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FOREWORD

The National Insurance Institute is happy to present the third issue of the *Social Security Journal* in English, published every few years, to the professional community.

As in the past, the volume includes selected articles which appeared in the Hebrew editions of *Social Security* over the past two years. Unlike in previous years, it was decided this time not to concentrate on a single topic, but rather to present a variety of topics which together provide an updated picture of what has been happening in Israel in the different fields of social welfare: problems high on the public agenda, the different approaches to these problems, achievements and failures.

Two articles on the subject of health are presented here, in order to present the background to the controversy over the introduction of the State Health Insurance Law in Israel; the first — a glimpse at the various medical services of the 1990s, focussing on the trends of change in these services, such as a reduction in the government's role as provider of health services and a parallel strengthening of individual responsibility and the private market in this area. The second — a summary of the conflicting approaches at the root of the debate over health policy in Israel, as expressed in the Majority and Minority Reports of the State Commission of Inquiry submitted to the Prime Minister in August 1990, and reflected in the new Law.

Also connected to the field of health is another article which brings a historical description and analysis of mental health policies and services in Israel, while discussing the question whether the limited development of these services in the community, the dominance of the mental hospital in the provision and administration of these services and the strengthening of the medical orientation of the system of services are a sign of progress or of stagnation in the field.

The article devoted to the Long-Term Care Insurance Law covers four years of the law's implementation and reviews the achievements of the Law and the implications of these achievements, particularly concerning the issue of integration among the various systems — the state, the community and

the private sector — as a basis for the provision of services and benefits to the needy target population groups.

Another article deals with the organizational dilemmas in the provision of home care services. The theoretical framework of the discussion is based on a political economy model of organizations, according to which the methods of service and provision are a function of adjustment to economic and political forces in the internal and external environment, in this case, mainly: the existence of a turbulent environment, a service technology, a service delivered outside the organizational boundaries, and reliance on unskilled labor.

Since Israeli society lives in a state which has been characteirzed since its establishment by, on the one hand, hostile actions against its citizens and on the other hand, a steady absorption of immigrants from all the diasporas, this issue includes two comprehensive surveys of the following subjects: the historical development of social policy as regards civil casualties of hostile actions until their recognition by law in 1970 as entitled to the benefits granted to injured soldiers and to families of fallen soldiers; the Israeli population's positive/negative attitudes to the immigrants of the 1990s, based on a comparison of the findings of surveys of attitudes of the Israeli public towards immigration in general and towards immigrants in particular, carried out between 1986 and 1992. In addition, operative questions are examined regarding the capacity of the veteran population to spontaneously develop transitional systems of non-formal support as well as the policy regarding population.

A problem not unique to Israel — unemployment and insurance against this contingency — is dealt with in an article which examines the historical development of the Unemployment Insurance Law since the first two decades after the establishment of the state, when it was subject to opposition on the part of the political leadership — until the enactment first of the Law in 1973 and later of the various amendments up to the middle of the 1990s, as a function of the changing attitudes on this subject.

This issue of *Social Security* closes with an article on the multi-dimensionality of social justice judgements among eighth and ninth graders in junior high schools in Israel — the generation of the future, who in due time will be the policy makers of social security. The content facets are: (a) nine distributive values derived from the three basic principles of justice; (b) four resources: money, prestige, power and educational opportunities. It was proposed to examine the similarities and differences between the social justice judgements of youth and those of other age groups — adults

and children — as well as what is universal in the system and what is unique to each culture.

I would like to thank Ms. Irah Kahneman, Director of the Publications Department and Chairman of the Editorial Board of this important and prestigous journal, as well as Mr. Shlomo Cohen, Deputy Director General, Research and Planning, in the National Insurance Institute, which sponsors the publication of the journal.

My thanks are extended also to all the authors who agreed to publish their articles in the present issue of the journal, thereby contributing greatly to the Israeli experience in the fields under discussion.

Yossi Tamir
Director General
National Insurance Institute of Israel

THE HEALTH SERVICES IN ISRAEL: THE PROSPECT OF THE 1990s

by Prof. Abraham Doron*

Introduction

Israel is presently in the midst of a crucial debate about the future of its health care services. For a long time, the social organisation of Israeli health care has been at the center of a political controversy that characterised it since pre-statehood times. While the earliest debates centered mostly around means rather than ends, the prevailing consensus was that medical services should be organised on a collective basis and be free at the point of use, by the early 1990s the focus of the debate had changed. The debate was no longer about means, i.e. the proper social organisation of collectively provided health care services, but about the nature and extent of collective responsibility for the provision of health care.

Even before Israel's independence in 1948, it was generally agreed in the Jewish community that health care should be provided through a socially organised arrangement. The Zohar committee, appointed in 1977 by the first right wing Likud government headed by Mr. Menachem Begin, had a mandate to review the existing health care system. Even this mostly conservative group endorsed the earlier position, by declaring that: "In one way or another the provision of health care must be the responsibility of the state" (Report of the Committee for Reform of the Health Services, 1978, *p. 1*).

In recent years, however, this consensus has broken down. Although the current debate continues the formal commitment to maintaining governmental responsibility for health care services, the focus has shifted from the collective provision of health care to the introduction of market

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forces. In particular, the planned reforms include higher user charges, the privatisation of parts of the health care system increased competition, and the transformation of health care into a self-financing system devoid of direct support from general revenues. The hidden agenda in this debate is how to change the existing collective system of provision which is committed in principle to providing the whole range of medical services at no cost at the point of use, to a hierarchical service in which access will be increasingly controlled by the ability to pay.

The Evolution of the Existing Health Care System

The social ogranisation of health care in Israel is based on voluntary or semi-voluntary health insurance in public non-profit sick-funds, known as Kupat Holim. Most of the sick funds have a long standing political identity, or are in one way or another affiliated with political groups. The largest of these sick funds, the General Kupat Holim, is run by the Histadrut (the General Federation of Labour) and is politically affiliated with the Israeli labour movement. The General Kupat Holim covers nearly 70 percent of the total population. The other sick funds cover an additional 24 percent. In effect, the current arrangements provide health insurance coverage to about 94 percent of the country's population.

In recent years there has been a significant change in the composition of the membership in the various sick funds. In the middle 1980s the General Kupat Holim covered 85 percent of the employee population and about 70 percent of the non-employee population (Report of the State Committee of Inquiry on the Functioning and Efficiency of the Health Care System in Israel, 1990, p. 37). However, the membership of the employee population in the General Kupat Holim has declined in the last few years, and by 1989, only 76 percent of employees remained while the others moved to various sick funds (National Insurance Institute, 20 November 1990). This trend has continued since then. Stronger employee groups tend to leave the General Kupat Holim and move to other, smaller sick fundns, that claim to provide better and more efficient service to their members.

The evolution of the voluntary, non-profit sick funds has its historical roots in the Israeli labour movement. As in many European countries, public medical services in Israel developed initially within organised labour. The General Kupat Holim was established in 1911 by the then agricultural workers union (Halevi, 1979). The essential purpose of this consumer-operated and funded organisation was to protect the welfare of its members in times

of illness. Unlike many other nations, the organisation of health service consumers in Israel preceded the organisation of health care providers.

As a consumer movement, the General Kupat Holim grew up in the special circumstances that marked the development of Israeli society. Specifically, the General Kupat Holim developed at a time when most of the population had a low standard of living; when there was an abundant supply of doctors with a relatively weak professional organisation; and when the medical profession contained a significant body of opinion that identified with the collective aims of the country rather than with the pecuniary self-interest of its members.

Under these circumstances the General Kupat Holim (and the other sick funds) was able to develop rapidly and to provide its members with a fairly comprehensive range of medical services. The decisive factor in the orientation of the Kupat Holim was the strong influence of consumers in determining the policies of the organisation. In the ensuing years these favourable conditions gradually changed and led to increased difficulties in maintaining the organisation based on its initial consumer orientation.

In the last decade the Kupat Holim system has experienced increased difficulties, including: (1) ever growing strains in its relationship with the medical profession; (2) the rising cost of medical care; (3) the changed attitudes of the Israeli government towards the Kupat Holim system; and (4) the negative impact of increased bureaucratization and inefficient management of its consumer-members.

First, as the medical profession and its professional association grew in strenght during the last two decades, it became a powerful organisation that militantly promoted the self interest of its members. The friction between the management of the Kupat Holim and the doctors sharpened as the balance of power gradually shifted to the doctors. The struggle increasingly became a contest for power between the providers and consumers of medical care. As a result, the doctors' strikes grew in frequency throughout the 1980s and they regularly undermined the normal provision of medical care for the population.

Secondly, the cost of medical care in Israel (like other countries) increased sharply over the last two decades. Expenditure on health care as percentage of GDP grew from 5.7% in the years 1970–1974 to 7.3% in 1980. Although in 1985 the percentage of GDP spent on health care was slightly lower and stood at 6.9%, throughout the 1980s these expenditures ran at about 7.2% and they increased again at the early 1990s to 7.9% (Budget Proposal of the Ministry of Health for the Fiscal Year 1994). Per capita health care

expenditures increased from US $504 in 1980 to $860 in 1987 (Almog, 1990). Since the early 1960s, the annual rates of change in health expenditure have been higher than those of the population growth (Shamai & Tamir, 1991).

The increase in health care costs can be attributed to several factors. For one, the growth of the elderly population has increased the strain on the health care system and led to higher costs (Even though Israel's elderly population in 1980 was only 9 percent, lower than any OECD country, it still added up to significant health care expenditures). The effect of the "global economy of medicine" was also felt in Israel. In particular, the growth of medical technology in the western world has dramatically raised consumers' expectations of medical care. especially for the middle classes. No longer content with an emphasis on widespread primary care, consumers expect state-of-the-art medical care replete with the newest and most sophisticated technology, medicines, and medical procedures. Moreover, doctors and especially specialists located in hospitals, demand the level of facilities, laboratories, and equipment available in the more advanced medical centers in the US and Western Europe. These expectations both on the part of consumers and the Medical profession result in significantly higher medical costs.

Thirdly, the main sources of income for the sick funds are the contributions paid by insured members, a parallel health insurance tax paid by employers, and health care fees paid directly by consumers. All of these were increased considerably in the last decade. However, wages and incomes to which employee and employer contributions are linked have remained static since the late 1980s, and even suffered a slight decline in the 1990s. The income of the sick funds inevitably lagged behind the costs, especially for the General Kupat Holim, which covers most of the low-income population.

Moreover, the direct contribution of the government to the sick funds decreased sharply during the 1980s. For example, government contributions fell from 7 percent of the total sick fund expenditure in 1984 to only 2 percent in 1988 (Almog, 1990), and it has fallen even further since. The system of sick funds in general, and the General Kupat Holim in particular, were faced with increasing difficulties in financing and maintaining its services.

Fourthly, the ascent to power of the right wing Likud bloc in 1977 brought to an end the long rule of the Israeli social democratic labour parties. Most labour governments were favourably disposed towards the General Kupat Holim and they provided it with generous financial and other help. This ended abruptly in the late 1970s. Since then, the government's attitude toward the Kupat Holim has remained cool, and at times, outrightly

hostile. Very little change occured in this attitude with the advent of the newly elected Labour government in 1993. Consequently, the General Kupat Holim found itself increasingly immersed in crisis situations, without the benefit of sufficient governmental help.

Fifthly, the General Kupat Holim began its operation as a very small organization. For a long time it succeeded in preserving intact its consumer-oriented membership base. However, with continuous growth it gradually became more bureaucratised and lost touch with much of its membership. Given the above difficulties, i.e. problems in funding, the strained relationship with doctors, and the strained relations with the government, it became increasingly more difficult for the Kupat Holim to provide an efficient and satisfactory service. Though in principle it continues to maintain its consumer orientation, in practice it was forced to curtail and ration its services by instituting consumer fees, having long waiting lists for hospital and specialist services, and by adding other types of red tape and delays.

In combination with the growing dissatisfaction of the population with the existing health care system, these difficulties led to a health care crisis throughout most of the 1980s. This crisis eventually paved the way for the growing demand that the government step in and provide a solution to the necessary but long delayed reforms in the health care system.

The Nature of the Reform Debate

Two main periods can be distinguished in the long debate about reforming the Israeli health care system. First, there was the period until the middle 1980s, in which the debate was chiefly about the means, i.e., how the national health care system should be organised. In the second and subsequent period, the debate increasingly took the form of disputing the ends, i.e., the proper role and function of a national health care system.

The main thrust of the debate from pre-statehood until the middle 1980s involved the rivalry for control of health care between the Histadrut affiliated labour parties and the non-labour parties of the political right. These parties, and in particular the Herut (Freedom) party (the predecessor of the Likud), never became reconciled to the control over important social resources, such as health care, that remained with the labour movement. Statehood added a further dimension to this controversy; namely, the rivalry between the government and the General Kupat Holim over the latter's provision of medical care to the majority of the population. The political and ideological debate on this issue never abated and it faithfully mirrored the constant struggle for power in Israeli society.

This long debate eventually produced change proposals intended to achieve two main goals: (1) to change the voluntary basis of the system into a statutory and compulsory requirement; and (2) to remove the responsibility for the provision of health care from the politically affiliated voluntary sick funds and transfer it to the state. However, the labour parties' support of the sick fund system prevented such a radical change. On the other hand, the right wing parties never acceded to a solution preferred by labour; that is, to introduce a state-sponsored compulsory health insurance scheme operated by the existing sick funds. Because of this struggle, little progress was made until the middle 1980s.

In the middle 1980s the debate changed and it became increasingly focussed on how to weaken the collective nature of the health care system by opening it to private medicine and market forces. This change in direction found expression in the recommendations of two major public committees in the late 1980s that were entrusted with the task of reviewing the health care system. It also found expression in the policy statements of people at the top of the country's political, economic, and medical establishment.

Both of the two public committees on health care chose to recommend a breakaway from the current arrangements by openly introducing market elements into the public health care system. The Trainin Committee recommended the establishment of a system named "Sharan" (Additional Medical Care) under which government and public health care facilities would offer the sale of medical services at market prices to those willing and able to pay (Recommendations of the Public Professional Committee on Policy Making and the Organizational and Functional Structure of the Health System, 1988). In-fact, the proposal was intended to legitimate the provision of private medical care within the public system and to thus create a two tier system of health care differentiated by the capacity to pay.

In the same vein, the Netanyahu Committee recommended the "incorporation of private medical care into the public health care system" (Report of State Committee of Inquiry on the Functioning and Efficiency of the Health Care System, 1990). These recommendations included a number of limitations on proposed private care so as to prevent the danger of abuse. Basically, it also envisaged the creation of a class-based two tier system of medical care. This time, the Likud's Minister of Health accepted these recommendations without delay and announced that he would proceed with their implementation.

Actually, the recommendations of the two committees only reinforced the officially stated positions of people at the top of Israel's political and

economic establishment. The then Minister of Finance, Mr. Yitzhak Modai, repeatedly stated that he would like to sell the government hospitals to private companies and turn the health services into a marketplace commodity, such as car insurance. The Governor of the Bank of Israel, Prof. Michael Bruno, declared that he is "absolutely for privatisation in the area of health care, and those able should purchase medical care for themselves". He added, however, that "the state should nevertheless provide some minimum to those without the capacity to do this" (*Yediot Achronot*, 26 October 1990).

The medical establshment voiced similar opinions. The most explicit support for these views was given by Prof. Penchas, the head of the highly influential Hadassah Medical Orghanization. While outlining the future direction of medicine, Prof. Penchas emphatically argued for two different levels of public medical care: a basic level available to all within the framework of a public health insurance scheme, and a higher level, in accordance with the degree of sophistication and medical procedures, which will be provided for pay. Prof. Penchas added an ideological justification, stating that there is a social consensus and "readiness to agree on the existence of two levels of medical care and two 'classes' of recipients of care". According to Penchas, this consensus is a direct result of a general economic liberalisation that makes possible free choice in the medical care field (Public Health and the 21st Century, 1990).

These opinions of the Issraeli establishment are a far cry from the traditional and earlier support for a health care system that is universal and free at point of access. The current mode of thinking appears to be directed at weakening the public-collective dimension of Israeli health care provision.

Under these circumstances the question is how and in what manner will Israeli society redefine its social policy goals with regard to the organisation and provision of health care. These issues exist on at least three levels: (1) Will the ends of the future policy be directed towards a fair and equitable distribution of health care services? (2) What form might the social organisation of the health care system take? (3) What are the prospects for health care services to remain accessible to all classes and population groups on the distributional ladder?

While it is difficult to provide a precise answer to these questions, at the beginning of the 1990's there were three possible directions in which the Israeli health care system could have evolved. First, the continuing functioning of the Kupat Holim sick funds as consumer-oriented organisations motivated to safeguard the interests of their members. Secondly, the establishment

of some form of national health insurance with an ensuing change of orientation. Lastly, privatization of significant parts of the existing health care system and their maintenance on a commercial for-profit basis.

The Continuing Maintenance of the Kupat Holim System

In the first scenario, the existing health care arrangements would have continued to operate in more or less the same manner as in the past, with only small incremental changes. Under these arrangements, the sick funds, and especially the General Kupat Holim of the Histadrut, were envisaged to continue to play a major role in shaping the orientation of the system and in providing health care services to the entire population.

The political climate that evolved since 1993 made, however, the materialization of this scenario increasingly difficult. Eventually, with the passing of the National Health Insurance Law in the summer of 1994, it became mostly obsolete. The social and political drama which led to the demise of the existing Kupat Holim system included some extremely complicated factors.

Untill recently, the affiliation of the major sick funds to political movements provided them with a major source of support, financial and otherwise, and made it possible for them to operate under various adverse conditions. For instance, the health care services provided by the General Kupat Holim remained a major factor in the mobilisation and maintenance of members for the Histadrut. Histadrut membership fees were a combination of union fees and health insurance contributions. The fees collected thus constituted a major financial resource of the Histadrut that made possible its functioning, and the functioning of other political organisations affiliated with it. The survival of the Histadrut, in its present form, seemed to be, to a large degree, dependent on its connections with the Kupat Holim.

The organisational survival of the Histadrut was in itself not a sufficient cause to justify the continuing existence of the Kupat Holim system. One has also to take into account the political aspiration of the Histadrut, and of large parts of the labour movenment supporting it, to continue maintaining the consumer-member orientation of the Kupat Holim and its commitment to the equitable provision of health care services. It is these elements which for many years generated the support for the Kupat Holim among large segments of Israel's working population.

However, there were other important factors working in an opposite direction. First, the right wing political forces in Israel were united in

their opposition to the maintenance of what they considered a politicised health care system. Paradoxically, for many years the political right has advocated the introduction of national health insurance while the labour parties have strongly opposed it. When the right wing Likud bloc assumed power in 1977 its declared policy was to bring an end to the existing sick fund system. In practical terms the Likud governments pursued policies openly hostile to the General Kupat Holim by starving it of funds, thereby threatening its capacity to survive. The dismantling of the Kupat Holim did not materialise because of a lack of will, but because the government did not have a viable alternative to replace it.

For the first time an ideologically acceptable and feasible alternative was provided by the Netanyahu committee report. This report recommended the introduction of a national health insurance scheme that would bring to an end the consumer-oriented sick funds. To the extent that the sick funds would be able to survive under the new system, they would have to transform themselves into organisations of providers operating under contracts from the national health insurance authorities. It was, therfore, no surprise that the Likud government hastened to adopt these recommendations.

Secondly, the traditional source of support for the Kupat Holim, i.e., the Labour movement and the Labour Party, declined significantly in recent years. The rapid deradicalisation of the Labour Party, and the lack of commitment among some of its younger leadership toward an egalitarian health care system did not bode well for the sick fund system. Also, the Labour Party became tired of its support for the Kupat Holim. Most of its leaders do not want any longer to bear the responsibility for providing health care to most of the population. For instance, the present Prime Minister and leader of the Labour Party, Mr. Yitzhak Rabin, openly declared his support for national health insurance during the 1992 election campaign. In practice, support for national health insurance effectively meant the abandonment of the Kupat Holim system (Levi, 1992).

Thirdly, for some time developments within the General Kupat Holim cast doubts on its capacity to function in a satisfactory manner and to meet the health care needs of its members. Specifically, the growing bureaucratization of the Kupat Holim has severely eroded its membership base. Although the quality of primary care has improved somewhat in the last few years, it had remained far from being adequate. Kupat Holim members continue to encounter great barriers in accessing specialist services and hospital care. The introduction of charges for prescription drugs and a range of other services, has not endeared the Kupat Holim to its members.

Lastly, the increasing difficulty of the Kupat Holim to efficiently manage its finances and maintain industrial peace with doctors, has contributed to a general feeling of dissatisfaction with the system. However, in spite of its limitations and the growing wave of opinion against it, the Kupat Holim was thought to remain the last bastion of defense against dismantling a basically egalitarian health care service.

Establishment of a National Health Insurance Scheme

Of all the possible scenarios, the one that stands out is the creation of a national health insurance scheme. The bill to establish such a scheme introduced by the present Labour government was passed, after long and acrimonious debates within the Labour party itself, by the Knesset (Israel's parliament) in the summer of 1994. In this legislation the government accepted direct responsibility for the provision of health care to the entire population. When implemented, it would result in the abolition of the sick fund system in its present form. While the actual production and delivery of health care services may remain in the hands of non-governmental bodies, including most of the existing sick funds, these will cease to be consumer organisations and function mainly as contractual providers of services to the national health insurance scheme.

The new legislation would certainly have an important impact on the functioning of the Israeli health care system. In principle, national health insurance may provide a solution to some of the more difficult problems of the existing system. For example, it extends coverage to all residents; it removes discrimination in coverage on the basis of age, organisational affiliation, employment status, chronic illness or disability, and so forth; it promised to assure the provision of a clearly defined basket of medical services to all; and, above all, it grounds the health care system on a firmer financial footing and may thus resolve the perennial crisis of insufficient resources.

The possible implementation of these changes have to be judged within the context of the prevailing political climate in Israel. Given the strong opposition to a publicly-funded health care system among the ruling elites, there is a serious danger that national health insurance could fall short of its goals. Instead, the new national health insurance system may even exacerbate the existing difficulties and actually raise the barriers of access for most of the population.

