition to nursing home care, as families may attempt to manage care at home for longer periods, hoping for improvement or alternative solutions. This delay, however,

often results in elderly individuals being admitted to nursing homes in a much more deteriorated state than if they had received timely care. By the time they are admitted, many patients require more intensive and costly interventions, which places additional strain on nursing home staff and resources [20].

While the administrative tool of regulating waiting times can potentially save costs and reduce the overuse of health services when used appropriately [1], excessively long waiting periods may have the opposite effect. Prolonged waiting times increase healthcare system expenses and can significantly harm the health of patients. The Institute of Medicine (IOM) recognized in 2001 that long waiting times waste both healthcare resources and the time of patients, which in turn affects society as a whole [14]. Extended waiting times also increase the likelihood of complications, hospitalizations, and negative outcomes after treatment, driving up out-of-pocket expenses as patients turn to private healthcare to expedite their care [15]. Moreover, waiting for medical appointments imposes non-monetary costs on patients, such as stress and effort, depending on their illness and life circumstances. Delays in receiving medical care can also negatively impact an individual's ability to work, reducing income and ultimately leading to a lower quality of life [14, 18, 26]. Thus, prolonged waiting times not only affect patients' mental and physical health but also impose significant financial burdens.

As a result, prolonged waiting times for medical assistance before nursing home admission have significant economic implications for healthcare systems, patients, and society. Delays in accessing necessary medical care can lead to worsened health outcomes, increased healthcare costs, and substantial economic burdens on families and caregivers.

Delayed medical care often results in the progression of illnesses to more severe stages, necessitating more intensive and costly treatments. For instance, prolonged waiting times in emergency departments are associated with higher treatment costs and longer hospital stays for elderly patients. A study focusing on critically ill medical patients over 65 years old found that extended boarding times in emergency departments led to increased healthcare expenses and longer intensive care unit stays [12]. Similarly, research indicates that longer wait times for elective hospital treatments correlate with greater consumption of healthcare resources, thereby escalating overall healthcare expenditures [21].

Families frequently incur out-of-pocket expenses for medical supplies, home modifications, and other care-related needs during waiting periods. These expenditures can significantly deplete household savings and strain financial resources, especially for low- and middle-income families. The cumulative effect of these costs can lead to financial instability and increased reliance on public assistance programs. Assuming caregiving duties often requires family members to reduce their working hours or exit the labor force entirely, resulting in lost wages and diminished career advancement opportunities. This reduction in income not only affects immediate financial stability but also has long-term implications, such as decreased retirement savings and reduced Social Security benefits. The economic impact is particularly pronounced among women, who comprise a significant proportion of caregivers and are more likely to experience career interruptions due to caregiving responsibilities.

Caregivers may deplete personal savings or incur debt

to cover care-related expenses, compromising their financial well-being and ability to plan for their own future needs. Additionally, the stress associated with caregiving can lead to health issues for caregivers, potentially resulting in increased medical expenses and further economic hardship.

E.g., prolonged waiting times for medical assistance in the United States have profound economic consequences, impacting both the healthcare system and the broader economy. These delays can exacerbate health conditions, leading to increased healthcare expenditures, reduced workforce productivity, and significant financial burdens on individuals and families. One of the primary economic impacts of delayed medical care is the progression of untreated health conditions, which often necessitates more intensive and costly treatments. For instance, in 2022, approximately 8% of adults reported delaying or not receiving medical care due to cost concerns [22]. This avoidance can result in emergency situations that require expensive interventions, thereby increasing overall healthcare spending.

Chronic diseases, which are prevalent in the U.S., significantly contribute to healthcare costs, especially when treatment is delayed. The Centers for Disease Control and Prevention (CDC) reports that 90% of the nation's \$4.1 trillion in annual healthcare expenditures are for people with chronic and mental health conditions. The financial strain on the healthcare system is further compounded by the high prevalence of chronic diseases. For example, arthritis affects about 53.2 million adults in the United States, leading to over \$300 billion in medical costs and earning losses [6]. Delays in treatment can exacerbate such conditions, resulting in increased disability and higher healthcare expenditures.

Addressing the economic impact of prolonged waiting times for medical assistance requires comprehensive policy interventions. Investing in home and community-based services (HCBS) has been shown to prevent or delay long-term nursing home placement, thereby reducing associated costs [9]. Policies that enhance access to timely medical care, streamline referral processes, and expand the healthcare workforce, particularly in geriatric care, are essential to mitigate the economic burdens on healthcare systems and families. Despite the extensive body of research, the issue of prolonged waiting for medical care prior to hospitalization in a nursing home remains insufficiently explored and requires further in-depth investigation.

The **PURPOSE** of the paper is to analyze the waiting time for medical care among older individuals in Israel and to assess the socio-economic consequences of such delays for the care system. By identifying these effects, the study aims to provide recommendations for improving timely access to care and easing the burden on both families and long-term care systems.

RESULTS

307 families participated in this study. An online survey was sent and completed by caregivers of elderly people. Table 1 shows the socio-demographic information of the sample.

A total of 307 elderly individuals were represented in this study, with slightly more females (53.8%) than males (46.2%). The majority of participants resided in the central region of Israel (57.4%), followed by the north (19.5%), Jerusalem (17.1%), and the south (6.0%).

Table 1 – The socio-demographic information of the sample [developed by the author]

Variable	Response	N	Percentage
Gender of the Elderly	Female	163	53.8%
	Male	140	46.2%
Residential Region	Central	171	57.4%
	North	58	19.5%
	Jerusalem	51	17.1%
	South	18	6.0%
Current Living Situation	Nursing Home	240	79.5%
	At Home	45	14.9%
	Assisted Living	16	5.3%
Religion of the Elderly	Jewish	203	66.1%
	Muslim	73	23.8%
	Christian	17	5.5%
	Other	10	3.3%
	Armenian	4	1.3%
Country of Birth	Western Asia (e.g., Israel)	115	37.5%
	Eastern Europe (e.g., Ukraine, Russia)	92	30.0%
	North Africa (e.g., Morocco, Algeria)	28	9.1%
Marital Status of the Elderly	Widowed	131	43.0%
	Married	113	37.1%
	Divorced	34	11.2%
	Single	18	5.9%
	Separated	9	3.0%
Source of Income	Pension from employment	154	50.3%
	Pension and Income Supplement	31	10.1%
	Income Supplement and Other Sources	24	7.8%
	Pension and Reparations	11	3.6%
	Pension, Reparations, and Income Supplement	2	0.7%

Most of the elderly participants lived in nursing homes (79.5%), while a smaller proportion lived at home (14.9%) or in assisted living facilities (5.3%). In terms of religious affiliation, the sample was predominantly Jewish (66.1%), with smaller groups identifying as Muslim (23.8%), Christian (5.5%), Other (3.3%), or Armenian (1.3%).

Regarding country of birth, the largest group was from Western Asia, including Israel (37.5%), followed by individuals from Eastern Europe (30.0%) and North Africa (9.1%). Marital status varied, with 43.0% of the elderly being widowed, 37.1% married, 11.2% divorced, 5.9% single, and 3.0% separated.

In terms of income sources, half of the sample (50.3%) received a pension from employment. Other combinations of income sources included pension and income supplement (10.1%), income supplement with other sources (7.8%), pension and reparations (3.6%), and a small percentage receiving a combination of pension, reparations, and income supplement (0.7%).

The questionnaire included questions regarding the following topics: Involvement in Decision; Frequency of Visits; Time to Decision; Quality of Home Care; Influence of Hospitalizations on Decision; Influence of Condition Deterioration on Decision; Lack of Factor for Referral; Elderly's Ability to Walk at Home; Elderly's Need for Daily Assistance; Psychological Burden; and financial Burden.

Table 2 shows the descriptive statistics and Pearson correlations between study variables. The study examined the relationships between several key variables associated with elderly care, focusing on factors such as decision-making involvement, quality of care, physical and psychological burdens, and the need for assistance. A correlation matrix revealed significant relationships between these variables, shedding light on the complex dynamics that affect both elderly individuals and their caregivers.

A central finding was the significant positive correlation

between involvement in decision-making and the time taken to make care decisions ($r = 0.18, p < .01$). This indicates that greater involvement of the elderly in the decision-making process is associated with a longer decision-making period. Interestingly, this greater involvement also correlated positively with satisfaction with the quality of home care ($r = 0.13, p < .05$), suggesting that when the elderly have more input in care decisions, they report higher levels of satisfaction with the care they receive. However, this dynamic is nuanced, as higher levels of education were negatively correlated with satisfaction in home care ($r = -0.14, p < .05$), indicating that more educated individuals may have higher expectations for care quality that are not always met.

The results also highlighted the significant impact of health deterioration on both the elderly and their caregivers. As health declines, the need for daily assistance increases, as indicated by the strong positive correlation between condition deterioration and the need for daily help ($r = 0.22, p < .01$). Moreover, this decline also corresponded with increased psychological burdens on both the elderly and their caregivers ($r = 0.26, p < .01$). These findings illustrate the wide-ranging effects of worsening health conditions, which contribute to both emotional and logistical challenges in caregiving.