Putting into effect of the new national health insurance scheme would

comprise the following: (1) it would concentrate all decision making power for health care financing in the hands of the Finance Ministry; (2) it would transfer control of the actual operation of the health services to doctors and other service providers; (3) it would mostly neutralise the influence of the existing consumer-oriented organisations currently involved in the provision of health care.

Under the new scheme, all the crucial financial decisions would invariably gravitate into the hands of a small group of senior officials in the Ministry of Finance. Supporters of the scheme claim that this will bring about a depoliticisation in the allocation of health care resources. While a certain degree of depoliticisation is possible, the senior Treasury officials although apolitical in one sense, are highly political in another.. Most are identified with a free market economic approach committed to reducing general public expenditures, especially social welfare expenditures. Moreover, as mentioned earlier, some of the top financial advisers to the government, are openly hostile to the public provision of health care services. In fact, many Finance Ministry officials consistently advocated for privatisation, the widespread use of charges and means testing in health care, and have encouraged private medical practice and the spread of private health insurance.

One has to bear in mind that this group of civil servants has gained almost unparalleled power in the Israeli political and economic system. This concentration of power stems partly from the absence of any clear ideology with regard to social policy among the leading political parties. Due to the lack of clear orientation to social policy, economic arguments tend to prevail, and these are mostly of the new-conservative or new-right persuasion. It is therefore reasonable to assume that these same economic attitudes will prevail in the allocational decisions of the national health insurance scheme.

On the other hand, the replacement of the sick fund system by national health insurance will neutralise the power of consumer-oriented organisations in the production and delivery of medical care. For a long time, Israeli doctors were well aware of the power of the sick funds to determine the nature of health care provisions. In their struggle against the Kupat Holim, they claimed that only physicians as qualified professionals have the capacity and skills to run the health care services. They also argued that medical services must become depoliticised and that the responsibility for health care needs to be removed from the control of the particularistic, politically affiliated, sick funds. The establishment of national health insurance would

at last make it possible for doctors to achieve their long cherished goal — the practical control of the health services.

Regardless of the logic claimed by the medical profession, there is no assurance that medically-controlled services would be more responsive to the general welfare of the population. In fact, there is much evidence to the contrary. Specifically, such control may effectively raise the barriers of access for large groups in the population. Moreover, the only solution offered by doctors in the last decade was to allow them to practise privately in addition to their regular salaried positions. This practise was to occur in public health care facilities and hospitals. This claim was accepted by the Trainin and Netanyahu committees, which recently reviewed the functioning of health care services. It was also accepted by Mr. Ehud Olmert, the former Minister of Health, as part of his plan for the partial privatisation of the major government hospitals (Ishai, 1994). While such a change would certainly serve the pecuniary interest of doctors, it is extremely doubtful whether it will improve access to medical care for those unwilling or unable to pay the private fees.

Not surprisingly, top civil servants in the Ministry of Finance support the demands of doctors to enlarge their private practice in publicly owned health facilities. In part, this support is based on the similarity of political and ideological views between the civil servants and the doctors. It is also based on the perception that enlarged private practice is a natural precursor for the eventual privatisation of health care services. Furthermore, it is a way to deflect the continuous claims of doctors for higher pay (from the public purse) by enabling them to augment their incomes by directly charging their patients.

In theory, the establishment of a national health insurance scheme sounds highly promising, and it has a strong appeal to important groups in the Israeli population. The law establishing the scheme has received wide support in the Knesset. However, the results of this reform could be entirely different. Instead of improving the health care system, the reform could make it more difficult for Israelis to receive proper medical care.

Privatisation

Following developments in other countries, privatisation has become a fashionable solution for many social and economic problems in Israeli society. Consequently, a variety of proposals to privatise all or some health care services were discussed in the last few years. But, no concrete plan was

presented to the public. Despite this lack of a clear policy, various forms of privatisation are currently being implemented in the health services.

Privatisation often takes various unconspicuous forms. For example, one form of privatisation is the continued increase in health service charges. Secondly, new complementary private health insurance plans are being launched to cover medical services that were intended to be covered by the existing public arrangements. Lastly, private medical practice is spreading within public and government-owned health care facilities. All of these measures are basically indirect or hidden forms of privatisation. All of them also have significant effects on access to medical care, especially for weaker population groups.

In addition, two further dimensions of privatisation are being seriously discussed: (1) contracting out to private firms for the production and delivery of key medical services, and (2) the corporatisation of the health care system.

Contracting out for the production and delivery of medical care to private, mostly for-profit firms, is usually presented as a way of reducing costs, increasing competition, providing more choice, and making the system more efficient. It is doubtful whether in practice any of these goals can actually be achieved, or even whether their unintended results are worthwhile. The motivating factor for their use, however, is predominantly ideological and the real outcomes have only a marginal value in this debate.

In instances where a reduction of costs by contracting out was actually achieved, it was often obtained with the clear understanding that a low level, substandard service, will be provided to clients. Private hospitals for the long-term chronically ill in Israel are a case in point. They provide a low level of custodial care that has been repeatedly criticised as inadequate by the State Auditor (State Auditor Report, 1976, p. 261, and 1985, p. 221). In effect, these hospitals serve more as an alibi for government to release itself from the responsibility of providing a proper service.

Corporatisation means the large scale entry of for-profit corporate firms into the production and delivery of health care and other social services. It also reflects the preference for market strategies in dealing with social problems (Stoesz & Karger, 1991). Such a shift to a corporate mode of health care entails a major transformation in the public responsibility for health services. It may also lead to the build up of a new medical-industrial complex which will eventually encroach on the public, government, and voluntary health care services and engender a fundamental change in the character and purpose of a nation's health care system (Salmon, 1990, pp. 5–9).

Essentially, corporatisation of the Israeli health care system will mean a massive roll back of the accepted and long standing system of public provision. It will mean a reordering of priorities in the provision of medical care to the entire population. And, it will mainly affect the most vulnerable population groups in their ability to access and use these services.

All of these dimensions of privatisation are policy options that may in the near future shape the country's health care system, notwithstanding the national health insurance scheme. These options have a strong appeal to the Israeli middle classes and to the powerful managerial elites, as many of whom stand to reap significant gains in either financial terms or in a preferred status and access to health services. On the whole, increased privatisation and corporatisation would not, in most instances, provide a desirable or equitable solution to the present difficulties of the Israeli health care services.

Summary

In summary, it is important to note that the debate about the organisation of the Israeli health care system is mostly about ends, i.e., what should be the nature of health care provision to the population as a whole. Although form may seem important in this debate, i.e., whether the country should have a national health insurance scheme, or whether it should continue with the semi-voluntary sick fund system, in fact, form is much less important than might be evident. The choice opted for recently of a national health insurance scheme does not basically change this situation.

The most important factor that determines the nature of a system is the political willingness of the ruling elites to support it and provide it with the necessary resources to achieve its goals. For example, national health insurance may in theory seem more promising than a semi-voluntary system of health care. However, under the guise of national health insurance a very unequitable system can be created, especially when there is a lack of political commitment to contest it. This seems to be the current situation in Israel.

The recent changes to a form of national health insurance and creeping privatisation going along with it, are firmly based on the currently fashionable neoclassical economic paradigm. This paradigm has patently failed to accomodate the unique mix of normative, clinical and financial concerns that an appropriately configured health care system must address (Saltman & Von Otter, 1992, p. 8). It is possible, therefore, that under prevailing circumstances, the recent changes of form may serve as a device to conceal

the intention to develop a highly stratified health care system in which access to medical care is based on class, status and income.

As to the preference of the Israeli public, the general impression is that the large majority would have preferred the continuation of the Kupat Holim member-consumer oriented system. It is a system with which they were acquainted and one that on the whole has served them well. The Kupat Holim system assured reasonable access to most medical services at no cost at the point of access. Experience has shown that private medical care, in any form or disguise, is simply beyond the means of the majority of the population. At the same time there were widespread and very strong feelings about the need to reform and streamline the system and rid it of some of the more cumbersome bureaucratic features that it has acquired.

A small part of the population, including the financial, managerial, business elites, the upper middle classes, and other interest groups, were strongly opposed to the continued existence of the sick fund system. Interestingly, these groups have already for a long time stopped using the rather spartan Kupat Holim services and have opted for more lavish private medical care. The driving force in their opposition to the Kupat Holim was their desire to legitimise and institutionalise their preferred health care status and privileges. Since most political power is concentrated in the hands of these groups, they used their influence to prevent the allocation of adequate resources to enable Kupat Holim to function properly, and in this way, to force change in the direction they desired.

Eventually, the national health insurance scheme enacted in May 1994, signals the triumph of the Israeli middle classes. At the present it is difficult, however, to foresee what will be the nature of the Israeli health care system in the years to come. Supporters of the reform claim that it will bring about an improvement of the prevailing unsatisfactory situation. Opponents of the reform argue that under the existing political circumstances, only the preservation of the Kupat Holim system with some improvements in it, offered the promise of a consumer-oriented and equitable distribution of medical care. However, this scenario was rejected by the more powerful groups in Israeli society.

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THE EVOLVEMENT OF A NATIONAL HEALTH POLICY IN ISRAEL, 1990–1994: THE CONTROVERSY OVER THE STATE COMMISSION'S REPORT AND ITS AFTERMATH

by Prof. Arie Shirom*

Introduction

In the advanced market countries, the question is *when* to join the club of countries that have experimented with a significant reform of their health care sector, *not if to consider joining*. Many countries in both Eastern and Western Europe have introduced planned reforms in their health care systems (Hurst, 1991; Saltman, 1990; Culyer, 1990). This article focusses on health care systems in advanced market economies, since they developed similar components of health care delivery, including those of primary, secondary and tertiary care (Hunt, 1988; Rosenthal & Frenkel, 1992).

The reasons for this trend were detailed in several reports issued by the Organization for Economic Cooperation and Development (OECD, 1990, 1992). After many years of deliberations and internal political struggles, Israel has introduced in its health sector a significant reform. The reform started with the tertiary sector, at first involving only acute care hospitals. It culminated with the passage of the new National Health Insurance Law, in June 1994. This development allows one to assess the practicality of two alternative strategies to health care system reform that were proposed to the Israeli cabinet (and legislature) by a State Commission of Inquiry that functioned in the years 1988–1990. The first strategy called for a far-reaching transformation of the health care system, and it was based on a comprehensive accumulation of all the system's ills and malfunctions. The second strategy involved a modular, focused approach to health systems reform and was preceded by a focussed diagnosis of the system's major

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ineffectiveness and their sources. The objective of this study is to compare the actual reform with the two proposed strategies. It is posited that the Israeli experience has relevance to other countries struggling to find the most valid and practical approach to a health care system reform.

The State Commission of Inquiry

In August 1990, the Prime Minister of Israel at that time, Mr. Shamir of the Likud (conservative right-wing) party, was formally presented with the two volumes of the final report of the State Commission of Inquiry into the Functioning and Effectiveness of the Israeli Health Care System (abbreviated henceforth as the Commission). This occasion marked the beginning of a heated public controversy over the desired or optimal government policy toward reforming the health care system. The public debate continued almost unabated during the early 90's, and focused on the different proposals for the enactment of a national health insurance law, as discussed at that time in the Israeli parliament. This law, which was finally enacted in June 1994, was inspired to a significant extent by the Commission's report.

Yet another avenue of the same basic debate concerned the attempts, by two health ministers, Mr. Ehud Ulmert, M.K., of the Likud Party (1989–1992) and Mr. Chaim Ramon, M.K., of the Labor Party (July 1992–February 1994), to implement one of the Commission's key proposals for change. Both ministers, each adopting a different strategy, pursued the policy of removing all government-owned hospitals from the direct, day-to-day operation by the Ministry of Health. Mr. Ulmert planned to have them operate as hospital trusts, like those formed in the U.K., but was largely unsuccessful in his efforts. Mr. Ramon followed the strategy of having the government-owned general hospitals operate as autonomous budgetary units within the civil service. This is the strategy currently being implemented, in an incremental and gradual way.

From the perspective of the internal Israeli political scene, the passage of the National Health Insurance Law probably represents an imminent major transformation of a social institution, the Histadrut. This social institution, the country's multi-functional labor movement, has been in existence since 1920 as a relatively autonomous "labor society" within the state, without undergoing significant changes in its core functions and structures. However, this is not the perspective of this study. Our interest is in ferreting out,

from the language of the new Law as well as from the experience that has accumulated with the hospital reform, the basic principles of health care reform embodied in them.

Several reservations should be noted before presenting the two opposing views, namely those of the majority and minority in the Commission. First, these views were not the only proposals for the reform of the Israeli health care system. Other proposals have been discussed during the public debate which accompanied the legislative process in the Knesset (i.e., the Israeli Parliament). However, as noted, the two views expressed in the two volumes of the Commission's report (1990) did influence to a considerable extent the legislative process. Most of the other proposals for reform of the Israeli health care system were reviewed, and in some instances included, in the majority and/or the minority positions, as expressed in the Commission's report (1990). Second, the work of the Commission was preceded by many public bodies, including advisory committees that were established by the Ministry of Health, the Israeli Medical Association, and the major sick fund, Kupat Holim Clalit (KHC). As above, the Commission's report reflected, to a very large extent, ideas and material assembled by its predecessors.

The next two sections present descriptive material necessary for understanding (a) the meaning and significance of state commissions of inquiry in Israel, and (b) key features of the Israeli health care system *before* the reform effected by the new law. Subsequently, the two drastically different diagnostic models used by the minority and the majority, and their implications for the reform recommended by each, are presented. The following section introduces the actual reforms implemented in Israel in the aftermath of the work of the Commission, as expressed in the new law and in the reform of the acute care hospital sector, alluded to above. The concluding section draws some lessons from the Israeli experience which appear to be pertinent to other countries.

Commissions of Inquiry in Israel

Commissions of inquiry, as an official fact-finding organ established by the state to investigate a certain matter, were created before the establishment of the State of Israel in 1948. During that period, they were established by the British Mandate's High Commissioner, on the basis of ordinances promulgated on the basis of British laws (on the history of committees of inquiry during that period, see Elman, 1971). In 1968, the Knesset passed

the Commission of Inquiry Law, which served as the legal basis for the work of the Commission. In England, this legal mechanism has a very long history (note the many Royal Commissions established in England, including several that dealt with the British National Health Service), for reasons having to do with its functional adaptability. In Israel, only seven such commissions were established by the State. All of them were set up to deal with well defined domains. To illustrate, commissions of inquiry were established to investigate the issues that concerned the Sabra and Shatila Massacre of 1982, the surprise attack of the Eyptian Army on the Israeli Army in 1973, the attempt to set fire to the Al-Aqza Mosque, and alleged cases of bribery in football games. The Law allows the Government to set up a commission of inquiry whenever it seems to it that there is a matter of vital public importance which requires clarification. However, as evident from the above examples of past commissions, the Commission was an exception in that it was set up to deal with the functioning and effectiveness of a whole sector in the country's economy.

There were other noteworthy differences between the Commission under discussion and its predecessors. In the government decision that established the Commission, it was determined that it should submit to the government findings and recommendations, including those that concern required reforms in the structure and processes of the health care system. None of its predecessors was armed with such a broad and far reaching mandate. Last, but not least, the issues dealt with by the Commission were not legalistic or juridical. Competence in jurisprudence among the Commission's members was necessary, and indeed was required by a clause in the law that stipulated that a senior judge should chair any commission. Nonetheless, it could be anticipated that the Commission would have to resort to knowledge and expertise including medicine, economics, organizational behavior and labor relations. This consideration led several leading journalists in the country to criticize the Government's decision to establish a state commission of inquiry, in itself a juridical entity acting like a court of law, for the study of such a complex and far-reaching set of issues. In response, it could be pointed out that other countries have appointed similar public committees or royal commissions for the study of needed reforms in their health care system (examples are England, Norway, Sweden, Italy, and the Netherlands; see, as examples, Ham, Robinson, & Benzeval, 1990: and Hurst, 1991). In principle, the Commission of Inquiry Law of 1968 provides the commission with considerable flexibility to gather the material it needs and to determine its own mode of operation. One of the inflexibilities in this law is the

aforementioned stipulation that the chairperson must be a judge of either the Supreme or District Court. The relatively short history of commissions of inquiry in Israel indicates that on some occaions their chairpersons adhered to the formalities of a court of law in setting their procedure, determined to disclose the truth exclusively via the legalistic method of cross-examining witnesses.

In the Government's decision that established the Commission, it was constrained to take into account, in formulating its recommendations, the economic situation of the country and the constraints on public funds that can possibly be allocated to the health care system. Therefore, it is appropriate to describe these constraints, in the broader context of the major features of the Israeli health care system.

The Israeli Health Care System

The descriptive and analytic literature on the Israeli health care system is not extensive (for useful sources, see: Chinitz & Cohen, 1993; Ellencweig, 1983, 1992; Shuval, 1992; Steinberg & Bick, 1992). Therefore, a brief summary of its main features follows. It should be noted that the description reflects the pre-Law conditions, and that some of the structural elements below are going to be changed from 1995. The nature of these changes is delineated in the section describing the reform introduced by the new Law.

Sick funds. Primary and secondary care is provided by four sick funds, which cover about 94% of the population of Israel (this figure relates to 1992. See: National Insurance Institute, 1993). Practically, this means that all permanent residents of the country have access to a relatively wide range of health services through their membership in a sick fund. These sick funds resemble the staff-model health maintenance organizations in the USA in several respects. Membership in them is voluntary, and they have complete discretion to determine restrictions on the acceptance of new members (most curtail and restrict acceptance of new members with chronic illness or above the age of 62). The sick funds have also complete autonomy to decide what's included in their basic basket of services, provided to their members in return for membership fees. These fees are currently about 4% of the gross salary for employees, and for most members are paid directly to the sick funds by the members' employers (Slightly different arrangements prevail with respect to the self-employed). Of the four sick funds, the General Sick Fund (KHC) is the largest, with about 65% (as

of June, 1994) of the population as members. It owns and operates a network of public clinics. Most of these clinics are quite large, and include in addition to general practitioners and specialists a variety of diagnostic and laboratory equipment, pharmacies, and other primary care curative services. The KHC has been playing a central role in Israel's health care delivery services as a result of its pioneering status, size, affiliation with the powerful Histadrut, and commitment to the ideology of providing health services on the basis of need while charging membership fees on the basis of ability to pay, Throughout the history of the country, the KHC has influenced and shaped to a considerable extent the functions and behavior of the other sick funds.

The other, smaller sick funds, covered together in most years only about 10–15% of the population. However, the intensifying competition among the sick funds, and the serious financial difficulties of the KHC, brought about a major shift from the KHC to the three smaller sick funds. They were able to increase their share of the population to about 35% in 1994. Their mode of operation resembles that of the KHC. There are two major exceptions to this. First, the smaller sick funds tend to provide primary care services more through their agreements with private primary care physicians than through clinics wherein salaried physicians are employed, as is the prevailing pattern in the KHC. The physicians who signed agreements with the smaller sick funds usually provide care to their members in the physicians' own clinics. Second, the smaller sick funds do not own and operate hospitals (one of them recently acquired a small hospital in the Tel-Aviv area). They also collect from their members prepaid income-based membership fees. Adverse selection of new members is more vigorously practiced by the smaller sick funds. but their basket of services is comparable to that of the KHC. This basket of services does not include long term care, which is under the responsibility of the government, and dental care, for which a sick fund member is financially responsible on an individual basis.

Hospitals. The KHC owns and operates 17% of the country's general hospital beds. However, most hospitals are owned by the government (45% of all general hospital beds: see Central Bureau of Statistics, 1993), and by nonprofit organizations such as Haddassa. The operation of the sick funds in the tertiary sector is augmented by a number of not-for-profit organizations that have established hospitals as well as other medical facilities. An example is the network of hospitals established by religious denominations in most cities, but especially by several Christian churches in Nazareth.

The Ministry of Health. The Ministry of Health has the customary ministerial responsibilities for the planning, regulation, and coordination of the health care system, for the general assessment and control of the sick funds' operations and for the initiation of legislation in these areas. Because of certain historical circumstances the Ministry is also the major provider of individual preventive health services, hospital care (including most long term care), and public health services. It regulates the input of manpower, technology and net capital investments in the health sector by licensing physicians, nurses, health institutions, etc. Individual preventive health care services are provided by the Ministry through a network of family and infants clinics, wherein it provides vaccination and routine check-up to infants and their mothers. It also runs some adult individual preventive health services, in addition to the public health services. In 1992, there were about 94,500 persons employed in the country's health system, making up about 5.7% of all employed persons (Central Bureau of Statistics, 1993, p. 362). Total expenditure on health has been about 7.5% of the gross national product in 1991 (Central Bureau of Statistics, 1993, p. 715).

Private Medical Services. Privately operated medical services are predominant only in dental care, to which about 13% of the national expenditure on health was directed in 1991 (Central Bureau of Statistics, 1993). Private M.D.'s were responsible in the same year for about 6% of the total expenditure on health, which is indicative of the *de facto* universal public health insurance through the sick funds that exists in Israel.

Health and Politics. Historical developments led to the direct or indirect affiliation of most sick funds with established political parties. In the case of the KHC, this is most obvious. The Histadrut has been ruled by a coalition of left-of-center political parties at the helm of which has traditionally been the Labor party and its predecessors. Since the Histadrut is ruled by political parties, and because of the ties of some of the smaller sick funds to certain political parties, the determination of health policy for the country has been a highly politicized process involving entrenched political interests.

Strengths of the Health Care System

It is often posited that for a health care system to be considered effective, several fundamental requirements have to be fulfilled: universal access and eligibility, high quality, moderate cost, and most importantly — appreciable benefits in terms of both longevity and quality of life, as assessed relative to comparable other countries (cf., OECD, 1990, 1992).