Another important factor identified in the study was the lack of a referral system, which was positively correlated with the influence of hospitalizations on decision-making ($r = 0.32, p < .01$). This suggests that when hospitalizations play a significant role in care decisions, the absence of a clear referral pathway becomes more pronounced, increasing the burden on caregivers to navigate the care system independently. Additionally, a lack of referral guidance was associated with higher levels of involvement in decision-making ($r = 0.13, p < .05$), perhaps reflecting the need for families to fill the gaps left by inadequate professional input.

Table 2 – Descriptive statistics and Pearson correlations between study variables [developed by the author]

	1	2	3	4	5	6	7	8	9	10	11	12
1. Elderly's Education												
2. Involvement in Decision	-0.06											
3. Frequency of Visits	-0.05	0.01										
4. Time to Decision	0.01	0.18**	0.04									
5. Quality of Home Care	-0.14*	0.13*	0.15*	0.01								
6. Influence of Hospitalizations on Decision	-0.02	0.04	-0.08	-0.03	-0.07							
7. Influence of Condition Deterioration on Decision	0.11	-0.1	-0.01	-0.05	-0.03	0.07						
8. Lack of Factor for Referral	-0.05	0.13*	0.01	-0.07	0	0.32**	0.1					
9. Elderly's Ability to Walk at Home	0.04	0.04	-0.06	-0.06	0.04	-0.03	0.01	-0.08				
10. Elderly's Need for Daily Assistance	-0.12*	-0.14**	0.14**	0.07	-0.03	0.12	0.22**	0.08	-0.36**			
11. Psychological Burden	0.07	-0.13*	0.07	0.07	-0.03	0.05	0.26**	0.05	-0.15*	0.21**		
12. Financial Burden	-0.12*	0.06	0.09	0.17**	0.06	0.15*	0.09	0.13*	-0.12*	0.20**	0.25**	
Mean (M)	2.11	2.37	3.95	3.05	3.74	3.19	3.72	2.19	3.31	2.46	3.2	2.42
Standard Deviation (SD)	1.38	1.17	1.15	1.58	1.22	1.06	0.61	0.85	1.3	0.66	0.9	0.95

The need for daily assistance emerged as a crucial variable, negatively correlated with the elderly's ability to walk at home ($r = -0.36, p < .01$). This relationship underscores how reduced mobility significantly increases the need for caregiving support. It was also linked to greater financial ($r = 0.20, p < .01$) and psychological burdens ($r = 0.21, p < .01$), demonstrating that the need for daily help contributes to a range of challenges for families.

Financial burden, in particular, was a recurring theme throughout the study, significantly associated with increased psychological stress ($r = 0.25, p < .01$). Frequent hospitalizations also contributed to financial strain ($r = 0.15, p < .05$), indicating that ongoing medical needs place considerable pressure on families already struggling to meet caregiving demands.

In terms of descriptive statistics, the highest reported average was for "Frequency of Visits" ($M = 3.95, SD = 1.15$), reflecting frequent professional interactions in the home care context. In contrast, "Lack of Factor for Referral" had the lowest average ($M = 2.19, SD = 0.85$), suggesting that professional guidance and referrals are relatively scarce. The standard deviations indicated that some variables, such as "Time to Decision" ($SD = 1.58$), displayed higher variability, pointing to differences in the decision-making experience among participants.

In order to examine differences across residential regions, one-way Analysis of Variance (ANOVA) tests were conducted (Table 3). These tests aimed to determine whether differences existed among elderly individuals residing in the center, north, south, and Jerusalem regions with respect to the following variables: satisfaction with the quality of care received at home, frequency of visits by a doctor or nurse at

home, frequency of community nurse visits, frequency of physiotherapist visits, and frequency of visits by a geriatrician or psychogeriatrician. The results are presented in Table 2. The data indicate significant differences between regions only for the variables of satisfaction with the quality of home care [$F(3, 291) = 6.86, p < .001$] and frequency of community nurse visits [$F(3, 284) = 8.84, p < .001$].

To identify the source of these differences, Bonferroni post-hoc tests were performed. For the variable of satisfaction with the quality of home care, it was found that satisfaction in the northern region was significantly higher than in the southern region ($p = .011$), Jerusalem ($p < .001$), and the center ($p = .006$). No significant differences were found between satisfaction levels in the southern, central, and northern regions. For the variable of community nurse visits, post-hoc analyses revealed that the frequency in the center was significantly lower than in the southern region ($p = .011$) and northern region ($p < .001$). Additionally, the frequency of visits in Jerusalem was significantly lower than in the northern region ($p = .027$).

CONCLUSIONS

The study highlights key economic and managerial challenges within the long-term care system for older adults, particularly in relation to their involvement in decision-making, the burden placed on caregivers, and regional disparities in service access. From a management and policy perspective, the findings emphasize the need for patient-centered approaches, structured service coordination, and targeted support for caregiving families.