A balanced assessment of both the strenghts and weaknesses, or points of effective and ineffective functioning, of the Israeli health care system is a prerequisite for an informed decision about the required reforms in it. It is primarily a factual evaluation, and therefore follows the presentation of its structural features. Some of the strengths of the system have already been noted above; namely, eligibility and accessibility. In many other OECD countries, universal coverage of the population by a publicly funded health care system is still a desired national goal (e.g., in the Netherlands, Portugal, Belgium, USA). In Israel, as noted above, access to curative and preventive medical services has been available to over 94% of the population. It should be noted that practically universal coverage of the population was in existence long before the enactment of the new Law. Accessibility of a primary health care center to members of the sick funds is yet another strength of the Israeli system of health care. It has gradually developed over the years, with the sick funds establishing primary health care clinics in most neighborhoods. For over 80% of the members of the sick funds, there is no financial barrier to service utilization. There are contentions that one of the inefficiences of the Israeli system of health care is the lack of any co-payment requirement for visits to primary care physicians (including family physicians and specialists who work in primary care clinics), presumably resulting in overutilization and unnecessary visits. However, there is hardly any substantive evidence to support this claim, and hence the inclusion of this characteristic among the system's strong points.

Commonly used indicators of the effectiveness of a health care system (Rosen, 1987; Kop, 1994) include life expectancy of the population, infant mortality, and the incidence of various kinds of diseases in the country. There are several reasons why these indicators, related to the outcomes of the health care system, are considered problematic (cf., OECD, 1993). First, the most accepted definition of health regards health not as the absence of a disease, but as one's ability to use one's capabilities to the fullest while functioning independently and comfortably (cf. World Health Organization, 1985). Second, comprehensive indicators of the outcomes of health care systems are hardly available (OECD, 1993). Third, the state of health of the population at large is determined primarily by factors unrelated to the functioning of the health care system, such as the population standard of living, health habits, eating customs, and the extent to which it enjoys clean air, water and environment (cf. Hughes, 1993). The functioning and effectiveness of the health care system does have some impact on the above criterion, but the other factors are known to be much more

influential (cf. Ham, Robinson & Benzeval, 1992). Bearing in mind the above reservations, the outcomes of the health care system were assessed.

As in other advanced economies, causes of death in Israel are primarily cardiovascular diseases, cancer, and roads accidents. Most of the evidence available supports the observation that when assessed according to the criteria developed by the World Health Organization for its' European Region, the health of the population of Israel is relatively high (cf. Kop, 1994; Rosen, 1987; Shuval, 1992). The following is intended to serve as selective portrayal of the factual data that supports this conclusion. As noted in the comparative assessment of Rosen (1987), the incidence of most infectious diseases has been declining, and the rate of decline in Israel of some of the chronic and cardiovascular diseases has been more marked than in most European countries. In terms of infant mortality per 1,000 live births, the rate in Israel declined from 31.3 in 1960 to 24.2 in 1970 and to 14.9 in 1980 (Rosen, 1987). For males, life expectancy at birth (in years) in Israel as compared with the OECD countries has been 74.9 vs. 72.9, and, for females, 78.9 vs. 79.2 (Kop, 1994). Thus, while female life expectancy in Israel is a bit lower than that of the OECD average for 1990, for males it is significantly higher. This is the typical situation that emerges in most epidemiological studies of life expectancy in Israel, and can be interpreted as indicative of the relatively robust state of health of Israel's population.

A highly relevant criterion for the effectiveness of the Israeli health care system is the cost associated with the above outcomes. To the extent that the above set of effective outcomes of the health care system were accompanied by soaring health expenditures, as gauged by the share of the health care services out of the total national spending, then the accomplishments noted above carried a high price tag and could have led to growing public sector deficits, as occurred in other OECD countires (OECD, 1990, 1992). This is evidently not the case in Israel. In 1991, the share of health care expenditure was about 7.5% of the gross national product, on par with the average for OECD countries (Kop, 1994). The ratio of health workers to the population in 1991 was in Israel about 18 health workers per 1,000 people (Central Bureau of Statistics, 1993) as compared with 24 in the same year in OECD countires (OECD, 1993). Finally, the tertiary (hospital) sector of the health care system in Israel is quite effective. The ratio of hospital beds per capita fell from about 7 per 1,000 in the 1980s to about 6 per 1,000 in the 1990s. This has occurred largely because the great influx of new immigrants from the former Soviet Union to Israel was not paralleled by an expansion of the hospital sector. This ratio is considerably below the average for OECD

countries (OECD, 1992). The average per capita days of hospitalization was about 2 days in the early 1990s (Central Bureau of Statistics, 1993) as compared with the OECD average of about 3 days for the same period (OECD, 1992).

In sum, Kop (1994) has compared Israel's relative ranking among OECD countries in the 1980s and 1990s. He concluded that Israel has continuously improved its relative position over this period. In 1991, only 4 of the 19 developed countries have allocated to health care services a lower percent of their gross domestic product in comparison with Israel. This process of economising on health care service delivery costs, characteristic of Israel throughout the 1980s and 1990s, was accomplished while maintaining the highest standards of care, incorporating highly advanced diagnostic and treatment procedures, and absorbing (particularly since 1989) massive waves of immigration from the former Soviet Union and from Ethiopia. This background information on the Israeli health care system leads directly to the long list of ineffective outcomes and processes, as it emerges from the diagnosis and proposals for reform in the majority and minority reports of the Commission, described below.

The Commission's Diagnoses and Recommendations

The following summary of the majority and minority diagnoses draws on earlier summaries, including those prepared by Rosen (1991) and Kop (1994). All references in the following discussion of the two diagnostic models presented in the Commission's report will be to the English translation of the majority's opinion (1990) and to the Hebrew-language original of the minority's opinion (1990; unfortunately, the Commission's Chairperson decided to translate only the majority's opinion into English).

The majority's diagnosis. The majority's diagnosis is essentailly an attempt to implicitly adopt a comprehensive system-wide approach and identify all problems, all points of ineffectiveness, in the Israeli health care system. The objective was to compile all the facts on all problems. This diagnostic approach was applied serially — for each of the system's main components, the majority provided a long list of what's wrong with it. This may be illustrated by surveying the sections in the majority's report that deal with the diagnosis.

The issues dealt with first in the majority's report concerned the series of strikes and other interruptions of service that have occurred in the health care system in the 1980s. The strikes and work stoppages initiated by labor

unions in the health services were due in part to the employees' dissatisfaction with their working conditions and wages. These interruptions brought about long queues for elective surgery and various diagnostic procedures and other non-acute medical treatments. The queues and long wating times were more evident in the KHC, because of specific reasons discussed below.

Members of the sick funds, and particularly KHC members, reacted to the above developments by either or a combination of the following routes. Many have left the KHC and moved to the other, smaller sick funds (whose membership swelled almost three-fold during this period, as explained above). Some members opted for queue-jumping through additional-payments of all kinds (e.g., donations for the purpose of medical research to the responsible doctor(s) and/or their hospital department). A sizable segment of the affected KHC members resorted to services of the private sector of the health care system. These developments have occurred against the background of rising consumer expectations for timely and high quality health care services.

Another major problem dealt with at length in the majority report was the faulty budgeting procedures and financial arrangements in the health care system. The share of the Ministry of Health in the government's budget was described as almost exclusively determined by the Ministry of the Treasury. The Ministry of the Treasury officials, headed by the Minister, have assumed the decisive role in the post-factum annual fixation of the KHC deficits, mostly by grants-in-aid or other forms of subsidies accorded to the KHC. This financial arrangement, a sort of annual horse-trading involving the top echelons of the Ministry, the Histadrut and KHC, took place throughout the 1980s and early 1990s. It should be noted that during this period either the Ministry of the Treasury or the Ministry of Health or both were headed by representatives of parties opposed to the Labor Pary, whose representatives were (until July 1994) at the helm of both the Histadrut and the KHC. A problem related to the above was that the annual intra-ministerial negotiations concerning the following year's budget of the Ministry of Health did not take into account any explicit need-for-funds formula, like one which considers population growth, population aging, and technological advances in the health industry.

Other financial arrangements that were singled out as faulty included the regressive structure of membership fees in the KHC and to some extent also in the other sick funds, and the per-diem basis of hospital reimbursement by the sick funds, which hardly provides incentives to economize in the country's public hospitals.

Fragmentation in the health care delivery system was another major issue discussed in the majority's diagnosis. The claim was made that the intensifying competiton among the sick funds in the 1980s led to duplication of services, personnel, facilities, and equipment in many locations in the country's coastal plain (where most of the population resides). Duplication of services was also noted between hospitals' outpaitent departments and the primary health care clinics of the sick funds. Both employed specialists and provided ambulatory services, sometimes to the same patients, but the transfer of information among the hospitals and the sick funds was found to be inadequate. This has led to a situation wherein diagnostic and laboratory procedures completed within the primary health care system were repeated when the patient was referred to a hospital.

Related to the above is the structural deficiency of over-centralized management of both the KHC and the Ministry of Health. Also noted was the inadequate managerial structure of hospitals, wherein doctors who are heads of departments are appointed for life. Critical shortage of trained managerial personnel for all units of the health care system was underscored, as was the over-supply of medical doctors.

The above description of the system's faults, as depicted in the majority report, omits certain categories that reappeared (with slight variations) in the minority report (As noted in the majority report, the minority wrote several chapters of it, chapters on which there was unanimity of opinion in the Commission). One category is that of deficiencies in the health status of the population, as revealed in a comparative assessment of it (Rosen, 1987). These shoretcomings included the major problems of queues for long-term psychiatric and geriatric hospitalization, of poor oral health, of the relatively high incidence of certain infectious diseases and of infant mortality in the non-Jewish sector, and the high rates of mortality from ischemic heart diseases relative to the European Region of the World Health Organization. Another category related to the lack of consumers' "bill of rights" in the health sector. There were several specific deficiencies that were found to be associated with this absence of an explicit statement of the rights of the consumer of health care. They included the fact that the sick funds were free to practice adverse selection and to change the basket of services which they provided, and the lack of sufficient sensitivity to individual patients' needs and desires for freedom of choice among providers, for privacy, and for efficient use of their time. Yet another important category, described below, concerned the constraints on the functioning of the Ministry of Health as a ministry. Both the minority and the majority regarded the preoccupation

of the Ministry of Health officials with the day-to-day operation of the hospitals it owns and operates as severely constraining their ability to engage in policy making, monitoring, and regulation of the country's providers of health care to the population. There was unanimity of opinion among the majority and the minority in the Commission that the Ministry of Health has not been fulfilling its fundamental ministerial functions, including setting health policies and regulating and controlling the country's system of health care.

The minority's diagnosis. The minority's approach to the diagnosis of the country's health care system was entirely different from that of the majority. It started by defining explicit criteria for the determination of the system's effectiveness. These criterion, which in general followed the literature on health systems' effectiveness (for a list of sources consulted, see Shirom, 1993), included the following: First, the extent to which the overall outcomes of the system contributed to keep people healthy, to increase longevity of life, and to decrease the incidence of chronic and infectious diseases in line with the developments in other advanced market economies like the OECD countries (e.g., Salmela, 1991). The second criterion was the extent to which the above outcomes were provided at a reasonable cost, thus supporting growth-sustaining public policies followed by the government. The third criterion was the extent to which the system provided its services to the population with reasonable access, coverage, and on an equitable basis. The results of the assessment of the system's effectiveness on these criteria are self-evident from the preceding section describing the system's main features. As may be recalled from this brief introduction to the Israeli system of health care, a satisfactory picture emerged when the system's performance was evaluated on the three criteria. These results have led the minority to focus on the ineffective outcomes of the system. Foremost among them were the various inadequacies in the service provided to the public, including the strikes that often disrupted the provision of services, the substantial queues that existed while expensive equipment lay idle, and the low level of employee satisfaction and motivation.

The roots of these problems, according to the minority diagnosis, were the following, in descending order of importance: First, the poor functioning of the Ministry of Health. Figuratively, the minority described the health care system as operating without a brain. This referred to the aforementioned deficient policy making process within the Ministry. There were many indicators of the ineffective functioning of the Ministry of Health. Prevention and health education have not received adequate resources. Medical

manpower planning has hardly taken place. The regulation of technology diffusion and quality assurance activities have been deficient. Information systems on the population health care needs, like epidemiological surveys of the state of health of the country's residents, simply do not exist. In this policy vacuum, the hospitals engaged in prestige-enhancing battles, for example for the most sophisticated devices of new diagnostic technology. Often these battles that were totally unrelated to health consumers' and societal needs.

The second major cause was identified as stemming out of the Ministry of the Treasury and Ministry of Health strategy of incrementally reducing their share in the financing of the country's health services. The major problem with this was the drastic nature of the actual budgetary reductions. To exemplify, the share of the government budget (not including the earmarked employer's tax, collected by the National Insurance Institute) declined from 23% in 1985 to 19% in 1990 (Central Bureau of Statistics, 1993). When this decline in governmental direct expenditures on health is examined in terms of US$ per capita (cf. Kop, 1994), the drastic nature of the above policies becomes more evident. From a level of expenditure of about $165–200 per capita in the years 1976–1980, there was a decline to a level of about $107–125 in the years 1989–1990. During the same period, the share of the household sector in the total health expenditure (namely, the out-of-pocket expenditure of health care services to consumers) rose from 20% to 28%, reflecting a substantial increase in expenses on dental care and private physicians (Central Bureau of Statistics, 1993). This trend did not contribute to a drastic increase of the cost of health services to the national economy. However, the above reductions were one of the reasons for the huge deficits accumulated by the KHC. These deficits, in turn, led to persistent requests by the KHC to the government for subsidies and help. The negotiations about the kind and amount of such financial help were in many cases protracted and involved sanctions and withholding of key services by the KHC, as one way of exerting political pressure on the government.

The third major cause had to do with inadequate collective bargaining processes and structures, and faulty compensation policies followed by public sector employers. The strikes of doctors and other medical personnel, which became more frequent during the 1980s, were regarded as due in part to these reasons. One of the most traumatic events in the country's labor relations history was the national strike of all salaried physicians in the country declared by the Israeli Medical Association, a strike which lasted about four months in 1983 (Harrison, 1991).

Two Proposals for System Reform

The widely divergent diagnoses of the system's ills led both the majority and the minority in the Commission each to develop a different proposed reform and entirely dissimilar reform strategies. The account provided below does not relate to the common elements in the proposed reforms. To a considerable extent, these common elements are in the process of being implemented. Therefore, they are detailed in the section which deals with the reform that was carried out in the wake of the Commission's work.

The Reforms Proposed by the Majority. Two major components of the reform proposed by the majority, namely the reorganization of the Ministry of Health and the divestiture of government owned hospitals from the Ministry of Health, were components that reappear in the minority report, with slight variations, and are currently in the process of implementation. The overview of the reforms proposed by the majority covers only those that were associated, in the majority's report, with the passage of a national health insurance law. For each, I shall describe briefly why the minority opposed it. Most of them were rejected by the cabinet or the legislature and were not included in the new National Health Insurance Law.

The State was proposed as the insurer. That is, the majority recommended legislated national health insurance. The minority was of the opinion that the State should assume the overall responsibility for funding the basket of basic of health services to which each resident is entitled by virtue of the law, and that the State should exercise its responsibilities by requiring each adult resident to register as a member of a sick fund of her/his choice. The minority position was the one that was incorporated in the new Law.

The majority recommended that a separate National Health Authority be established. The new Authority would undertake full responsibility for allocating to the sick funds the public health budget, for the regulation of the health services delivery system, and for generally overseeing the sick funds and representing their members' interests. The National Health Authority would operate through several regional health offices, each with full authority to certify, monitor, and control the regional sick funds in the region. This recommendation was rejected by the Minister of Health and the Government, primarily because it involved adding more layers of largely unnecessary bureaucracy. The minority report argues against it for similar reasons.

A central recommendation of the majority was that regionalization should

become the guiding principle of health care service delivery by the sick funds. It was proposed that the whole country would be divided into six or five separate regions, and each sick fund would restructure itself accordingly to six or five autonomous and financially independent regional sick funds. The formation of new sick funds would be encouraged. The minority maintained that for a small country like Israel, regionalization was inappropriate and did not address any real problem in the system. It favored, instead, providing incentives to the sick funds to voluntarily decentralize their operations. Also, the minority's opinion was that the four competing sick funds were sufficient, and that new ones would necessarily mean duplication and fragmentation of services, equipment, and buildings, thus resulting in inefficiencies. The new Law does not refer to regional sick funds and does not encourage the formation of new ones, much like the minority's opinion.

The recommendation of the majority to introduce private medical practices into public hospitals, notwithstanding the well known implications for equity in the tertiary sector (e.g., Young 1990) has not yet been considered or implemented.

Finally, the majority recommended that the financing of the public health care system by centralized, by funding it primarily through payroll taxes on employers and employees, to be collected by the National Insurance Institute, with supplemnetary funding from government general revenues and other sources. The sick funds would no longer collect membership fees from their members. The minority recommended allowing the sick funds to continue to collect membership fees directly from their members, thereby enabling them to compete on price as well as on quality of service. The new Law accepted the recommendation made by the majority, and channeled funds from most sources into a general pool of funds for the purpose of funding the public health care delivery system. This created a clear-cut separation of membership in the Histadrut and KHC. The crucial financial link between the respective taxing systems of the Histadrut and of the KHC, symbolized in the "joint tax" that all members of the Histadrut paid to cover both types of membership, was indeed broken by the National Health Insurance Law.

Reforms Proposed by the Minority. The reforms proposed by the minority stemmed directly from the above diagnosis. As noted, the decline in the public share of health system financing was viewed as one of the major causes of the health system's problems. Therefore, the need to increase the public share of health system financing was advocated (cf. Culyer, 1990), to be carried out gradually over a period of time. The minority regarded

the not-for-profit sick funds as a highly effective social instrument for the provision of health care which simultaneously was also economically efficient (cf. Colwill, 1993). This is the rationale for the proposal to strengthen the sick funds by requiring all residents to become members in one of them and for the proposal that was already mentioned to allow the sick funds to continue to collect membership fees.

The minority's contention was that enhanced effectiveness of the Israeli health care system can optimally be brought about by focusing on a small number of critical change levers, namely the key inputs of money, manpower, and technology (cf. Rosen, 1991). The intervention strategy advocated was to introduce the required changes in these inputs in a modular fashion. The argument was made in the minority report that by adjusting the change levers associated with the system inputs, in a gradual and modular change strategy, vital changes would ensue in the short run, and the system would be able to embark on a long-run improvement process. This strategy of change was contradictory to the emphases on transformational changes, which involved the whole structure of the health care system in the majority report.

A major exception to the change strategy and targets recommended in the minority report concerned the Ministry of Health. On the issue of the needed structural reform of the Ministry of Health, namely reorganizing it in such a way to have the sick funds provide all individual-based services that the Ministry had been providing in the past and reconstituting it as a policy making and regulatory authority, the minority and majority recommendations were quite comparable. Therefore it was recommended in both reports that the Ministry would cease to provide individual health care services, including in the area of preventive health to individuals. It was further recommended that the Ministry establish staff functions that did not exist, like quality assessment, licensing of medical technology, and technology assessment.

Reforms Implemented in the Health System

The actual reforms implemented in the Israeli health care system in the aftermath of the Commission's final report included three interrelated change programs. The first is the reorganization of the Ministry of Health. This change program has proceeded at a rather slow pace, and at the time of writing (1994) is still in its infancy. It is likely that with the passing of the National Health Insurance Law and the planned transfer of the

individual preventive and curative services provided by the Ministry to the sick funds, the reorganization of the Ministry of Health would proceed at a more substantial pace.

The second change program relates to the autonomous functioning, first as independent budgetary units and subsequently as public corporations, of all government hospitals. This change program has been gradually implemented. At this stage, it covers only about six government hospitals which were granted financial autonomy within the civil service, in a format resembling a government-owned corporation. The most substantive and far reaching reform that was influenced by the Commission's report is the enactment of the new Law.

The Reforms Associated with the New Law. With the enactment of the new National Health Insurance Law, all permanent residents in the country will be entitled to receive the basket of health services specified in the addenda to the Law through one of the sick funds. Thus the four sick funds would become the backbone of the country's health care system. As pointed out above, the financing of the basic basket of services, provided by the sick funds to those insured in them, would be carried out by allocating to each, on the basis of the capitation formula described above, an appropriate share of the pool of public health funds. To this pool, managed by the National Insurance Institute, the employers, employees and self-employed will each pay an earmarked tax based on income (for employees, gross salary; for employers, total wage bill). Supplementary funding, from the general government revenuess, would cover the cost of the basket of health services provided by the sick funds. It is noteworthy that these principles of funding the public health care services embody the basic notion that it is the overall responsibility of the government to provide adequate financial resources to the sick funds.

The new Law is quite explicit on the rights of the members of the sick funds. There are very few limitations on the freedom of movement among sick funds, and the funds are enjoined by law not to engage in any adverse selection of members. Every resident of the country is entitled to a basket of basic health services, to be received by enrolling in one of the sick funds. This basket of basic health services is in fact quite comprehensive, and includes virtually unlimited outpatient, inpatient and rehabilitative services. The Law stipulates that the basket would follow the one actually in force at the KHC, and in addition certain preventive dental health services and long term hospitalization.

It is of some importance to note areas of health care not covered by the

Law. First, it deals almost exclusively with the primary sector of health care. Hospitals are hardly mentioned in the new Law. Second, it does not regulate the mode of service delivery by the sick funds except indirectly, by providing to the insured (namely, all the residents of the country entitled to receive health services in accordance with the new Law) the 'bill of rights' discussed above. The new Law is silent on the financing of hospitals, including the nature of their contracts with sick funds.

Discussion and Conclusions

The major objective of this article was to present the two approaches toward the required reform in the country's health care services, as embodied in the two volumes of the Commission's report (1990), respectfully representing the majority's and the minority's opinions, in the context of the actual reform decided upon by the Israeli Kenesset, as embodied in the new Law. It is claimed that the juxtaposition of the two approaches may allow a better understanding of some of the major issues involved in health care system reform.

There are several conclusions, of relevance to those interested in the issues of health care reform, that could be reached on the basis of a careful comparison of key clauses of the National Health Insurance Law with the major proposals for the reform of the Israeli health care system that were reviewed above. First, the text of the National Health Insurance Law reflects, to a very significant extent, the principles of reform advocated by the minority in the Commission. Therefore, in retrospect, the relative emphasis given above to each of the two volumes of the report may be justified by their dissimilar influence on the legislation process that followed the Commission's work. What are some of the reasons for the more compelling persuasiveness of the minority report?