The involvement of older individuals in decision-making processes has been found to enhance satisfaction with

Table 3 – Results of One-Way ANOVA: Descriptive Statistics by Region for Elderly Care Variables [developed by the author]

Variable	South (N = 18)		Jerusalem (N = 51)		Center (N = 169)		North (N = 57)		F (df)	p
	M	SD	M	SD	M	SD	M	SD		
Satisfaction with Quality of Home Care	3.33	1.33	3.41	1.2	3.73	1.21	4.33	0.95	6.86 (3, 291)	< .001
Frequency of Doctor/Nurse Visits at Home	3.67	1.24	3.84	1.36	3.75	1.48	3.69	1.37	0.13 (3, 289)	0.944
Frequency of Community Nurse Visits	2.53	1.23	1.81	1.14	1.68	1.01	2.4	1.07	8.84 (3, 284)	< .001
Frequency of Physiotherapist Visits	1.41	0.51	1.73	1.15	1.48	0.95	1.57	0.9	1.04 (3, 290)	0.376
Frequency of Geriatrician Visits	2.15	0.8	1.83	0.88	1.73	0.85	1.9	0.83	1.35 (3, 233)	0.258

care services, yet it also extends administrative timelines, necessitating adaptation of management models to these evolving dynamics. As patients' health deteriorates, the demand for intensive daily care increases, leading to higher expenditures for both households and the state, while simultaneously contributing to caregiver burnout. This underscores the need for adequate funding of caregiver support, training, and burnout prevention programs.

Particular attention should be given to reforming the referral system – currently, the absence of clear care pathways

leads to disorganized decision-making and inefficient resource utilization. Regional disparities in access to quality care further indicate the need for a more balanced allocation of resources and optimization of service delivery models.

The study's findings can serve as a foundation for strategic managerial decisions aimed at improving the efficiency of long-term care systems, reducing financial strain, and promoting more equitable access to healthcare and social services for the elderly.

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ТРИВАЛЕ ОЧІКУВАННЯ МЕДИЧНОЇ ДОПОМОГИ ПЕРЕД ГОСПІТАЛІЗАЦІЄЮ ДО БУДИНКУ ПРЕСТАРІЛИХ: УПРАВЛІНСЬКО-ЕКОНОМІЧНІ АСПЕКТИ

У контексті глобального старіння населення питання ефективного управління ресурсами у сфері охорони здоров'я набуває стратегічного значення. Затримки у наданні медичної допомоги особам похилого віку не лише погіршують їхній фізичний стан і збільшують кількість госпіталізацій, але й призводять до зростання фінансового навантаження на домогосподарства та системи довгострокового догляду. Крім того, непрогнозовані витрати та збільшення потреб у спеціалізованому догляді ускладнюють планування бюджету як на мікро-, так і на макрорівні.

Метою дослідження є аналіз тривалості очікування медичної допомоги літніми особами в Ізраїлі та оцінювання соціально-економічних наслідків таких затримок для системи догляду, а також розроблення управлінських рішень для її оптимізації. Особливу увагу приділено критичному етапу переходу від домашнього до інституційного догляду, що вимагає значних фінансових та організаційних зусиль.

У дослідженні проаналізовано системні, економічні та управлінські чинники, що обумовлюють затримки: неефективна координація між службами, обмежене фінансування первинної медичної допомоги, недостатній розвиток інфраструктури довгострокового догляду. Поперечне опитування 307 членів родин літніх осіб дало змогу виявити ключові ризики: збільшення витрат на догляд, емоційне вигорання опікунів, зниження якості життя пацієнтів.

Залучення пацієнтів до процесу прийняття рішень продемонструвало двоякий ефект: з одного боку, це подовжувало період ухвалення управлінських рішень, а з іншого – підвищувало задоволеність від отримуваних послуг. Водночас серед осіб з вищою освітою спостерігалось зростання критичності стосовно якості догляду.

Погіршення фізичного стану літніх людей призводило до необхідності інтенсивнішого щоденного догляду, що прямо впливало на зростання витрат як з боку держави, так і з боку домогосподарств. Зниження мобільності супроводжувалося збільшенням потреб у спеціальному обладнанні та послугах, що генерувало додаткове навантаження на систему соціального забезпечення.

Отримані результати висвітлюють необхідність розроблення та впровадження ефективної управлінської моделі координації між медичними та соціальними службами, що передбачає раннє виявлення потреб пацієнтів, фінансову підтримку родин, які здійснюють догляд, та гнучке бюджетування довгострокових програм догляду. Рекомендації дослідження може бути застосовано управліннями та політиками для підвищення ефективності прийняття рішень, забезпечення сталого фінансування та покращення якості життя осіб похилого віку.

Ключові слова: люди похилого віку, економічний тягар, прийняття рішень, залучення сім'ї, будинки престарілих, управління