A possible explanation that was proposed by Chinitz, Ellencweig, and Moscovice (1994) is that the majority report was hardly based on any implementation planning and analysis. These authors went on to offer several implementation strategies that could enhance the likelihood of adoption of some strategies that would increase support for the kind of reform proposed by the majority in the Commission. To illustrate, they suggested the strategy of reducing the government's direct management of processes of health care and emphasizing outcomes of health care.

An explanation that I prefer is the more valid diagnosis performed in

the minority report. The diagnostic model applied by the minority was relatively simple, and easy to understand for policy makers. Yet it was based on current theory and thinking in the organizational sciences and in organization development applied to the macro system of a country's health care system. It may be recalled that the diagnostic model started out by an overall assessment of effective versus ineffective outcomes of the Israeli health care system. At this stage of the diagnostic effort, the criteria which were applied rested upon explicit recommendations of the World Health Organization and the OECD with respect to assessments of the effectiveness of health care systems in advanced economies (cf. OECD, 1993; WHO, 1985). As a reminder, these criteria had to do with the extent to which the health status of the Israeli population was marked by continuous improvements in longevity of life, in the incidence rates of chronic and infectious diseases, etc.; the extent to which these outcomes were achieved at a reasonable cost to the economy; and the extent to which health services were available to the whole population of the country on an equitable basis.

The Israeli health care system got relatively satisfactory marks on all the above criteria. Thus, when the ineffective outcomes were culled and examined, it was possible to reach a very important conclusion: that there is no need for a structural transformation of the system. On the other hand, the diagnostic approach followed by the majority in the Commission, which essentially involved creating a check-list of the system's ills, misled the majority into the firm conviction that nothing short of a major overhaul of the system's structure and process would remedy the long list of ills that the majority was able to compile.

As evident from the actual reform decided upon by the Israeli Knesset and implemented by the govenment, this approach was viewed as irrelevant to the optimal curing process of the system's major points of ineffective functioning. Excepting the one recommendation for the centralization of the various sources of funding of the public health care system and the abolition of the right of sick funds to collect membership fees from their members in return for the basket of basic services, practically all the other structural reforms that the majority incorporated in its recommended version of the national health insurance law were rejected in the legislative and policy making processes that followed the Commission's work.

The next stage of the diagnostic process in the minority opinion had to do with uncovering the roots of each of the major ineffective outcomes. As could be expected, several common sources were identified, involving specific elements of the health care system's processes, structure and inputs.

The implementation problem then became how to intervene optimally in a macro system to deal with certain ineffective outcomes.

Reformers, acting in a context whose major characteristics resemple those described above, should focus on a small number of critical change levers. It was posited that these critical change levers are most likely to be one or more of the inputs of money, manpower and technology into the system. It should be emphasized that the recommended intervention strategy was offered for the specific circumstances described above, when the health care system is functioning at a satisfactory level of performance. Under these conditions, the optimal interventions that policy makers should follow are those that focus on specific changes in the system's inputs. It would not be beneficial to intervene in the delivery process or structure. The focus on inputs may relate to the combination of them that is expected to bring about the desired changes in the system's ineffective outcomes.

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MENTAL HEALTH POLICY AND SERVICES IN ISRAEL: STAGNATION OR PROGRESS?

by Prof. Uri Aviram*

Introduction

Israel's mental health policy and services reflect the country and the people they serve. Although Israel gained its independence only forty six years ago, it is a state of people with an ancient history. Understanding the current problems and continuing issues of the country's mental health services cannot be done without taking into account the political and social conditions of the country as well as the historical and cultural background of its people.

There are about 7,000 patients hospitalized in 38 psychiatric inpatient facilities in the country. More than 11,000 admissions per year have been reported by these facilities. Mentally ill people occupy more than one-fourth of the total number of inpatient beds in the country (Central Bureau of Statistics, 1989; Israel Ministry of Finance, 1989). An estimated 650,000 psychiatric patient care contacts take place each year in about 60 outpatient mental health services (Mental Health Services, 1986; Siegel *et al.*, 1989; Ministry of Health, 1989). There are about 90 other mental health services in the community, such as day care units, social clubs, sheltered housing

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and rehabilitation services (Popper & Rahav, 1984; Ministry of Health, 1989). Mental health services are allocated a substantial part of the state's health budget. Although mental health services have not been at the top priority list of the public agenda, these services and the condition of the mentally ill have drawn public attention. The disability and vulnerability of the mentally ill and the quality of services provided for them have been, from time to time, a cause for public concern.

The purpose of this paper is to describe the mental health policies and services of Israel and to analyze the major issues they face. Some of the problems of the mental health service delivery system stem from organizational and financial difficulties, while others reflect deeply embedded structural factors

The paper has three major parts: 1. introduction, 2. Israel's mental health delivery system, and 3. current issues and continuing problems.

The Introduction includes a brief history of mental health policies and services. The second part, which focuses on describing the mental health service delivery system, starts with a discussion of epidemiological data revealing recent trends in mental health services. It is followed by an analysis of institutional care, community services and psychiatric rehabilitation programs. This part is concluded by a section on budgetary and personnel issues and touches upon disability and income maintenance legislation and programs pertinent to mentally ill persons. Finally, in the third part of the paper, three interrelated issues of the mental health system will be addressed: The limited development of community mental health services, the dominance of the mental hospital in the provision and administration of mental health services in the country, and the medicalization of mental health services.

A Brief History of Mental Health Services

Early Developments

Although the formal history of mental health services in Israel can only start from the time the State was established, the beginning of mental health services goes back more than 50 additional years. The first institution designated specifically for mentally disordered persons was established in 1895. Two compassionate women founded the "Ezrat-Nashim" shelter in Jerusalem. Medical care, when available, was provided by general practitioners. It was not until 1921, that a trained psychiatrist practiced in the country (Dagan, 1988; Hailprin, 1937).

At the time of independence, there were 1,200 psychiatric beds in Israel. Only 200 of these beds were provided by the government. There were two government mental hospitals, two public[1] mental hospitals and two inpatient psychiatric units in general hospitals. About two-thirds of the psychiatric beds were provided by private, for profit hospitals. The rate of psychiatric beds for the country was 1.32 beds per 1,000 in the general population (Miller, 1977).

Three factors were accountable for the state of psychiatric services in the country upon its independence: The organized Jewish community and the services that it developed; the British government which ruled the country; psychiatric services developed by the Israeli military during the war of independence (Miller *et al.*, 1968).

The poor state of psychiatric services of the newly established state was a reflection of the ideologies and attitudes of the people and was affected by the social, political, and economic circumstances that existed at the time. The British government, ruling the country until 1948, tried to minimize its investments in social and health care, including mental health services. Although, prior to the establishment of the State, the organized Jewish community paid a great deal of attention to the development of health and social services in general, mental health services were given low priority among these services. The General Sick Fund (Kupat Holim), the medical insurance and health care program of the major labor union (similar to HMO in the U.S.), which covered about 80% of the population, resisted for a long time to include mental illness under its coverage (Brill, 1974). This fact, as well as the circumstances associated with the war of independence and the waves of immigrants that came into the country immediately after its establishment, explain the inadequate level of mental health services in the early years of Israel's history.

Mental health services were far from being able to respond adequately to the new circumstances which resulted from hundreds of thousands of immigrants that poured into the new country. It seems that a disproportionate number of mentally ill arrived in the country with many other immigrant groups (Aviram & Shnit, 1981). In addition, mental health needs among the survivors of the Holocaust were believed to be enormous. Attitudes regarding mentaly ill persons, which in the pre-State era were rather intolerant (Heilprin, 1937; Aviram & Shnit, 1981), changed. The general

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1. In Israel, the term "Public Mental Hospital" denotes a non-government, not-for-profit mental hospital.

public, as well as the government, were sensitive to the needs of, and felt a moral commitment to provide services to, the concentration camp survivors (Ramon, 1981).

The major efforts of the mental health services of the new state during their first decade were to provide more psychiatric beds in response to the increased demand for inpatient care. The government used old army camps, an ancient Ottoman castle and jail, or deserted Arab villages, and also built new facilities in an effort to meet the demand for institutional beds. The General Sick Fund of the General Federation of Labor opened its second mental hospital in 1949. In one decade the number of beds increased by more than 2.5 times. In 1958 the number of psychiatric beds in Israel was 4,335. The rate of beds was 2.2 per 1,000 of the population, an increase of about 70% over the rate that existed ten years earlier, when the State was founded. Until 1963 the increase in the number of psychiatric beds was proportionately higher than the general increase in the population (Chesler-Gampel, 1970). This achievement is indeed impressive, especially in view of the tremendous increase of the general population of the country during this period.

During the first half of the 1950s another process that shaped the mental health services for years to come was taking place. This was the legislation of the Mental Health Act, which in 1955 replaced the antiquated and inadequate Ottoman law that was in effect since the 19th century. Although at the time mental health services in Israel already represented different types of treatment and care, the Legislature chose to enact a law which related exclusively to inpatient hospitalization. The orientation of the law was based on the medical model, providing physicians with broad discretionary power regarding mental hospitalization and commitment (Aviram & Shnit, 1981; Bazak, 1972, 1979; Shnit, 1982).

Consolidation of the Structure of Mental Health Services

During the 1960s, new mental health services were added, and the system was consolidated. The major increase in ambulatory mental health services occurred during the second half of the 1960s and the beginning of the 1970s. Between 1965 and 1977 the number of outpatient service units increased by 70%, from 37 to 63 units. The increase during the following decade was only 10% (Popper & Rahav, 1984).

The structure of mental health services as it exists today was already in place in the early sixties. Mental health services included special psychiatric

hospitals, inpatient psychiatric units in general hospitals, outpatient clinics, child guidance clinics, day hospitals, transitional facilities, institutions for long term care, and some rehabilitation services.

During the 1970s several community mental health centers were established, a few drug rehabilitation services were opened, and mental health hotlines began operating (Miller, 1977; Aviram & Shnit, 1981). The additions of the 1980s were primarily in the after care service — social clubs (Moss & Davidson, 1980; Naftally, 1986), sheltered homes (Hammerman, 1984), and rehabilitation services (Moss & Davidson, 1984; Levy & Davidson, 1988).

Inpatient services have mainly been provided by governmental hospitals or by private (for-profit) hospitals, paid for by the government. The General Sick Fund's share in the provision of ambulatory mental health services was larger than its share in the provision of inpatient psychiatric services (Popper & Rahav, 1984; Kupat Holim, 1980; 1983). However, while the government was hardly involved in the provision of ambulatory general medical services in the country (those services were provided mainly by the Sick Fund), a substantial proportion of ambulatory mental health services was provided directly by the government.

Reorganization Plans and Policy Changes

During the 1970s two major policy changes were undertaken. In 1972 a plan for the reorganization of mental health services was announced by the government (Ministry of Finance, 1973). In its basic approach this "Reorganization Plan" was similar to the American model of the Community Mental Health Centers program. It called for the delivery of comprehensive mental health services in a geographically defined community (Tramer, 1975; Falik, 1978).

In 1977 the Government reached an agreement with the General Sick Fund regarding the provision of psychiatric services in the country. The guiding principle of this agreement, which became effective in 1978, was that psychiatric services should be provided on a regional basis, according to medical needs, and be free of charge. The Sick Fund was required to provide psychiatric services in the regions under its responsibility to all applicants, regardless of their insurance coverage, and in return, the government assumed the costs of providing mental health services to members of the Sick Fund, as well as to anyone else, free of charge. It was an ambitious plan that attempted, among other things, to promote the Reorganization

Plan and improve the delivery of mental health services in the country (Aviram & Shnit, 1981).

Following this agreement, the General Sick Fund amended its insurance coverage policy and eliminated coverage for psychiatric services for its members as of 1978 (Kupat Holim, 1986). Although there were no immediate practical consequences, this policy change represented a major retrenchment of the Sick Fund from its previously accepted responsibility toward the insured population, and created problems that surfaced later. Recently, in 1989, the Government changed its policy of providing psychiatric services free of charge, and has been attempting to collect fees for psychiatric services.

Until recently the Mental Health Services central administration was a separate branch of the Ministry of Health. Its independent status was never established by law and was rather an administrative arrangement. At the end of 1989, the Ministry of Health announced its intention to change this organizational structure, and incorporate Mental Health Services, including its inpatient and outpatient services, into the Hospitalization Service Branch of the Ministry. At the time of the writing of this paper, the process of this administrative change has not been completed.

Israel's Mental Health Service System

Changing trends in Mental Health Services

The major efforts of mental health services during the first 15 years of the new state, until about the mid-sixties, were to increase the number of psychiatric beds and to organize the psychiatric inpatient services. This is not to say that professionals and policy makers were unaware of other needs, or that they completely neglected the development of other forms of mental health services.

During the 1960s, as immigration into the country decreased and economic conditions improved, attention shifted to ambulatory services. The number of outpatient clinics almost doubled, and the number of visits in them quadrupled between the years 1965 and 1977 (Rahav & Popper, 1984). Day care programs[2], not available until the late sixties, became available. The number of day care unit beds tripled during the seventies, and in 1985 exceeded 1,000 (Central Bureau of Statistics, 1978; 1989).

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2. The term which is synonymously used in Israel for a day hospital is "Day Care Unit" (used henceforth).

After-care services, rehabilitation, and community care programs for long term mentally ill patients have been recognized needs, as well as being among the declared goals of mental health services for quite some time (Tramer, 1975; Miller, 1977). However, not until the 1980s could one observe some action in this arena. During this period social clubs and rehabilitation services were developed, and increased attention was given to the establishment of sheltered housing for mentally ill persons in the community.

There has been a noticeable decline in inpatient hospitalizations during the last decade. Epidemiological data reveal that this trend is reflected in all the usual indicators of inpatient services — the number of beds, resident population, and admissions. The trend is manifested in both absolute numbers and rates per population (Popper & Horowitz, 1989; 1990). The number of patients in mental institutions in Israel continued to climb and peaked in 1978, with close to 9,000 resident patients. By the end of 1988, the number dropped roughly 20% (7,000). There is a similar trend of decline in the number of psychiatric beds. The trend of decline was a modest one at the beginning of the period, accelerating to an average of 4% decline per year during the later part of the period. The decline in the rates of patients per 1,000 of the population is even more impressive. The highest rate of inpatients per population was measured in the second half of the sixties. After 1970, the rate, which was about 2.7 per 1,000 of the population, started to decline. The trend of decline accelerated during the last decade reaching about 30%, to 1.6 per 1,000 in 1988 (Popper & Horowitz, 1989; Central Bureau of Statistics, 1989). The decline in the number of resident patients in institutions was for the short stay and the long stay patients as well. Between 1975 and 1988, the number of patients who were hospitalized one year or less declined by 19%. The rate of decline for this period for the longer stay patient was only 5.6%. During this period the proportion of the long stay patients in Israel mental institutions increased from 63% to 66.5% (Popper & Horowitz, 1990).

The number of admissions flunctuated during the second half of the 1970s and early 1980s averaging about 13,000 per year. It started to decline after 1981, dropping by about 15% between 1981 and 1988. The rates of admissions declined by 36% between 1973 to 1988, from 3.9 to 2.5 per 1,000 of the population. An even higher rate of decline has been reported in regard to first admissions (Popper & Horowitz, 1989). Between 1975 and 1988, first admissions to mental hospitals declined by 50%, from 1.4 per 1,000 of the population in 1975 to 0.7 in 1988 (see table 1).

The decline in inpatient hospitalizations is indeed impressive. Although the rate of decline is not so high as in the U.S., it is similar to the rates in other countries (Goldman, 1983), such as Britain, where deinstitutionalization trends were present during the last 25 years (Brown, 1985). In assessing this trend, Popper and Horowitz (1989; 1990), pointed out the increase in the number of day care unit patients, and the development of alternative care facilities in the community during about the same period. They attributed the changes to a configuration of factors — demographic, social, and clinical as well.

Table 1. Inpatients and Day Patients in Psychiatric Care Facilities in Israel: Numbers and Rates of Resident Patients and Admissions in Selected Years: 1948–1988[1]

	1948	1958	1970[2]	1978	1988
			absolute numbers		
End of year					
Inpatients	1,197	4,188	8.038	8,925	7,036
Day Patients	—	—	303	896	1,220
during the year					
Admissions for Inpatient Care					
Total	n/a	4,619	10,577	12,995	11,035
First Admissions[3]	n/a	2,593	n/a	4,853	2,933
Readmissions[4]	n/a	2,026	n/a	8,139	8,102
			rates per 1000 poulation		
End of year					
Inpatients	1.3	2.1	2.7	2.4	1.6
Day Patients	—	—	0.1	0.3	0.2
During the year					
Admissions					
Total	n/a	2.3	3.6	3.5	2.5
First Admissions	n/a	1.3	n/a	1.3	0.7
Readmissions	n/a	1.0	n/a	2.2	1.8

1 Source (Data is based on the Psychiatric Case Register reports): Central Bureau of Statistics (1989) for 1958, 1970; 1988; Chesler-Gampel (1970) for 1948; Popper & Horowitz (1989) for 1978.

2 From 1970 numbers do not include mentally retarded.

3 Some figures are based on estimates.

4 Some figures are based on estimates

Institutional Care

Facilities. Psychiatric institutional treatment and care are mainly provided by two types of facilities: special psychiatric hospitals and psychiatric inpatient units in general hospitals. There is considerable variability within these facilities by the type of care, patient characteristics, costs, staff, ownership, and level of care. At the end of 1987, there were 38 psychiatric inpatient facilities in the country (Table 2). Almost half of the beds were in government special psychiatric hospitals. The second largest provider were private (for profit) psychiatric facilities. About 40% of the beds were in these hospitals (Table 3). Since the government pays for most of the patients in private hospitals as well as regulates these hospitals (Halevi, 1984; Ministry of Finance, 1989), one could say that about 90% of the psychiatric beds in the country are government beds.

In 1980, there were 50 psychiatric inpatient facilities in the country. During an eight year period this number declined by one fourth (Table 2). The major decline occurred in the number of private hospitals. The total number of beds in private psychiatric hospitals diminished during this period by about 25%. This figure accounts for about 75% of the total decline in the number of psychiatric beds in the country. At the end of 1988, there were 7,362 psychiatric inpatient beds in Israel (Table 3; Central Bureau of Statistics, 1989).

Table 2. Psychiatric Inpatient Facilities by Type and Ownership, 1975, 1980, 1987[1]

	1975	1980	1987
Special Psychiatric Hospitals			
Government[2]	12	15	12
Private (for profit)	22	21	12
General Sick Fund	3	3	3
Other Not-for-Profit	3	3	2
Psychiatric Units in General Hospitals			
Government	3	4	5
General Sick Fund	1	1	3
Other Not-for-Profit	1	1	1
Total	45	50	38

1 Source: Popper & Horowitz (1989); Mental Health Services (1989).

2 Includes a forensic unit in a prison.

Table 3. Number and Proportion of Psychiatric Beds in Israel by Type and Ownership, Selected Years 1975–1987[1]

	1975	1977	1983	1987
Special Psychiatric Facility				
Government				
#	3,593	3,796	3,881	3,513
%[2]	44.1	42.9	46.5	47.2
Private				
#	3,644	4,094	3,571	3,080
%	44.7	46.3	42.8	41.4
General Sick Fund				
#	498	516	481	451
%	6.1	5.8	5.8	6.1
Other Not-for-Profit				
#	250	248	192	143
%	3.0	2.6	2.3	1.9
In General Hospitals				
Psychiatric Units[3]				
#	168	210	221	257
%	2.1	2.4	2.6	3.4
Total				
#	8,153	8,846	8,346	7,444
%	100.0	100.0	100.0	100.0

1 Source: Popper & Horowitz (1988).

2 Percentages are for columns.

3 Includes units in governmental, General Sick Fund and other public, not-for-profit hospitals.

The public (other than government) sector provides about 8% of the beds in special psychiatric facilities (Table 3). These beds are provided by not-for-profit organizations, of which the largest is the General Sick Fund. Considering that this health organization covers about 70% of the population and provides 31% of general hospital beds in the country, the number and the 7% proportion of psychiatric beds provided by the Sick Fund, is relatively small (Ministry of Finance, 1989). Although there was a remarkable increase in the number of psychiatric beds in general hospitals during the last 15 years (53% between 1975 and 1987), the proportion of 3.4% of psychiatric beds provided by this sector is rather small (Tables 2; 3).

Acute and Long Term Care Facilities. Psychiatric units in general hospitals and the Sick Fund hospitals provide mostly acute psychiatric inpatient services. About 40% of the admissions to inpatient psychiatric services in Israel during 1988 occurred in these facilities, which comprise only about 10% of the psychiatric beds in the country. Although also government hospitals were a major provider of acute psychiatric care, the large proportion of long stay patients in these hospitals (Popper & Horowitz, 1990), resulted in a lower rate of the number of admissions per bed in comparison with the general hospitals and the Sick Fund facilities (Table 4). Only 4% of inpatient care occurs in general hospitals. This proportion is lower than in other countries (Siegel *et al.*, 1990).

Table 4. Admissions to Psychiatric Facilities in Israel by Type, 1988[1]

Type of Facility		Admissions[2]	Beds[3]	Number of Admissions per Bed
Government Special Psychiatric Hospitals				
	#	6,566	3,513	1.87
	%	55.9	47.2	
Private Special Psychiatric Hospitals				
	#	470	3,080	0.15
	%	4.0	41.4	
Sick Fund Special Psychiatric Hospitals				
	#	2,507	451	5.56
	%	21.3	6.1	
Other Non-Profit Special Psychiatric Hospitals				
	#	235	143	1.64
	%	2.0	1.9	
Psychiatric Units in General Hospitals				
	#	1,978	257	7.70
	%	16.8	3.4	
Total				
	#	11,756	7,444	1.58
	%	100.0	100.0	

1 Source: Mental Health Services (1989); Popper & Horowitz (1989).
2 Includes admissions to day care in psychiatric hospitals (about 1/2% of total admissions).
3 Figures for end of 1987.

Private psychiatric hospitals mainly provide long term care. Although 41% of the psychiatric beds in the country are in these hospitals, their proportionate share of the total yearly psychiatric admissions in the country was only 4% in 1988. A recent Ministry of Health Policy decision discouraged new admissions to private hospitals. Ninety percent of the patients in these hospitals are hospitalized for periods longer than a year (Popper & Horowitz, 1990). These institutions are similar to nursing homes. They provide shelter and maintenance, with relatively little medical, social, or rehabilitative services. Staffing ratio per patient and cost of care are much lower than in other hospitals. The government sets up the fee schedules (which varies according to the type of population cared for), and regulates these institutions (Halevi, 1984). The quality of care in some of these institutions caused public concern, from time to time, and has been considered by some a disgrace (Neumann, 1982).

Admissions and Resident Patients. As already mentioned, there were about 11,000 admissions to psychiatric facilities in Israel during 1988. The rate of admission per 1,000 of the population was 2.5. The number of resident patients at the end of 1988 was 7,035 and the rate was 1.6 per 1,000 of the population (Table 1). The majority of the admissions (73.4%) were readmissions. About 55% of all admissions are males. Admission by age and gender shows interesting differences. About 70% of male admissions are for the age groups of 18–44. The proportion of first admissions of these age groups among women is much lower, about 50%. The proportion of the 65+ age group among women admissions is more than twice than that for males (17% and 7.8% respectively). Children up to 17 years old constitute 8.4% of first admissions. About one fourth of all admissions are between the ages of 18–24.

Admission data by age groups and type of hospitals reveal other interesting distinctions. Almost 60% of all admissions to private hospitals are for the 65+ age group, compared to 12% of this group for the whole country. These hospitals also differ from others in the diagnostic categories of their admissions. Fifty eight percent of first admissions to private hospitals in 1988 were diagnosed as organic conditions, compared to the 9.2% of this diagnostic category for all psychiatric admissions. These two figures further emphasize the fact that the private hospitals are mainly geared to the care of chronic, long term patients (Popper & Horowitz, 1989; Mental Health Services, 1989).

Mental Commitments. The majority of the admissions to Israeli mental hospitals are voluntary. According to 1988 data, about 13% were admitted as civil commitments, and 4.5% were committed under the criminal code (Popper, 1989). Civil commitment is defined by the Israeli law within the realm of medicine, authorizing specially appointed district psychiatrists to issue commitment orders. Based on earlier data, the proportion of involuntary hospitalization may be actually higher, at about 24% of all admissions (Aviram & Shnit, 1984). This proportion is more compatible with other countries (National Institute of Mental Health, 1987). These earlier data indicated that most involuntary admissions were urgent admissions, in which district psychiatrists' commitment orders could not be obtained prior to admission. Although undoubtedly the recent data may indeed indicate actual decline in the number and proportion of involuntary hospitalizations, the size of the difference might also be a result of reporting practices or due to the level of the reliablility of data collected at either one of the two periods.

Diagnostic Categories and Chronicity. Schizophrenia is the major diagnostic category of persons admitted to institutions in Israel; 55% were so classified. Affective disorders are the second largest category, constituting 14% of all admissions. The proportion of this category among women is twice as high as for men (19.2% and 9.5% repectively) (Mental Health Services, 1989). Only 2.6 of the patients did not have any of the psychotic diagnoses (Siegel, 1990).

There is no accurate information regarding the proportion of chronically mentally ill persons in the country. Data on the length of stay of patients in Mental Hospitals reveal that 68.7% were hospitalized by the end of 1988 for more than a year. Almost 50% of all patients were hospitalized for 5 years or longer. The largest proportion of long stay patients was in the private hospitals (89.4%). The proportion of this category of patients in the government and the Sick Fund hospitals was lower (60.4% and 16.2% respectively) (Popper & Horowitz, 1990). These figures reflect the function of these hospitals and policies of their governing boards.

Lenght of Hospitalization. Total number of hospitalization days for mental illnesses for 1988 was 537.8 per 1,000 of the general population. Psychiatric hospitalization constituted 27% of all hospitalization days in the country. Excluding hospitalization days for chronic illnesses and rehabilitation,

hospitalization in psychiatric facilities was 40% of total hospitalization days in the country.

The average duration of stay for those released during 1988 from psychiatric inpatient facilities (excluding psychiatric units of general hospitals) was 224 days (compared to 5.1 days for those discharged from general hospitals) (Central Bureau of Statistics, 1989). The increase in the average length of stay for those discharged from mental hospitals in recent years, compared with 15 and 20 years ago, coupled with the declining numbers of residents and admissions in mental hospitals, indicate that recently a relatively larger number of long term patients have been discharged from mental hospitals than in previous years. These figures may also reflect deaths of long term patients and transfers of chronic patients to private psychiatric facilities. This matter requires further study.

The average length of stay of 184.2 days for all patients in mental hospitals in 1987 was about the same as in the past (Ministry of Health, 1986). The average bed occupancy rates have been declining during the 1980s. This may indicate an improvement of hospitalization conditions. While during the 1960s and 1970s the occupancy rates were about 100%, for 1988 it dropped to 86.1%, becoming similar to the bed occupancy rate of medical beds (Central Bureau of Statistics, 1989).

Treatment Modalities. The knowledge which is available and the high quality of training of mental health professionals provide mental institutions with access to high standards of treatment methodologies. Institutions use a variety of approaches to treatment and care. Specific information on the exact types of treatment methodologies and their differential use among institutions is not available, nor is there information on the distribution of professionals employed in the institutions by type of training and level of education. However, a review of the minimum requirements for those who wish to be hired, as well as the teaching material used for educating the professionals (e.g. Elizur *et al.*, 1987) allow the conclusion that the level of training is high by any western standards, and that mental health services use a variety of mental health treatment modes such as psychodynamic, biological, pshychosocial and so on. Although Israeli mental health professionals were initially heavily influenced by the Central European psychiatric tradition of the 1930s, and the psychodynamic tradition is still quite influential, other approaches seem to be expanding. There is a need for more specific and accurate information on this subject matter. Additional information

regarding mental health personnel is discussed in the section related to staff.

Mental Health Services in the Community. The decline in the number and the rates of mental hospitalizations in Israel during the last decade has been attributed by some to the development of mental health services in the community (Popper & Rahav, 1984; Popper & Horowitz, 1989; 1990). Indeed, the addition of outpatient clinics, day care units, community mental health centers, and some after care and rehabilitation services has changed the nature of mental health services in Israel. However, there is a need for studies assessing the direct influence of the community mental health services on the reduction of the resident population in inpatient care, and the exact contribution of the development of mental health services in the community to mental health services in general.

Based on a 1986 survey of psychiatric care utilization (Siegel *et al.*, 1990), 68% of the care delivered in the week of the survey was in community facilities. During this week, 14,952 patient care contacts occurred in mental health facilities in the community. Since the survey was restricted to mental health facilities and since many patients receive care from other social and rehabilitation services such as the National Insurance, local social service departments, as well as from private mental health practitioners, one may conclude that the number of care contacts of mental patients is substantially larger.

The bulk of the non-residential community services were provided by outpatient clinics, which represented 80.8% of the patients care contacts during the week of the survey. Day care units provided 9.6% and social clubs 4.5%. The proportion of mental health consultation was 5.2% of patients care contacts. About one half of the patients receiving care in community facilities had psychotic diagnoses, major affective or organic diagnoses, or were recipients of disability insurance. This group was considered in general as comprising dependent patients. The others were rated as less dependent (Siegel *et al.*, 1990).

Day Care Units. There were 1,200 patients receiving care in 28 day care units at the end of 1988. These units were budgeted by number of approved beds. The total number of beds was 938 (Table 5; Central Bureau of Statistics, 1989). Seventy five percent of the day care units were either in, or administered by, inpatient facilities. About two thirds of the units were run by the government. Day care services were developed in the late sixties

Table 5. Outpatient and Other Community Mental Health Facilities by Type and Affiliation, 1989[1]

	Government	Sick Fund	Public (other)	Total
Day Care Units — Total	18	8	2	28
At inpatient psychiatric facility	15	5	1	21
In the community	3	3	1	7
Ambulatory Units — Total	39[2]	19[3]	4	62
At inpatient psychiatric facility	14	10	1	25
In the community	22[4]	7	3	32
Followup outpatient unit (at psychiatric facility)	3	2	—	5
Occupational Rehabilitations Units — Total	7	—	—	7
At inpatient psychiatric facility	3	—	—	3
In the community	4	—	—	4
Drug Treatment & Consultation — Total	6	1	10	17
Outpatients	4	1	10[5]	15
Day Treatment	2	—	—	2
Consultation[6] — Total		1	2	3
Social Clubs — Total	—	—	33	33
Hot line — Total	—	—	8	8
Consultation for Students — Total	—	—	5	5
Sheltered Residential Programs in community[7]— Total	8	—	4	12
				182

1 Source: Ministry of Health, Mental Health Services, Information and Evaluation Department, *List of Psychiatric Services in Israel,* Ministry of Health, Jerusalem 1989.

2 In addition, 6 clinic branches.

3 In addition, 2 clinic branches.

4 Most units are administratively connected to psychiatric inpatient facilities.

5 Consultation services "Al-Sam".

6 Not including psychiatric consultation services in general hospitals.

7 Total for 1989, 177 residences; 285 residents. Sourçes: Report of the Committee on Sheltered Residence for Mentally Ill (1989); Hammerman (1984).

and early seventies. In 1970 there were 300 patients in these services in the country. The number peaked by 1987 and surpassed 1,300, and later slightly declined.

Day care is mainly provided by the government and the Sick Fund facilities. The proportion of day patients per inpatients was higher in the Sick Fund facilities than in the government ones (454 and 290 per 1,000 of the population, respectively, for 1987). The 1986 survey revealed that 80% of the day patients were adults, 11% were aged, 6% were adolescents and 3% were children (Ministry of Finance, 1989).

Since the classification of day care unit beds is not clear and the reporting system on day care patients has not been accurate, it is hard to judge how much of the increase in the reported day care is a reflection of a more reliable reporting system, and how much of it reflects a real growth. No doubt that much more attention is currently given to this mode of treatment by practitioners and policy makers alike.

There has been an impressive change in the proportion of day care patients compared with the total number of inpatients, from 10% in 1980 to 15% in 1988. However, this change is mainly a result of the decline in the number of inpatients during this period. Furthermore, the increase in the number of day care unit beds since 1980 consists only 10% of the number of inpatient beds which were closed since that time. Nor was there a significant change in the number of day care units in the country during the last decade (Ministry of Finance, 1987). Also, the rates of day care beds per population have remained about the same. While the rate of inpatient beds declined by about 27% between the years 1980 and 1988 (from 2.2 to 1.6 per 1,000 of the population), the day care unit bed rate of 0.2 per 1,000 of the population remained constant throughout the whole period (Central Bureau of Statistics, 1989).

Outpatient Mental Health Services. Outpatient mental health services are provided by about 60 facilities. Approximately one half of these facilities are located in the community while the rest are in, or attached to, inpatient facilities. The number of the Sick Fund facilities is about 30% of the total number of outpatient mental health facilities in the country (Table 5). Until recently, outpatient services were provided free of charge. A new policy instituted a small fee for service. Decisions regarding the treatment and its duration are within the discretion of each clinic (Mental Health Services, 1984).

Information regarding the number and characteristics of patients receiving

outpatient mental health services is less comprehensive than that about inpatients. According to the 1986 survey, there were 13,779 persons receiving ambulatory care in the community during the week of the survey (Ministry of Finance, 1989). Based on 1982 figures, it was estimated that there were about 36,200 new admissions to all outpatient psychiatric services in the country (Popper & Rahav, 1984). The number of contacts in outpatient services increased from 144,000 contacts during 1965 to 555,300 contacts during 1977 (Mental Health Services, 1984). and was estimated to reach about 700,000 in 1986 (Mental Health Services, 1990).

A recent study of mental health outpatient services in Jerusalem illuminates some of the questions regarding characteristics of outpatients and types of services provided for them. About 40% of all patients who had attended the adult outpatient clinics in Jerusalem during a five weeks period in 1986 were in regular contact with the clinics for at least one year. Two thirds of those (or 27% of all patients) were diagnosed with one of the major psychiatric disorders, and either had previous mental hospitalization or received disability insurance or both. More than 90% of those diagnosed with major psychiatric disorders received psychotropic medication. The mode of treatment for the majority of these patients was non-psychodynamic. About 75% of them received treatment such as drug follow-up, supportive treatment, social clubs etc. (Lerner *et al.*, 1991).

Community mental health centers (CMHC) were one of the central components of the 1972 Reorganization Plan of the Israeli Mental Health Services (Tramer, 1975). The first CMHCs, intended to serve as models for the rest of the country, were established in Ashkelon and Jaffa. Although other mental health outpatient clinics bear the title of CMHC or provide some of the services envisioned by the Plan, the concepts of the CMHC program are far from being implemented in full. The 1978 agreement between the government Mental Health Services and the Sick Fund was reached in order to assure the delivery of comprehensive mental health services on a regional basis throughout the country. However, so far, no systematic assessment of the changes and their effect has been done.

Data on personnel in outpatient facilities is limited. Data from the 1986 mental health survey reveal that the total number of the equivalent of full time positions employed in public mental health services in the community was 714 (Mental Health Services, 1986). Since this number included also those employed in day care units and rehabilitation units administered by community mental health agencies, we can estimate that the number of positions in outpatient units was about 650. Research on personnel

utilization in this type of mental health services has not yet been initiated in any substantial form and the information is only sketchy. Data on the Sick Fund mental health outpatient services, serving about 45% of the country's population, shows that at the beginning of 1985 the total number of positions was 233. Thirty two percent were psychiatrists, 21% psychologists, 16% social workers, 7% occupational therapists, 4% nurses, and 20% administration and maintenance (Kupat Holim 1985).

Information regarding the type and scope of services delivered by outpatient services throughout the country is rather limited. Nor is there any study which reported effectiveness and efficiency of these services. It is not known, for example, what proportion of the recipients are severely mentally ill and what proportion of resources each type of recipients uses of the total resources allocated to the outpatient clinics. It could very well be that the increase in the number of contacts in outpatient services reflected services delivered to new identified clientele rather than an increase in services to former clients or to those recently discharged from mental hospitals.

Emergency Mental Health Services. Emergency mental health services on a 24-hour-a-day, 7-day-a-week basis are mainly provided by inpatient mental health facilities and by emergency rooms of general hospitals. Recently, the Sick Fund psychiatric hospitals and some of the government hospitals have developed special admission units with emergency holding facilities that provide intensive care on a short term basis. In addition, an emotional first aid hotline service is provided by Eran, a public (not-for-profit) organization, in eight locations in the country. Some outpatient community mental health services provide emergency services, however these are limited to regular working hours. There is rather limited information on this type of services.

Most of the general hospitals in the country have psychiatric consultation services. These services are available also in emergencies. Indeed, many of the mental health emergencies are first seen in the emergency rooms of general hospitals. A study of psychiatric referrals to a general hospital emergency room revealed that about two thirds of the referrals were unjustified. The study suggested that a combination of poor understanding of the general practitioner or the family doctor of when to refer urgently, efforts by these physicians to bypass clinic waiting lists, and lack of alternative community facilities might have accounted for the finding (Vigiser *et al.*, 1984).

Rehabilitation Services. Increased interest of policy makers and some program administrators in mental health rehabilitation during the last

decade resulted in several new policies and programs. However, in spite of some interesting and successful individual programs in this area, the scope of these services and the budgetary allocations for mental health rehabilitation services fall short of the needs. Rehabilitation has yet to assume its appropriate place on the mental health services priority list of policy makers in Israel (Levy & Davidson, 1988). Prior to the last decade the few rehabilitation programs were more or less a result of individual or local interest (e.g. Spivak, 1977) and not an outcome of a concerted policy effort.

Policies and programs in the area of psychiatric rehabilitation are within the domain of three governmental agencies:

1. Rehabilitation Services of the Ministry of Labor and Social Affairs.
2. National Insurance Institute.
3. Mental Health Services of the Ministry of Health.

Former mental patients are considered within the target population of the Rehabilitation Services of the Ministry of Labor Social and Affairs. The number of ex-mental patients among the clients of the rehabilitation centers administered by the Ministry of Labor and Social Affairs throughout the country is rather small. Two factors may account for this situation: Scarce resources and concerns about the potential negative effect of mentally ill clients on the programs and their public image. In view of the scarce resources and, perhaps, also other policy considerations, no specific programs were developed by the Ministry of Labor and Social Affairs for people with disability as a result of mental illness, and present facilities are limited in their ability to cater to the special needs of this population group. Also, program administrators and counsellors prefer investing their efforts in persons whom they consider as having better chances for success. The stigma attached to mental illness is another consideration. There has been concern that inclusion of large numbers of mentally disabled people among the clients of the rehabilitation centers might drive away non-mentally ill disabled persons.

As a result of the General Disability Law of 1974, the National Insurance Institute (NII) assumed a central role in rehabilitation programs for the mentally ill. This agency administers disability benefits programs, including income maintenance payments and rehabilitation services. Any person who becomes eligible for disability benefits is also eligible for rehabilitation services. Although one of the criteria for the benefits is a minimum of 40% medical impairment, those with 20% or more medical impairment

were eligible for rehabilitation services. Services of the NII Rehabilitation Department may include special training, placement services and payment of salary of the disabled employee for a limited period in order to provide an adjustment period for employment, and provide incentives to employers to try to employ disabled persons. The NII did not develop special rehabilitation services for psychiatrically disabled persons and focuses on the occupation aspect of rehabilitation. The Ministry of Defence provides similar rehabilitation services to disabled veterans.

In addition, the Fund for the Development of Services for the Disabled, established by the NII in 1976, has been providing grant supports for the development of new rehabilitation programs in the community. Support is provided for a limited period of time and is contingent on acceptance of future financial responsibility by the applying organization. Because of these restrictions some of the Fund resources have remained unused. Nevertheless, this Fund has supported quite a few innovative programs and has become an important factor in the development of mental health rehabilitation programs in the community during the last decade.

Mental Health Services increased their interests in psychiatric rehabilitation and their activities in this area during the last 10–15 years. Mental Health Services view psychiatric rehabilitation as part of their domain. In fact, policy makers at the Mental Health Services believe that the special problems of mentally ill persons require for the Mental Health Services to have the central role in the development and administration of rehabilitation services for mentally ill people whether they are located in the hospital or the community.

An indication of the increased interest of the Mental Health Services in rehabilitation services is the fact that since 1978, 10% of the disability benefits that the mental hospital receives for its patients from the NII is allocated for rehabilitation services. Most of these funds support rehabilitation services provided within hospitals or administered by the hospitals. Additional efforts of the Ministry of Health resulted in 1985 in the establishment of an association which supports the development of sheltered workshops for former mental patients in the community. Also, the Trust Fund for the Development of Psychiatric Services in Israel has devoted in recent years a portion of its budget for the development of rehabilitation programs.

Psychiatric rehabilitation services focus on the development of skills in three areas needed for successful community living — employment, social life, and housing. In the following sections, each of the services in these areas will be more specifically discussed.

Occupational Rehabilitation. Occupational rehabilitation services have been considered relatively better developed than the other types of rehabilitation services (Levy & Davidson, 1988). There are two types of psychiatric rehabilitation services:

1. Transitional rehabilitation and training agencies.
2. Sheltered workshops.

While the first type emphasizes the education and training aspect of rehabilitation and integrates their programs with treatment services, the second type focuses on the provision of stable and sheltered work places for disabled mentally ill people.

In 1989 there were seven transitional rehabilitation services in Israel, providing services to about 300 persons. Four of these were provided in the community, while three were part of hospitals (Table 5; Popper & Horowitz, 1989). The largest and most developed one was established in 1974 at the CMHC in Jaffa, and has been serving as a model for other services.

The involvement of the Sick Fund in rehabilitation services is much more limited than the government one, and the services are partial. There are two rehabilitation services attached to mental hospitals of the Fund and two services operate in the community on a limited scale.

In addition, several sheltered workshops have been developed during the last several years as a result of special efforts of the government Mental Health Services, in cooperation with the NII and the Ministry of Labor and Social Affairs. There are seven such workshops in the country with a total number of about 200 clients. In addition, there are some mentally ill persons among the 15 general sheltered workshops operated in Israel by Hameshakem, a not-for-profit public rehabilitation agency.

Psychosocial Rehabilitation. Although psychosocial aspects of rehabilitation are included in some of the transitional occupational rehabilitation services, the emphasis in those services is on the world of work. Psychosocial rehabilitation services geared to the training and education of former mental patients in and for community living are rather limited in their development in Israel (Spivak, 1977; Moss & Davidson, 1984).

Many new social clubs for mentally ill persons which have developed during the last decade, function as psychosocial rehabilitation centers in addition to their purpose of providing leisure time activities for mentally ill people in the community. The development of these clubs is a result of efforts undertaken by "Enosh", a voluntary organization established by

families of mentally ill persons in the late 1970s. In general, the established mental health service agencies have been supporting these efforts. Currently there are 33 such clubs in the country (Table 5; Naftally, 1986). The 1986 mental health survey revealed that 667 community service contacts during one week occurred in social clubs. This number represented 4.5% of patients in treatment by non-residential mental health services (Siegel *et al.*, 1990).

Sheltered Residences. Although early efforts in the development of sheltered care residences in the community started in Israel about thirty years ago, major efforts in this area have occurred during the late 1970s and 1980s (Hammerman, 1984; Levy & Davidson, 1988). A recent report indicated that there are 177 sheltered apartments for mentally ill persons located in the community. During the six year period, from 1983 to 1989, the number of residents in these facilities more than doubled. In 1989, 285 residents lived in these facilities. In addition there were about fifty residents in 3 hostels operated by mental hospitals and located in the community (*Report of the Committee on Sheltered Residence*, 1989).

The majority of the sheltered residences were developed by individual mental hospitals as a result of local initiative. Also, the administration and services for these residences have been provided by the mental hospitals. Community mental health services were hardly involved in the development of these residences. Only in recent years a concerted central policy effort has been undertaken by the Mental Health Services. Also "Enosh" has been devoting some efforts in recent years to the development of sheltered residences. By mid 1989, 11 such residences were established by this organization in a collabortaive effort with Mental Health Services (*Report of the Committee on Sheltered Residence*, 1989).

Sources of financial support for these facilities vary a great deal. Some are budgeted in total by mental hospitals, others are supported by public, not-for-profit, and voluntary organizations, while still others are paid for in full or in part by the residents. Disabled and dependent people are entitled to up to 95% of their rents (up to a certain level). Rental payments are provided to eligible individuals by the Ministry of Housing. In view of this fact, it is rather surprising that the number of mentally ill persons in sheltered facilities is not larger. Residents in some of the facilities which have been operated by hospitals continue to receive other services from the hospitals. Hospitals receive 50% of the disability NII benefits for those residents living in sheltered residences under the direct supervision of this hospital.

Mental Health Service Expenditures, Budgets and Personnel

Expenditures for Mental Health Services. Proportionately, Israel spends much less on mental health than on other medical services. While the number of general medical beds in the country was 1.6 times higher than the number of psychiatric beds, the proportion of the national expenditures on general medical hospitalization was 10 times higher than for psychiatric hospitalization (41.8% and 4.1% respectively). Figures regarding average cost for hospital day reveal a similar gap. Costs for a psychiatric day of hospitalization has varied between one fourth and one fifth of that in a general medical bed (Halevi, 1984). Using an index of 110.0, representing the average current cost per day for all hospitals, the average cost per day in a mental hospital is 35.0 compared to 177.7 for that in a general hospital (Central Bureau of Statistics, 1989).

Mental health services were allocated 12.7% of the total budget of the Ministry of Health for 1989. This amount was the equivalent of about 90 million dollars. There are no comparative figures for the budgets for mental health services provided by other sectors. Based on the fact that government expenditures for hospitalization in government hospitals and private hospitals are about 80% of all national expenditures on mental hospitalizations, a rough estimate for total expenditures for mental hospitalization would put the yearly figure between 110 to 115 million dollars.

Mental health services are the second largest item of direct costs (not conditional on income from outside resources) in the budget of the Ministry of Health. The government directly operates 60% of mental hospitalization in the country and has been financially responsible for about 80% of these services. This proportion is quite different from the government proportion of the operation and financing of all medical expenditures. In the 1987/88 budget year, the government was responsible for the operation of 21.5% fo total health service exdpenditures. It was financially responsible for 50% of these expenditures (Central Bureau of Statistics, 1989).

Distribution of Budget between Inpatient and Outpatient Services. Inpatient services take up 90.4% of the budget. Calculating only direct services, excluding central administration and central services. inpatient services take up an even larger portion of the budget (93.5%). Community services are allocated about 5.3% of the total budget. More than 25% of the community services are provided and administered by hospitals. Hospitals may provide additional community services, though these do not appear as a separate item in their budgets.

The high proportion of 90% or more of the mental health services budget allocated to inpatient services stands in sharp contrast to the distribution between inpatient and ambulatory care in the general medical services budget and expenditures. Expenditures for ambulatory medical services and preventive medicine are proportionally about the same as those for general hospital care (about 32% each) (Central Bureau of Statistics, 1989). The uneven distribution of the mental health budget has always been the case (Aviram, 1983; Halevi, 1984).

Staff. In May 1986 more 6,247 equivalent of fulltime positions were employed in all mental health services in Israel. About 10% were physicians, 29% nurses, 8.3% psychologists, 5.4% social workers, 5.3% occupational therapists, and 42% non professional, including orderlies, nursing aids, maintenance personnel and administrative personnel (Mental Health Services, 1990). About 50% (3,160 in 1988) of the mental health personnel was employed directly by the Ministry of Health. Only about 9% of all the people employed by Mental Health Services of the Ministry of Health were in community mental health facilities.

Training professionals for community mental health services have encountered difficulties. It seems that professionals prefer the more traditional inpatient and outpatient mental health services. Mental health services are considered among social workers as a relatively desirable place for employment (Aviram & Katan, 1989). The prestige, however of psychiatry among physicians in Israel is rather low. Neumann (1982) asserted that a very small percentage (much smaller than in the United States) of graduates of medical schools in Israel chose psychiatry as their specialty, and that most of the psychiatrists in Israel are immigrants from Europe or the Americas.

Several changes have taken place in the number and distribution of mental health personnel during the last decade. Data on mental health manpower in governmental services reveal that since 1979 the number of physicians increased by about 50%, the number of nurses and other professional personnel increased by 10%, while the number of maintenance and administrative staff remained the same (Ministry of Finance, 1979; 1989). If the numbers of professionals employed in mental health services, and their ratio to non-professionals is an indication of the quality of the services, then we must conclude that there has been an improvement in the mental health care services during the last ten years. In view of the fact that during the same period the numbers of resident patients in the government mental hospitals declined by 7%, the changes in the number

Table 6. Changes in Inpatients, Budgetary Allocations, and Manpower in Israel Mental Health Services, 1979–1988/89[1]

	1979	1988/89	Change
Inpatients			
Resident patients			
Numbers	8,774	7,036	(—) 20%
Rates[2]	2.3	1.6	(—) 26%
Admissions			
Numbers	12,958	11,035	(—) 15%
Rates[3]	3.4	2.5	(—) 26%
Budgetary allocations			
Percentage of Mental Health Services of total Ministry of Health budget	13.6	12.7	(—) 8%
Percentage of community mental health of Mental Health Services budget[4]	5.0	5.3	(+) 6%
Percentage of "conditional expenditures" of Mental health budgets[5]	1.0	28.0	
Manpower			
Ministry of Health — Total	19,176	19,823	(+) 647 (+) 3.4%
Mental Health Services — Total	3,040	3,160	(+) 120 (+) 3.9%
Psychiatric hospitals	2,763	2,853	(+) 93 (+) 3.4%
Community mental health	277.5	285.5	(+) 1 (+) 0.4%
Percentage of Mental Health Service of total Ministry of Health manpower	15.9	15.9	n.c.
Percentage of community mental health of total Mental Health Services manpower	9.1	8.9	(—) 2.2%

1 Sources:
  a. Inpatients (1979; 1988): Popper & Horowitz (1989); Mental Health Services (1989).
  b. Budgets and manpower (1979; 1989): Ministry of Finance (1979; 1989).
2 Rates per 1000 of the general population.
3 Rates per 1000 of the general population.
4 Including also drug abuse treatment and community mental health services adminsitered by hospitals.
5 Expenditures are conditioned on income from outside sources such as Disability Benefits or patients' payments.

and the distribution of the professional and non-professional staff is even more impressive.

However, the major part of the increase in the number of personnel occurred in inpatient services (Table 6). If indeed money would have followed the patients to the community, the 21% decline in the numbers of resident patients in all mental hospitals between the years 1978 and 1988 should have resulted in drastic changes in budgetary and personnel allocations for community mental health services. Instead of the present 5% or 6% budgetary allocation for, and 9% personnel positions in community services, the figure would be close to 25%, and the expenditures for community services more than four times higher than the current level.

Disability Insurance and Income Maintenance Programs. The Disability Law, implemented in 1974, had a paramount effect on services for the mentally ill and continues to affect the system for years to come. Discussing this law and its effect is beyond the scope of this paper. Briefly, the major effect of the law on the mental health service system is threefold:

1. It provided income maintenance benefits to disabled mentally ill persons.
2. It established rehabilitation services within the National Insurance Institute, financed them with a portion of insurers' conrtibutions, and offered rehabilitation services to mentally ill people who meet eligibility criteria.
3. It established, and continuously financed the Fund for the Development of Services for the Disabled, which has become one of the major funding sources for innovative programs in mental health rehabilitation.

Eligibility for disability benefits is based on two criteria: medical impairment, and loss of income earning ability. A 50% loss of income earning ability as a result of the impairment and a medical impairment of at least 40% are the minimum requirements for disability benefits eligibility. The level of disability benefits is based on the proportionate loss of earning ability. A full disability benefit for a disabled individual is 25% of the average wage in the country, and is periodically adjusted. A married disabled person is eligible for 37.5% with additional 5% for each of the first two children.

A mental hospital, where a person has been hospitalized for three nonths or longer, is entitled to 80% of the disability benefits of the individual. The patient is entitled to the other 20%. In recent years disability benefits have become a substantial portion of hospitals budgets (Table 6), and special efforts have been made to submit claims for disability benefits for eligible mental hospital patients. One might question whether this

financial arrangement does not hinder the financial incentives of the hospital to attempt an early as possible discharge of patients. The Social Security Administration in the U.S. disallowed financing mental institution through disability benefits because of such concerns.

Current Issues and Continuing Problems

Recent epidemiological data suggest that deinstitutionalization has been taking place in Israel. After a long period of stagnation, trends of mental hospitalization indicate, by all acceptable measures, that the change is real and substantial. Although this development could be attributed to a configuration of social, economic, and clinical trends, one should not minimize the contribution of the concerted policy efforts undertaken since 1972 to reduce mental hospitalizations and to increase and improve community services. The Israeli mental health service system faces three interrelated problems:

1. Limited development of community mental health services.
2. Dominance of the mental hospital in the provision and administration of mental health services in the country.
3. Medicalization of mental health services.

These problems reflect, on the one hand, current organizational and financial issues, and on the other deeply embedded cultural factors and traditional belief systems.

Limited Development of Community Mental Health Services. Israel's mental health policy, announced in 1972, and enhanced by a 1978 agreement between the Government and the General Sick Fund, called for drastic changes in the service delivery system. Based on the objectives of this policy and the experience gained in other countries, one would expect changes in the three most critical elements of the mental health system: patients, manpower, and financial resources. If indeed this policy had been implemented as stated, there would have been an observable change in the flow of these critical resources.

The significant decline in the number and rates of inpatient hospitalizations has not been accompanied by an equivalent increase in the resources provided for community services. Although, as has been noted, there were some positive changes in the provision of mental health service in the community, data indicate that those developments lag far behind what might be considered as justified and necessary.

Although there have been major declines in the numbers and rates of resident patients and admissions in mental institution during the last two

decades, the allocation of funds and personnel for, and within mental health services, has not been substantially changed (Tables 1, 6).. The 1989 Ministry of Health budget for mental health services allocated 5.3% for community mental health services, while the proportion for inpatient services was over 90%. Even if one adds the allocations for community services through trust funds and foundations of which the government is a part, the total proportion of community mental health services of the budget would not change by more than 1%. This small proportionate allocation for community services has remained about the same during the 1970s and the 1980s (Aviram, 1983; Halevi, 1984).

The slow pace of development of community mental health services was previously pointed out (Israel State Comptroller, 1980; Aviram, 1983). Although there has been an increased attention toward, and some important additions to community mental health services, budget allocation for, and personnel deployment in community mental health services indicate that the general trend has remained about the same. Considering the changes in hospitalization trends and the knowledge about needs for community care and rehabilitation services, there is still much to be desired in terms of community mental health services in Israel.

Dominance of the Mental Hospital and Inpatient Services

The mental hospital has been occupying a central and dominant position in the mental health service system in Israel. Inpatient services consume and control over 90% of the budget. They pay salaries at higher levels than community services, and attract able personnel, leaving community mental health services at a diadvantage in their efforts to attract and hire high quality mental health manpower. The fact that many of the innovative community care projects have been initiated and administered by mental hospitals, is perhaps another indication of the central position of hospitals in the mental health services in Israel.

Due to the mental health law and regulations, as well as the structure of services, inpatient psychiatric services have a great deal of control over the flow of patients to and from mental hospitals (Aviram & Shnit, 1984; Aviram, 1983). Many of the community mental health services are provided by mental hospitals. Some are actually located on the grounds of mental hospitals. Others, even though located in the community, are administered by the hospital, and the mental hospital has control over their budget. For example, 75% of the day care units are located in inpatient facilities.

In recent years many independent community mental health services were administratively attached, or put under the umbrella of mental hospitals. This trend is both a consequence and an indication of the supremacy of mental hospitals in the system.

This situation is not conducive to the development of community services, and is in contradiction to the knowledge regarding community care and rehabilitaion programs for former mental patients. Admittedly, the control over a large budget provides the mental hospital with the resources and flexibility needed for the development and running of new programs. Indeed, many innovative community programs were launched and are currently administered by mental hospitals. However, one must remember that the *raison d'etre* of the hospital is inpatient services, and community services have lower priority. In a budget crunch, community services would be more vulnerable than inpatient services. This is especially true in view of the fact that the number of beds is a major criterion in budgeting hospitals. In fact, hospitals are not just diverting resources from inpatient services in order to develope community services. A day care unit "bed" is budgeted at about fifty percent rate of an inpatient bed. About ninety percent of the referrals to day hospitals operated by inpatient services are from the inpatient services. Many former patients residing in sheltered residences continue to attend day care unit services provided by the hospital that had discharged them and placed them in one of the homes developed by the same hospital. Without minimizing the therapeutic considerations in placement and referral decisions, one cannot ignore the fact that organizational and budgetary considerations might at a certain point enter into play.

Furthermore, attachment of community programs to mental hospitals may enhance dependency inclinations in patients and slow community adjustments of clients. The stigma, unfortunately still attached to mental hospitalization, might also have a negative effect on the rehabilitation efforts.

A further indication of the dominant position of mental hospitals in the system is that the position of a mental hospital director has been considered the highest status position in the public mental health system. In many instances, hospital directors who were offered the directorship of the central office of the Mental Health Services declined to accept. Furthermore, directors of mental hospitals who had accepted, at one time or another, the position of the director of the country's Mental Health Services, retained their position as hospital director by taking a leave of absence for the period in which they assumed the directorship of the central office.

This situation is not only an indication of the strong position of the mental hospital, but also a reflection of the weak role of the central administration of the Mental Health Services in the system. This fact affects the chances to achieve drastic system changes. Hospitals are budgeted separately. Mental Health Services in Israel have been actually a consultative service; Budgetary and administrative responsibility has been with other sections of the Ministry of Health. Recently, a plan to eliminate the Mental Health Services as an independent branch within the Ministry of Health was announced by the Ministry. According to this plan, the responsibility for mental health services was transferred to the Ministry of Health Hospitalization Services (Milner, 1989). This undoubtedly further enhances the dominance of inpatient psychiatric services within the mental health service system.

Medicalization of Mental Health Services

Strong currents to further enhance the medical orientation of the mental health service system in Israel have recently been shaping the system. These trends have been influenced by ideological and theoretical convictions as well as by administrative considerations and professional-political interests. The recent decision of the Ministry of Health to change the organizational status of Mental Health Services from a separate branch to a section within the Ministry's Hospitalization Services (Milner, 1989) is a result of these trends and an indication of future directions.

Supporters of the administrative structural change have based their arguments on professional/theoretical reasons, as well as on administrative effectiveness and efficiency considerations. They claim that the medical model should guide the structure of mental health services and the treatment and services provided for mentally ill people. They argue that mental illness is a medical problem and within the domain of the medical profession. Recent research findings regarding the biological nature and etiology of the major mental illnesses — the argument continues — enhance these claims. Other professions, important as they are, are ancillary services. They emphasize that pshychiatry is not different from any other medical specialty and does not need any special arrangements for the regulation of its practice or for the population and services within its domain. Following this logic, a special administrative branch for mental health services is not needed, nor is there a need for special laws regarding the mentally ill and mental health services.

From the administrative perspective, supporters of the changes believe that incorporating mental health services into Hospitalization Services, the

dominant and strongest branch of the Ministry of Health, would strengthen the internal organizational status of mental health services, and improve their chances to get a larger portion of the budgetary allocation.

Those who object to the changes contest some of the arguments and claim that, given the present needs of the mentally ill, level of knowledge, and type and array of services needed for them, the change in the administrative arrangements and the principles of the service delivery structure, are not justified or, at least, premature. Some believe that the changes have also been driven by professional-political and sectorial interests. Some professionals, being critical of the changes and the new administrative structure of the mental health delivery system, have been arguing that these new trends represent a regression. They believe that these recent policy changes would hinder many positive developments that have happened, and would adversely affect the public mental health system in Israel.

The expectation that mental health services would fare better within the administratively strong section of Inpatient Services than remaining a weak, independent Branch in the Ministry of Health is questionable and could be proven unrealistic. In a situation in which the Government has continuously put pressure on the health care system to reduce its expenditures, mental health services is a rather weak competitor over the scarce resources. The decline in the proportion of mental health services of the total budget of the Ministry of Health, and the tremendous increase in the proportion of budgeted expenditure conditioned on external sources of income in the budget of mental health services, are cases in point (Table 6; Halevi, 1984). Not having a separate and independent mental health service administration, around which a professional and public constituency may identify and can be organized, would politically weaken the service. Furthermore, it may increase the fragmentation of the mental health services at a time when persistent and coordinated efforts are necessary in order to respond adequately to the diverse and complex needs of the mentally ill.

Regardless of the fact whether the organizational changes were driven by narrow sectorial or by professional interest of the medical profession to enhance its leadership position over the mental health treatment and care system, they would result in strengthening the dominance of psychiatry in the mental health service system. This may affect the interest of other professions in the public mental health system, and their contributions to this system.

However, these changes go beyond the professional rivalry arena. They represent a general trend of the medicalization of mental health services.

The issue is not whether the findings of bio-medical research on mental illness are valid. These findings have indeed revolutionized some concepts and practices of treatment of the mentally ill. No one should minimize the central role of the medical profession in the treatment of mental illnesses. However, many of the problems of the seriously mentally ill are clearly related to other systems of care and services, and interpreting them in strictly medical terms would be counterproductive to the social efforts to deal with the problem of mental illness.

Mental health services in Israel have traditionally been considered within the domain of medicine. The 1955 Mental Health Treatment Law was based on a medical model, and decisions regarding mental hospitalization, including involuntary commitment, have been considered as falling within the discretion of the medical profession (Aviram & Shnit, 1984). While including many positive changes, the reform of the Mental Health Treatment Law (1990), enacted at the time this paper was written, did not divert from the basic propositions of the medical model (Aviram, 1990a). Nevertheless, since 1972, other concepts influenced policies toward broader community care programs and rehabilitation programs. These policies had to face a strong inpatient orientation and a system heavily influenced by psychiatric hospitals. In spite of these, a slow process of development of community care programs did take place, especially during the last decade. Current medicalization trends may stop the progress and cause stagnation.

Medicalization of the services for the mentally ill is not unique to Israel. Indeed, the recent changes in orientation have been similar to trends in other countries (Aviram, 1990b). In Israel, where the deinstitutionalization movement has been a rather late arrival, and where the development of community care programs has been slow and far behind the needs, the effects of the intensive medicalization trends of the system might be quite negative. One of the problems resulting from the medicalization trends is that the model of service is mainly acute and does not deal appropriately with chronic conditions. The medical model and the practice of curative medicine, the dominant approach used in other branches of the Israeli health services system, does not sit well with the needs and the service delivery system required for a large segment of the mentally ill population whose problems demand a life-long medical and social care system.

Changes and improvements in social programs are usually not a result of a linear progression, but rather represent cycles with ups and downs. It seems that Israel's mental health services are currently at a crossroad. Specific policy decisions may determine whether progress continues, or

whether mental health services are entering a period of stagnation or even reversal of its previous positive achievements.

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THE LONG-TERM CARE INSURANCE LAW: ACHIEVEMENTS AND UNFORESEEN IMLPLICATIONS OF ITS IMPLEMENTATION

by Bracha Ben-Zvi*

Introduction

After four years of operation of the Long-term Care Insurance Law (LTCI), following years of planning, legislative work and implementation of the law, a unique system of services for severely dependent elderly persons is taking shape in Israel. Beside unsolved problems which still exist in this system, interesting and thought-provoking advantages are of prominence, both per se and as a model for emulation, perhaps also for organization of services for other target populations.

The uniqueness of the Long-term Care Insurance Law model lies in the following areas:

— Operation of services in kind according to an insurance law — these being universal, egalitarian implemented according to uniform rules;

— Setting of standards and norms for services in kind for the elderly that are accepted by the entire professional interdisciplinary community, and the determination of state bodies for making decisions and monitoring;

— Transfer of provision of services from the establishment to non-governmental organizations — some non-profit and others commercial;

— Determination of licensing procedures for firms providing services and determination of conditions, among them compliance with Employment and Minimum wage laws, employment of a social worker/nurse for instruction of attendants, supervision and monitoring over them, etc.;

— An unanticipated scope of severely dependent eligible elderly persons who receive services in kind in the community.

The impact of implementation of the Long-term Care Insurance Law is

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great and leaves its mark, first and foremost, on the recipients of the direct services — the severely dependent elderly — in easing the burden on their families, in organization of the services run by the professional establishment (departments for family and community services, nursing facilities of Kupat Holim, the Ministry of labor and Social Affairs, the Ministry of Health and the National Insurance Institute — NII), in provision of care services and in the status of elderly persons living in the community.

All these set a new model for the provision of services in kind; a discussion of the main points, application and implications of the Law follows.

The Purposes of the Law

In order to be able to examine the application and implications of the Law in relation to its stated purposes, some of its main principles as detailed in a previous article (Ben-Zvi, 1990) shall be briefly reviewed.

1. The Long-term Care Insurance Law has a community orientation. As such, it is intended to assist elderly persons who live with their families and in the community and *not those who are resident in nursing homes.*

2. Being a law that is designed to add to and integrate with the network for severely dependent patients in the community, it has to *use the existing organizational infrastructure that is functioning in practice* and integrate maximally with additional services, as a connecting link in a continuity of services for the benefit of elderly persons in need of nursing care.

3. The benefit is intended for severely dependent elderly who rely on others either totally or to a significant degree for the performance of their activities of daily living, i.e. *for elderly persons whose dependence on others is great.* It is not intended for elderly persons whose functional disability is relatively slight and whose dependence on the assistance of others is not great.

4. The Long-term care benefit is restricted to two levels of aid that are determined according to the severity of the limitations and the extent of the dependence on others and *is not intended to cover all the needs* of the elderly person for nursing services. The meaning of this principle is *that the Law will assist many elderly persons in relatively modest proportions* and will somewhat ease the burden on their families, rather than giving extensive aid to only a few elderly persons.

5. The benefit is not intended to replace the nursing that the elderly person receives from his family, but rather to assist them somewhat. Furthermore, the benefit, being relatively modest, relies upon natural inputs taken upon themselves by the families in caring for their elderly in their homes.

The help of relatives for the elderly person is perceived as a self-understood natural obligation that members of the family take upon themselves *and the family receives no payment or compensation for its services.*

6. The bebefit is intended to facilitate the family's daily coping with the difficulties imposed upon it so as *to delay, and perhaps even avoid, the breaking point*, i.e., that stage at which the family inclines to decide to move the elderly person from home and to hospitalize him in a geriatric ward.

7. The aim of the benefit being to ease the burden on the family of caring for the elderly person, it does, by its very nature, "take" part of the family's functions in basic daily and non-professional care of the elderly person. *It is not intended that the benefit take the place of professional forces that are an obligation of the health and welfare services*, such as physiotherapy, occupational therapy, medicine and psychosocial consultative services. The benefit is intended to replace partially those basic tasks that fall upon the shoulders of the family in daily caring, such as bathing, dressing, feeding, mobility in the home, dealing with excretions and risk prevention.

8. *The Law determines a priority for benefit in kind*, that is the provision of direct care services and home help for the elderly person. Only where these are not available may the benefit be converted into a cash allowance. From the intention behind this principle, it follows that aid focussed on the coping of the family with the heavy tasks imposed upon it will be assured by the provision of aid facilities for the elderly person. On the other hand, a cash allowance could be swallowed up in the family budget and will not necessarily be expended for the purpose for which this law was intended in easing the care burden.

9. Since the benefit is intended to pay for services according to the above principles, it follows that *the services have to be adapted to the characteristics of the family*: the forces operating therein, its way of life and choices. Thus, a permanent basket of services has been determined, the choice from which is as flexible as possible and is determined in consultation with the family. This basket includes personal care for the elderly person, assistance in running the household, attendance, day center at which care services are provided, absorptive products, laundry facilities, delivery of meals-on-wheels.

10. An outcome of this law being insurance-based is the principle that the benefit is assured for everyone who is eligible according to uniform and egalitarian rules that are set in the Law and regulations. *It is the responsibility of the National Insurance Institute to examine eligibility for the benefit,* and it is helped to this end by structured dependency tests that are as inbuilt and objective as possible.

11. According to the Law, *the responsibility for determination of the care program and concern to see it carried out falls on a regional professional committee*, consisting of a social worker from the local welfare services, a nurse representing the local health services and a regional claims clerk representing the National Insurance Institute.

12. Eligibility for *the long-term care benefit is conditional on a means test*. This stipulation does not sit well with the principle of a contributory insurance law and it can be considered a deviation from the system of benefits of the National Insurance Institute. This principle was, regrettably, introduced into the Law as a constraint because of budgetary restrictions. In practice, those who are not eligible because their income is too high are very few in number, perhaps because of the relatively low incidence of elderly persons among those with high incomes. It is possible that the extensive information campaign launched by the NII with the introduction of the Law, in which this point amongst others was emphasized, deterred high-income elderly from applying.

13. Another principle anchored in the Law is the right of appeal both against the determination of eligibility and against the care program. On the matter of eligibility, *the elderly person, or whoever represents him, may apply to the Labor Court and, to this end, he is entitled to legal aid in filing his complaint.* As to the care program and its implementation, the elderly person or whoever represents him may apply to an appeals committee especially appointed for long-term care insurance. Senior professional staff, such as nurses with professional experience in geriatrics, social workers with professional experience in the area of aging, health and rehabilitation and senior officials of the National Insurance Institute, serve on these appeal committees. An appeal against a decision of the appeal committees comes before the Labor Court.

Implementation of the Law — Facts and Figures

It became apparent at the early stages of the Law's implementation that the original estimates or the scope of the eligible population were much lower than in reality. One of the explanations for this is certainly the difference in timing between preparation of the estimate and implementation of the Law. Another explanation concerns the group of the cognitively impaired elderly, the full size of which was unknown in the health and welfare services, to some extent certainly because of family embarrassment and confusion. It is also clear that the experts in the various disciplines were lacking knowledge

of this impairment and were therefore unaware of the size of the problem. This fact again confirms what is known to anyone providing social services: if there are no services, persons in need do not apply for help, but problems and distress still exist.

We are thus aware of the dynamic whereby as the services are available, the distress comes to light and with it, the size of the problem that surprised all those dealing with the subject. Repeating our tests, such as research undertaken outside the NII, have confirmed that the size of the problem as it has come to light, really does reflect the reality of the situation (see the research work of Shtessman et al., 1991.).

The process of operating the services as planned and applied, is proving itself as loyally serving the eligible population, and indeed all those who are parties to the operation of the Law, such as representatives of the various ministries, are meeting the time-tables set in the Law. The eligibility process is the exclusive responsibility of the National Insurance Institute, for which purpose it hires the services of skilled nurses who carry out the dependency test in the elderly's home. The structured test takes about two and a half hours. This service is bought by the NII from the Public Health Association near the Ministry of Health.

As noted, the care program is determined by a local professional committee, appointed for the purpose under the Law: a social worker who serves also as coordinator of the committee from the Department for Family and Community Services; a senior nurse from Kupat Holim, representing the local health services; and a claims clerk from the local branch of the National Insurance Institute. The committee is sovereign in its decisions about the care program and determination of the service provider.

About 200 local professional committees, coordinated by senior social workers, are operationg alongside the Family and Community Departments throughout the country. The implementation, directives and follow-up are in the hands of an inter-disciplinary staff team including the management of the Rehabilitation and Long-term Care Insurance Bureau of the National Insuraance Institute, the management of the Service for the Aged of the Ministry of Labor and Social Affairs and the Management of the Nursing Bureau of Kupat Holim. The National Insurance Institute operates the payments system and the extensive computerized management system that accompanies the entire program and is distributed to all the relevant partners. The local committee has available to it a catalogue with a list of firms providing services that have received a license after being examined by the Service for the Aged of the Ministry of Labor and Social Affairs and

the signing of a contract with the National Insurance Institute. The contract specifies conditions, including the obligations of an employer under the law, the obligation of the firm to engage a social worker/nurse for instruction of those giving the care and for supervision over them, the qualifications of those giving the care, reporting and payment procedures, etc. The local committees may order care services only from those listed in the regional catalogue. The local professional committee also has the prerogative to select the specific service, oversee it and approve accounts for the services actually given.

Despite preliminary fears that people to give the care might not be found, since the incidence of the Law, there has been an exceptional acceleration of services and many firms have been set up (Before operation of the Law, only Matav Co. operated and provided services through some 900 personal care attendants).

Following are some figures from April 1992 (taken from the data of the Research and Planning Administration and the Computerized Data System of the National Insurance Institute that are accompanying operation of the Law):

— Persons eligible for long-term benefit	34,095
— Rate of those eligible from among those who apply for the long-term care benefit	47.3%
— Rate of rejected (level of dependence on others too low)	52.7%
— Mortality rate (1991)	23.1%

The services given:

— Recipients of personal care and home help services	31,488
— Visitors to day centers	2,151
— Visitors to private commercial day centers	273
— Recipients of absorptive products	3,124
— Recipients of laundry services	592
— Recipients of delivery of "meals-on-wheels"	6

Firms providing services:

— Number country-wide	178
— Non-profit organizations (including local associations, etc.)	72
— Private commercial companies	106

Distribution of hours of care:	
— Monthly attendance hours in homes of the elderly	1,501,948
— Through non-profit public companies	714,386
— Through private companies	750,092
— Other (including kibbutzim)	37,469
Estimate for benefit payments in 1992	NIS 315 million

Discusstion of Problems Arising from the Operation of the Law

1. Services in Kind as against Services in Cash

The debate over this issue has been with us for almost 10 years, starting with the committee that drafted the Long-term Care Insurance Law. The final decision was to give preference to services in kind, and those who so believe credit this preference for the great successs of the Law's implementation, as do those who have become believers in this method because of the Law's implementation. Either way, the debate is not over and there are those who still bitterly criticize the preference for services in kind. They dig themselves in at the opposing pole and come out in favor of a cash benefit which they consider as absolute support for the freedom of the individual to choose his own priorities. As against the cash benefit they place the services benefit that, they claim, is interference by the establishment in the life of the individual and sets patterns of care. However placing a cash benefit against services in kind is putting the subject on a single value track, on the individual's freedom versus interference in his life. This ignores the range of possibilities that accompanies the operation of services for the benefit of the dependent elderly and their families.

During the four years which have elapsed since application of the Law by way of services in kind, the experience accumulated points to the development of a most rich variety in the relationships of the elderly person and his family with the community elements operating the services.

For the purpose of operation of the services, the local professional committee has the task of setting a care program and seeing to its realization. The ability of the committee through professionals such as social workers and nurses, and the ethics that go with their activity, is based on multi-dimensional personal contacts: conversations with the elderly person and members of his family, listening to distress, forming trust, home visits, partnership in the burden of responsibility of the care program, supervision over the home helps, following up on the severely dependent elderly and the care he receives, being available to the family at times of need and operating

support services such as Kupat Holim clinics and departments for family and community welfare services.

Alongside the interference of the establishment, therefore, one should see the richness of the contact of the representatives of the establishment and the "profit" hereby gained by the elderly person and his family.

Doing something for another person has always entailed elements of interference in his private life. Let us look at the other side of the coin, at programs for a cash allowance where the person remains free to choose his own solutions. Let us recall that we are talking about dependent elderly persons, either living alone or with families that bear a heavy and ongoing care burden. Alongside the freedom to choose there is also the loneliness of distress, of decision and of the burden. The establishment is remote, even alienated, and relates with indifference and non-partnership to what is going on in the home. It may apparently be said that it is not essential for there to be no professional accompaniment alongside cash allowances but reality shows that when the contacts have no binding significance there is no chance for them to exist. Helping a person indeed means involvement in his life.

In practice, the special service programs for the disabled and services for handicapped children are recognized. The majority of this population group certainly faces situations of great distress but is unrecognized by the professional services and it is certain that a considerable portion of the cash allowances that are intended for these services becomes part of the total family income. It is thus dubious whether the allowance meets the aim for which it was intended.

The purpose of the long-term care benefit is to ease the lot of the elderly and their families in the community, in order to put off or prevent their placement in institution — and it is incumbent upon us to ensure that the benefits do serve this purpose, to which such large resources have been devoted. Our experience so far shows us that this way of a benefit in kind, including intrerference in the life of those eligible, maximally assures that the resources will be expended for their purpose. As to the apparent moral dilemma of reducing individual freedom, allowance has to be made for the specific characteristics of this group — the severely dependent elderly and their families — and of the care services for them.

2. Is it Possible to Give Some of the Elderly a Cash Benefit and Others a Benefit in Kind? All These Elderly be Viewed as One Group?

The legislator determined that a cash benefit may be given only where "there are no available services" — in other words, where the establishment

is unable to offer services, and only in such an instance is a cash benefit paid at a lower rate.

During the years that the Law has been in operation, the question has many times been addressed to us and many applications have been received for cash benefits to be given to ethnic groups (Bedouin, ultra-orthodox and others) as well as from various public representatives, individuals and other groups.

This issue, as the previous one, has many aspects: First, let us again recall the purpose of the benefit — to ease the care burden *at home* so that the family will be able to cope and to put off the need for an institutional arrangement. From familiarity with the population of eligible elderly persons, we have learned that their income is low and there is a real question as to whether a cash benefit, in terms of the family income, will be expended for the purpose for which it was intended. In situations of shortage there is a great difficulty in consuming services and the *inclination* to bear an additional work load and spend money on other needs is very understandable and quite tempting.

From research into the impact of the Long-term Care Insurance Law (Brenda Morgenstin and Sarit Baich, February 1992) we have learned that, although the families invest a great amount of work for the elderly person with them, they all pointed to many difficulties and the need for further help. Most of them mentioned tension, pressure, physical burden, loss of social contacts, health problems and so on. Establishment interference in the family's order of priorities in the provision of services, therefore, retains the aims of the benefit to ease the burden on the family of *care for the elderly* and in this way, as noted, postpones and perhaps prevents, the institutional placement.

It may be also assumed that most of the eligible elderly were not accustomed in their younger days to consuming bought services for the home because of the much lower standard of living prevalent in those days, both in Israel and in most of their countries of origin. Bringing ancillary help into the home to assist members of the family was certainly unacceptable decades ago.

There remains the question of ethnic groups, but it is superfluous to say that it would be intolerable for us to differentiate among the various ethnic groups — as such would be in complete contradiction to citizens' rights and equality before the law. It is further claimed that a Bedouin family, for example (as a family from any other ethnic group) is extended and united, does all that is necessary for its dependent dear one and considers

it unacceptable to bring in ancillary help. We recall that the purpose of the Law is to ensure that the help be used to ease the burden of caring for the elderly. It is reasonable to assume that a family, large or small, that has chosen to keep the dependent elderly person at home has taken upon itself heavy long-term tasks and will be able to receive assistance, at its choice, from the basket of services: absorptive products, day centers, home help, laundry facilities, delivery of meals-on-wheels and, apparently in the near future, also "personal alarm units". The aim of the Law is not provision of financial income per se nor even compensation for suffering but, as noted, an easing of the burden through services. We note that during the years the Law has been in effect new companies providing local services have been formed and are suitable for these special groups also.

In view of the applications of groups to receive cash benefits, we tried to examine and find other suitable groups but have not so far found such that we are able to classify with uniform criteria and obviate a breaking of the dam that will turn implementation of the Law in terms of its principles and equality into a matter of favoritism in making decisions over individual applications. Thus, for example, we ruled out the possibility of giving the local professional committee individual discretion in the provision of cash benefits.

Over five hundred members from three professional disciplines and various service organizations are active in local committees throughout the country. Apart from professional differences, there are certainly differences among them stemming from natural personal factors, such as stereotypes, biases and even learned opinions in the field of social sciences and psychology that are based on theories that are not unequivocal. Thus, the range of choice that would seem to us to be relevant for a family is that of its tastes in the consumption of items from the above mentioned basked of services.

In view of the aforesaid, it would seem to us that operation of services in kind *today* and in the prevailing social reality matches the aims of the Law and the target population. In a different social reality or in a different period, where patterns of service consumption are different, examination of additional ways could be possible.

3. The Development of the Extra-Establishment Services Market

Prof. Lester Salamon, Dr. Israel Katz and many others have stressed, in articles written in recent years, the advantages of non-profit organizations

that provide welfare and other services, as well as the disadvantages of the government and the establishment in the provision of direct services. This issue is now at the center of the public debate both in Israel and abroad, starting with the American model and continuing with European models, and with a similar trend in Israel. This developmental trend in the operation of the Long-term Care Insurance Law contitutes a breakthrough in quality, scope and uniqueness within the broad framework of provision of welfare services in Israel.

Since the Law was first operated, hundreds of companies have been set up and consolidated, half of them public non-profit organizations and half commercial profit-making companies.

Despite this surprising development, biting criticisms are heard on the one hand against private companies that "grow rich" as it were at the expense of the elderly and, on the other hand, against the public non-profit making companies that enjoy greater support and protection from the establishment. The criticisms come from within the companies themselves from public figures, political, economic and Histadrut circles and from private individuals.

The Israeli model combines establishment involvement in the determination of eligibility, determination of care programs and the finance for them, together with inculcation of the direct services themselves from non-governmental organizations. This model enables the establishment to engage in determination of organizational and professional policy, development of criteria, development of care standards, supervision and control. The follow-up and examination of the application of this innovative law are carried out intensively: Thousands of structured home visits by trained volunteers; orderly and planned control work according to representative samples by an outside company; supervision and control through the local professional committees; control, as a side product, from a large research project under the auspices of the Hebrew University of Jerusalem (Schmid & Sabbagh, 1990; 1991a; 1991b). All the findings from these different methods show great satisfaction: over 80%. We have learned that there are no large differences between the satisfaction of the elderly with non-profit making companies and their satisfaction with private companies, apart from a slight advantage for the Matav Co., that has a tradition of many years going for it, with small differences in satisfaction with the private commercial companies and, after them, with small differences, the public associations.

It may be noted that we further learned from the research that *most* of the income of the companies caring for the elderly came from the budget

of the Long-term Care Insurance Law. This strengthens our assupmtion about the patterns of service consumption, that most of the families who are eligible (as well as the others) are not used to purchasing personal care and home help services. This assumption should be examined over the years. The dependence of the companies and their staff on the operators of the Law and on the local committees imposes a grave responsibility upon us, since any significant change in the scope of orders for services could lead to economic crises, termination of a company's activity and dismissal of staff.

4. Manpower for the Benefit of Dependent Elderly

It follows from the above development that the referral of manpower for the benefit of dependent elderly and their families is important per se. The purpose of the Law is assistance for the dependent elderly, who rely on others, in the heavy daily burden imposed on members of the family in providing basic needs and prevention or postponment of institutional placement. It would appear that this is being achieved with the manpower that is being referred by virtue of the Long-term Care Insurance Law. We estimate that some 20,000 personal care attendants are making a partial or full living by virtue of this Law (with some of them providing services for more than one elderly person).

A majority of the attendants consider their work as a mission, that is a finding which came up in the research of the attendants (see Schmid & Sabbagh, 1991b), as well as in impressions from the cumulative field experience of the typical personal care attendant.

furthermore, this manpower, the scope of whose work is expressed in a million and a half man-hours of work per nonth, was not provisionaly available to the elderly in their homes. The Long-term Care Insurance Law has, without doubt, provided this significant addition, apart from its humanitarian contribution toward honoring the status of the dependent elderly in the community. Most of the companies have been investing more and more resources in instruction and cultivation of their employees and are developing an identification on the part of the employees with the companies and an esprit de corps in caring for the elderly.

It thus follows that the aims of this Law are being achieved by way of a benefit in kind almost optimally for the good of the elderly and constitute a unique net addition to the purposes that the Law posed.

It is difficult to ignore, and we shall certainly not deny the contribution of

the Law to assisting with unemployment distress in general and among new immigrants in particular. We know that many new immigrants have found jobs in this field (It is true that it was not a stated purpose of the Long-term Care Insurance Law to solve unemployment problems but, as has been said, "starting unintentionally it came to be done intentionally").

A debate that is occupying us in the sphere of manpower is the "proficiency boundary" of the personal care attendants. We want this manpower to replace tasks of the family and not those of professional manpower such as nurses, physiotherapists and so on. At the same time, manpower that devotes itself to this occupation must be allowed a path for promotion, as in any other professional occupation. Staff training, an important condition for giving a permit to operate under the auspices of the Law, tries to cope with the middle road between professionalization and proficiency.

Thought will have to be given in future to promoting careers in the long-term care field, in order to establish it as a specific and valuable occupation.

5. Choosing and Ordering Services from Companies at the Discretion of the Members of the Local Committee or Reducing them to Uniform Rules

Complaints about the cumulative power in the hands of the local professional committees in determining who will provide services come from all directions: from the commercial companies, the non-profit organizations, public figures, private complainants and others. The complaints cover many subjects: Does the committee not seek the easy way out and choose the most convenient? Do committee members have vested interests? Why are companies set up by public bodies not being chosen and encouraged? Why are the public companies being supported? Why are private companies being allowed to grow rich? etc.

This is a complex dilemma: On the one hand, we wish to retain the sovereignty of the committee so that it will be free to exercise its professional discretion in individual cases in which are a variety of personal factors. On the other hand, we want to reject any slanderous inference, knowing, as we do, that the discretion is exercised without any extraneous considerations. Moreover, with the very rapid development of this market, we wish to cautiously preserve the balance between the commercial devlopments and development of the public services market in community frameworks.

We consider this balance to be most important so long as this market is undergoing rapid development and has not yet stablilized and we do not yet have any firm imformation about its trends. Thus we attribute

great importance to reliance of the establishment in implementation of this Law on a balanced and varied market of public companies alongside commercial companies. We note that, in addition to an effective commercial market, local and national public associations have also developed and are pulling in many volunteers as a first-class work force that is contributing a great deal to carrying out social tasks in the community and for the individual, on the basis of "communal self-sufficiency", etc.

This positive social trend of development of associations that are close to the local establishment relies to no small extent on the economic activity generated with the services by virtue of the Long-term Care Insurance Law.

Together with this positive trend, it may be noted that the development of the local associations depends to a considerable extent on professional forces, particularly in the field of social work, and mostly from the local authority that have a deep attachment to services for the elderly. Thus, not a few social workers are involved in their direct or indirect work with the Long-term Care Insuarance Law and also in their direct or indirect activity with the local associations that provide services on behalf of the elderly.

The intensity of this problem is felt particularly in small places where the question of a conflict of interests may arise. Formally, a member of a committee may not participate in the activity of the association and there is initiated activity with instruction for improvement of the decision-making system of the committees. Strong emphasis is placed on active participation of three members of the committee in the decision-making so as to neutralize the possibility of accumulation of power in ordering services by just one member. Attempts are also being made to learn from experience and to add rules for decision-making with retention, as noted, of the power of the committee for individual discretion for the benefit of the elderldy person. The discussion on this point has not yet exhausted itself.

6. Living in the Community and its Boundaries for the Purpose of the Long-term Care Benefit

The Long-term Care Insurance Law, as is known, assures a service benefit for the elderly person who lives in the community and not for a nursing home resident. In delineating "living in the community", we relied on the definition of an institution of the Ministry of Health and the Ministry of Labor and Social Affairs, i.e., an institution in which care services are provided. A list has, therefore been issued of recognized and inspected

institutions, and no one staying at one of these is eligible for a long-term care benefit inasmuch as he receives care services by virtue of another public arrangement (the functions of the Ministry of Health and the Ministry of Labor and Social Affairs in the field of institutional care).

This provision is anchored in the law, but families find it difficult to understand why, just when the situation of the elderly person or of the family deteriorates, and they have to expend further amounts for him to be admitted as an inpatient, the long-term care benefit ceases. Moreover, the family has to undergo a means test, including the children, to pay for keeping the elderly person at the institution.

It is, as noted, difficult to understand this situation and families may find it unacceptable, as regards the long-term needs of institutional living. Moreover, anyone living or staying permanently in protected housing, unlicensed institutions or wards for the independent at geriatric institutions, whose main costs are not at public expense, is entitled to receive the long-term care benefit.

The discussion on expanding the insurance and its application to institutional arrangements also has not yet left the public agenda. On the other hand, in light of the unexpectedly large number of persons entiltled to benefits under the Long-term Care Insurance Law, it is doubtful whether it will be possible at this point to expand the services to include the institutional arrangement in a situation of budgetary deficit. The problem of institutional requirements and their solution has certainly not been exhausted and, in this situation, only a marginal rectification of injustices is possible, and almost certainly in the direction of greater stringency.

Summary

Despite the penetrating discussion of many issues, only some of which have beesn raised in this paper, the model of the Long-term Care Insurance Law seems to me most interesting for promotion of services for other target populations in general and for groups of people with disabilities in particular. It can be learned from the experience accrued from operation of the Long-term Care Insurance Law that the resources are expended for the right purpose in this model more than with other schemes with which we are familiar. Also, with this model the benefit that is paid under the Long-term Care Insurance Law does not stand on its own but its integration in the continuity of services for the elderly also ensures the organizational integration of the services for the elderly in all their frameworks. This

advantage has great importance for the effectiveness of the provision of the services, prevention of duplication and joint operation of many bodies for the sake of shared aims going beyond sectoral considerations. This achievement seems to me to be of exceptional importance in the Israeli reality.

In view of the lessons and conclusions that have been adduced from operation of the Long-term Care Insurance Law, other specific benefits that do not provide suplementary income should perhaps be re-examined. Should these benefits be in kind, in cash or perhaps a combination of both? Out of familiarity with other benefit programs that are intended for similar target populations, some in-depth clarification should be given to the benefits for disabled children, the benefits for special services for adults, benefits for housewives, benefits for the physically disabled, and perhaps others, too, with which I might not be familiar. One should not conclude from this that the Long-term Care Insurance Law can be adopted and adjusted in full and identically with respect to other target populations, but there is no doubt that other benefits should be re-examined in the light of the achievements of the Law as a law for in-kind services. To this end, an in-depth examination of the range of existing programs for the target population in question is essential, with attention being paid to needs, budgetary limitations, priorities, continuity of required services for the nature of the benefits within the overall system and with reference to the differential purposes. Just as operation of the Long-term Care Insurance Law was preceded by lengthy examination and planning by the best of the inter-disciplinary and inter-institutional experts, by means of surveys and research work, public debate, planning, and trial and error and application, so will this be necessary with respect to any other target population, where the benefit is not purely for subsistence purposes.

Re-examination of the systems intended for other needy target populations, would seem to me to be of exceptional importance for development of a future policy of services and benefits.

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ORGANIZATIONAL DILEMMAS IN THE PROVISION OF HOME-CARE SERVICES

by Dr. Hillel Schmid* and Prof. Yeheskel Hasenfeld**

The demand for home-care services to the frail elderly is increasing worldwide. According to the Work Health Organization, between the years 1980 and 2020, the total population is expected to increase by 95 percent, while the elderly population will increase by 240 percent.[1] Most of the increase will occur in the 75-and-older age group. By the turn of the century, almost half the elderly population will be above the age of 75. Women are overrepresented in the elderly population; by the year 2000, they are expected to constitute 58 percent of the over-65 population of the world.[2]

According to the Congressional Budget Office, demographic shifts are expected in the United States between 1990 and 2080 in the size and age structure of the population aged 65 and older.[3] Two factors are fundamental to these shifts. First, the "baby boom" begins to reach age 65 after 2010. In addition, mortality rates are projected to decline. Thus, the size of the population aged 65 and older is expected to surge upward until 2030, rising by 25 percent over 1990 levels by 2010, and more than doubling by 2030 (To place this in perspective, the total U.S. population is projected to increase by 20% between 1990 and 2030). The projected size of the oldest age group, 85 and older, will grow dramatically from its 1990 level — up 88 percent by 2010, 150 percent by 2030, and 370 percent by 2050.

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1. World Health Organization, *World Health Statistics Annual* (Geneva: World Health Organization, 1987).
2. D. Rice, "Long-Term Care of the Elderly and the Disabled", in: *Long-term Care and Social Security: Studies and Research*, No. 21, Geneva: International Social Security Administration, 1984.
3. Congressional Budget Office, *Policy Choices for Long-Term Care*, Washington, D.C.: Government Printing Office, 1991.

The costs of caring for the frail elderly have risen dramatically. In the United States, it is estimated that the total spending for nursing home care in 1988 was $44.3 billion, and for home care and community-based care, $13.6 billion.[4] Payments for this long-term care were divided almost equally between private sources (47%) and federal, state, and local government (53%). Almost all private payments (96%) for long-term care are made out-of-pocket by users or their families. By the years 2001 to 2005, the costs of nursing home care are expected to double, and the costs of home care are expected to increase by 70 percent.[5]

Not surprisingly, there has been growing pressure to provide home-care services as an alternative to institutional care.[6] In addition to the fiscal strain, these efforts are motivated by the early discharge of elderly patients from hospitals as a result of Medicare's prospective payment system and by the increasing awareness of the negative effects of institutional care on the elderly person's well-being. Although the research on the effectiveness of home-care services is limited and contradictory,[7] there are several studies indicating that the elderly clearly prefer to stay at home and that their quality of life may be enhanced by doing so.[8]

In response to the rapidly increasing demand for home care, especially unskilled home care, a burgeoning industry has emerged, comprising public, voluntary, and proprietary organizations and funded through public insurance and private payments. Primarily custodial, the services may include

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4. *Ibid.*
5. Alice Rivlin and Joshua Wiener, *Caring for the Disabled Elderly*, Washingnton, D.C.: Brookings Institution, 1988.
6. Although home care is cheaper than institutional care, this is apparently not the case for case-managed home care for elderly persons with high risk of institutionalization. See Hirsch S. Ruchlin, John N. Morris, Claire E. Gutkin and Sylvia Sherwood, "Expenditures for Long-Term Care Services by Community Elders", *Health Care Financing Review*, 10, no. 3 (1989), pp. 55–65.
7. Rosalie Kane and Robert Kane, *Long-Term Care*, New York: Springer, 1987.
8. Robert A. Applebaum, Jen B. Christianson, Margaret Harrigan and Jennifer Schore, "The Evaluation of the National Long-Term Care Demonstration: The Effect of Channeling on Mortality, Functioning and Well-Being", *Health Services Research*, 23, no. 1 (1988), pp. 143–159; Margaret W. Linn, Lee Gurel and Bernard S. Linn, "Patient Outcome as a Measure of Quality Nursing Home Care", *American Journal of Public Health*, 67 (1977), pp. 337–344; S. Bass and R. Rowland, *Client Satisfaction with Elderly Homemaker Services — an Evaluation*, Boston: University of Massachusetts, Gerontology Program, 1983; Janet B. Mitchell, "Patient Outcomes in Alternative Long-Term Care Settings", *Medical Care*, 16, no. 6 (1978), pp. 439–452.

personal care, companionship, shopping, housecleaning, the provision of hot meals, and household management. In the United States, the majority of the organizations providing unskilled care are either nonprofit or proprietary and the majority of revenue is received from self-paying patients, Medicare (for custodial services associated with acute care), and Medicaid.

Undoubtedly, the characteristics of the organiszations providing unskilled home care and the emerging structure of the industry have a profound effect on the nature and quality of the service the elderly receive. We review current research findings to assess the emerging dynamics of the home-care industry, especially the key organizational issues the industry faces, the organizational providers' adaptations and responses, and the potential consequences of the organizational dilemmas on the care itself.

Dynamics of the Home-Care Industry

As an industry, unskilled home care is characterized by considerable heterogeneity and instability and a high degree of organizational mortality — all earmarks of an industry operating in a turbulent environment.[9] Several factors contribute to such turbulence. First, there are considerable governmental constraints on the resources available to home-care organizations. Governmental funding includes Medicare, which spent $2.1 billion on home-health visits in 1986, approximately 55 percent of which went to nursing care; Medicaid, which spent $1.5 billion for home health care in 1986; the Older Americans Act, which spent $669 million in 1985 on senior center and supportive services, including home health care; social services block grants; and state and local matching funds.[10]

The estimated total spending on both home services and community-based services in 1988 — including nursing care, home-health aide services, homemaker services, home-delivered meals, and transportation — was $13.6 billion. Medicare accounted for $2.4 billion of the total; Medicaid, $1.3 billion; private out-of-pocket payments, $5.1 billion; and health insurance and all other sources of funding, the remainder.[11]

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9. Nancy Kane, "The Home Care Crisis of the Nineties", *Gerontologist*, 29, no. 1 (1989), pp. 24–31.
10. Maring Ruther and Charles Helbing, "Use and Cost of Home Health Agency Services under Medicare", *Health Care Financing Review*, 10, no. 1 (1988), pp. 105–108; Charlene Harrington and Leslie A. Grant, "The Delivery, Regulation, and Politics of Home Care: A California Case Study", *Gerontologist*, 30, no. 4 (1990), pp. 451–461.
11. Congressional Budget Office (n. 3 above): N. Kane (n. 9 above).

Government agencies control the industry by setting the rates and hours per visit for patients eligible for government payments. These rates are typically calculated to mirror the prevailing minimum wages in the unskilled service labor market. Self-paying patients, generally single women, may pay more, but their income tends to be quite limited. As a result, the margin of profit in the industry is exceedingly low.

A second and more ominous trend affecting the home-care industry is the move by governmental agencies to impose cost containment through restrictive reimbursement rules and caps on expenditures.[12] This move has constrained the expansion of the industry and resulted in several organizational changes (discussed below). To maintain profitability in the face of severe limits on the fees they can charge, provider organizations have had to minimize costs as much as possible. This effort has further depressed workers' wages and benefits and encouraged the employment of part-time and contract workers, exacerbating the instability of the home-care labor force.[13]

Third, in comparison to nursing care, the home-care industry is relatively unregulated, with minimal institutional controls.[14] For example, in many states, licensing requirements are few or nonexistent. There are few, if any, standards with which home-care organizations must comply, and providers are subject to minimal accountability requirements. When states do require licensing of home-care providers. the requirements echo the federal Medicare standards, which are weak.[15] Indeed, Leslie Grant and Charlene Harrington found quality-of-care problems to be similar for licensed and unlicensed home-care providers; licensure does not assure a more adequate quality of care.[16] There are even fewer regulations for the provision of unskilled care.[17]

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12. Andrew Szasz, "The Labor Impacts of Policy Change in Health Care: How Federal Policy Transformed Home Health Organizations and Their Labor Practices", *Journal of Health Politics, Policy and Law*, 15, no. 1 (1990), pp. 191–210.
13. Penny Feldman, *Who Cares for Them? Workers in the Home Care Industry*, New York: Greenwood, 1990.
14. Allen D. Spiegel, *Home Health Care* (2d ed)., Owings Mills, Md: National Publishing, 1987; Harrington and Grant (n. 10 above).
15. S.H. Johnson, "Assuring Quality of Home Health Care for the Elderly: Identifying and Developing Tools for Enforcement", report prepared for the American Association of Retired Persons/Andrus Foundation, St. Louis Universithy of Law, St. Louis, 1988.
16. Harrington and Grant (n. 10 above).
17. Although the National Association for Home Care, a trade association of home-care organizations, promulgates standards and criteria for the industry, it lacks any significant enforcement capabilities.

Moreover, because most home-care organizations are quite small, there are no dominant organizations that can establish and enforce standards for the others in the industry.

The lack of institutionalized rules regulating the industry creates difficulty in mobilizing legitimacy through accreditation, governmental licensing, or the support of leading professional and service organizations such as hospitals and the United Way.[18] The increase in the number of hospital-based, home-care agencies and the entry of affiliates of national health care chains are attempts, in part, to capitalize on the reputation and legitimacy of these larger organizations to develop a stable market niche. Because there are no set institutional expectations regarding organizational structure and processes, home-care organizations exhibit diverse organizational configurations, ranging from hospital-based agencies and multiservice centers to broker agencies and individual proprietors. This array of organizational forms for the delivery of home care further adds to the instability of the industry and contributes to a high rate of disbanding.[19]

Also, because the industry is largely unregulated, it is sensitive to even modest legislative changes. For example, the 1980 Omnibus Budget Reconciliation Act, which eliminated the Medicare state licensing requirement, initiated the entry of proprietary agencies into the market, which resulted in the restructuring of the industry. In 1966, public agencies dominated the Medicare-certified home health care industry with 45 percent of the agencies, and the Visiting Nurse Association constituted 40 percent of the agencies. By 1984, the proportion of public agencies declined to 28 percent in the industry and Visiting Nurse Association agencies to 12 percent. They were replaced, for the most part, by proprietary and hospital-based agencies.[20] The easing of Medicare regulations had initially encouraged the entry of large for-profit health care organizations. However, as Nancy Kane noted, many of these for-profit providers experienced losses and low profit margins, leading to their exit and thus leaving the industry to small proprietary and voluntary organizations.[21] These transformations

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18. John W. Meyer and W. Richard Scott (eds.), *Organizational Environments*, Beverly Hills, Calif.: Sage Publications, 1983.
19. Jitendra V. Singh, Robert J. House, and David J. Tucker, "Organizational Change and Organizational Mortality", *Administrative Science Quarterly*, 31, no. 4 (1986), pp. 587–611.
20. Tony Salvatore, "Organizational Adaptation in the VNA: Paradigm Change in the Voluntary Sector", *Home Health Care Services Quarterly*, 6, no. 2 (1985), pp. 19–31.
21. N. Kane (n. 9 above).

signaled the increasing competition in the industry, leading to higher rates of founding and disbanding.

To cope in such a turbulent environment, provider organizations can choose between generalist and specialist strategies. The generalist strategy aims to optimize existing and potential resources by developing a wide network of outside relationships. This strategy involves providing a variety of products, services, and programs. In contrast, a specialist strategy strives to develop a distinctive competence and entails concentrating products and service within a relatively narrow environmental domain.

Proprietary home-care organizations tend to adopt a generalist strategy. They suppply and differentiate among a wide variety of services and products in addition to custodial care. They may include, for example, private-duty nursing, medical equipment, laundry services, and transportation. The services are developed and provided rapidly and in diverse locations to ensure immediate return of capital, which the organization needs for its operations.[22]

Conversely, public home-care organizations adopt a specialist strategy, concentrating on providing mandated services.[23] Voluntary provider organizations usually begin with a specialist strategy, but as they encounter greater competition, especially from the proprietary agencies, they tend to shift to a generalist strategy.[24] Indeed, to survive, the voluntary agencies begin to emulate the proprietary providers or to develop their own satellite, for-profit entities. Consequently, voluntary and proprietary home-care organizations display an increasing degree of similarity.[25]

The generalist and specialist strategies affect home-care services in several

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22. Juanita B. Wood, "The Effects of Cost Containment on Home Health Agencies", *Home Health Care Services Quarterly*, 6, no. 4 (1985/1986), pp. 59–78.
23. Hillel Schmid and Clara Sabbagh, "Organizational and Structural Aspects of Public and Private Organizations Delivering Services to the Frail Elderly — a Comparative Analysis", *Social Security*, 36 (1991): 36, 49–67 (Hebrew).
24. Laura Reif, "Expansion and Merger of Home Care Agencies: Optimizing Existing Resources through Organizational Redesign", *Home Health Care Services Quarterly*, 1, no. 3 (1980),pp. 3–36; Salvatore (n. 20 above); Linda A. Bargthold, Carrol L. Estes, Pamela Hanes and James H. Swan, "Running as Fast as They Can: Organizational Changes in Home Health Care", in: Carrol Estes, Jaunita P. Wood and Associates (eds.), *Organizational and Community Responses to Medicare Policy*, San Francisco: University of California, Institute for Health and Aging, 1988.
25. Warren Balinsky and Jordan N. Freeman, "Proprietary and Voluntary Home Care Agency Evolution: The Emergence of a New Entity", *Home Health Care Services Quarterly*, 6, no. 2 (1985), pp. 5–18.

ways. A generalist strategy enables the organization to provide a more comprehensive system of care, to reach a broader target population, and to be responsive to changes in the demand for and supply of services. However, a generalist strategy may result in reduced efficiency.[26] It increases administrative costs, and it requires constant quality control over a wide range of activities. Hence, a generalist strategy may sacrifice effectiveness for diversification. A generalist strategy also reduces the stability of the service network as agencies "chase" new funding opportunities and discard services with shrinking funding. Finally, a generalist strategy increases the risk of fraud, especially among proprietary organizations.[27] An unscrupulous generalist agency can bill for skilled care while providing unskilled care, and it may substitute one occupational title for another (e.g. home-health aide for home-care worker) to obtain higher reimbursement rates for services performed.

A specialist atrategy enables an agency to provide high-quality service to a targeted population. Specialization reinforces a stable and predictable service network. It also produces fragmentation in the market and increases the costs of coordinating various services to the consumer. The specialist agency, furthermore, is slow to respond to changing market conditions, especially demand.

Difficulties in Delivering and Monitoring Services

The actual organization and delivery of home-care services are beset by structural problems that can adversely affect their effectiveness. These problems range from implementing a service technology requiring close interpersonal relations between worker and client to reliance on an unskilled and unstable work force. The organizational solutions to these problems influence the quality of care the frail elderly will receive.. Three specific issues are examined: the fit between home-care workers and clients; the dilemma of control and monitoring; and the reliance on a casual and unstable labor force.

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26. Michael T. Hannan and John H. Freeman, "The Population Ecology of Organizations", *American Journal of Sociology*, 82, no. 5 (1977), pp. 929–964.
27. Doris R. Fine, "Women Caregivers and Home Health Workers", *Research in the Sociology of Health Care*, 7 (1988), pp. 105–117.

The Fit between Worker and Client

Although the service itself — that is, the performance of the home chores — is quite simple, its success depends on a trusting interpersonal relationship between the worker and the recipient of services, a relationship that occurs outside organizational boundaries. It involves an intrusion into some of the most personal and intimate domains of the client's life. To paraphrase Eugene Litwak, the home-care worker is expected to develop a formal bureaucratic relationship as a functional substitute for intimate primary group relations.[28]

Moreover, the provision of care is made more difficult by the high degree of variability in the needs of the frail elderly and their families. Not surprisingly, home-care workers frequently indicate that one of the most difficult aspects of their work is the unpredictable physical and behavioral problems they encounter.[29] Frequently, the home-care worker intrudes on a complex family relationship, especially between the frail elderly and their children or spouses. This imbues home chores with complex and latent psychosocial ripple effects far beyond the chores themselves. As noted by Raymond Berger and Steve Anderson, "Family interference is one of the most difficult tasks facing the in-home worker".[30]

Unlike institutional care, home care occurs outside organizational boundaries, severely hampering the organization's ability to exercise effective control over it. A home-care organization must ensure that an appropriate and trusting relationship develops bewtween worker and client when the relationship is not readily visible to the organization. This task is further complicated by the fact that clients are highly dependent on their workers and therefore cannot readily exercise their rights as consumers or effectively monitor their home-care workers. The exceptions of course, are clients who pay privately and do not depend on public or other funding. Similarly, because the domain and scope of the work are not readily defined, the workers may encounter what they perceive to be unacceptable demands. Yet because they depend on the clients for a livelihood, they may have to acquiesce. In short, the home-care situation creates the potential for exploitative relationships.

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28. Eugene Litwak, *Helping the Elderly: The Complementary Roles of Informal Networks and Formal System*, New York: Guilford, 1985.
29. See, e.g., Feldman (n. 13 above).
30. Raymond B. Berger and Steve Anderson, "The In-Home Worker: Serving the Frail Elderly", *Social Work*, 29 (1984), pp. 456–461.

Typically, organizations offering comparable services technologies attempt to control them through professionalization.[31] This is clearly not possible for home-care organizations. Hence, effective management of services hinges on the fit between home-care worker and client. One strategy for assuring this fit is for the agency to assume an active matchmaker role; the agency tries to find home-care workers who are compatible with clients in terms of work expectations, cultural background, and temperament and who are sensitive to the emotional needs and physical disabilities of the elderly. To do so, the agency must invest resources in assessing the capabilities and needs of both the client and the home-care worker. Matchmaking depends on a stable pool of home-care workers, which can best be attained if the workers are full-time employees of the agency. Such a strategy is obviously costly and may not be feasible in the current economy of home care. It does, however, increase the probability of an appropriate, trusting and effective relationship between worker and client.

An alternative strategy is to shift the responsibility to clients and their families, despite the limitations imposed by communication barriers and inability to give clear expression to thoughts and feelings. Despite the fact that they may lack the capacity to make an imformed decision, clients and their families are left to determine which home-care worker is best suited to their needs and how to manage the relationship. Home-care workers must rely on their own knowledge, experience, and skills — which may be limited — to negotiate an appropriate relationship. The agency role is circumscribed to giving clients access to a registry of home-care workers, administrative monitoring of the workers, and certification of hours and payments. For the agency, such a strategy reduces operating costs and buffers it from failures since the clients and the home-care workers must absorb the costs of the matching process and its potential failure.

Structurally, home-care organizations attempt to manage the services offered by making procedures routine and services standard, especially by specifying the type and duration of each type of service. In doing so, agencies endeavor to reduce the discretion both of clients and of employees. The strategy is likely to meet with only limited success because it seeks to impose stability and predictability on what is inherently an unstable and unpredictable service. As Litwak points out, such a routine structure

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31. Yeheskel Hasenfeld, *Human Service Organizations*, Englewood Cliffs, N.J.: Prentice-Hall, 1983.

is mismatched with the requirements of the services offered unless it is augmented by the family's participation in its delivery.[32]

The Dilemma of Control and Monitoring

Because home care requires a carer to function under conditions not readily visible to the organization, providers encounter acute difficulties in controlling and monitoring their workers. The organization cannot rely solely on its consumers to supplant or complements its own monitoring function. Frail elderly clients become highly dependent on home-care workers and, as such, experience a considerable power disadvantage, which precludes effective control over the behavior and activities of the workers. Clients cannot readily exercise the option to terminate the relationship or to complain about the quality of the service.[33] As noted before, some workers may also be reluctant to exercise these options for fear of loss of income. In addition, one of the unique aspects of home-care work is the workers' isolation from coworkers and thus their inability to rely on peers for guidance and support.

Although home-care organizations may promulgate rules and procedures and develop supervisory and reporting requirements, they face the same dilemma experienced by "street-level bureaucracies".[34] That is, the workers are quite removed from the control center of the organization, and the organization is highly dependent on them for the information needed for monitoring. The workers, despite rules and procedures, can exercise considerable discretion in their interaction with clients. Hence, the capacity of the organiszation to detect deviations from organizational rules is greatly diminished, especially when either the client or the worker chooses to ignore them. The absence of institutionalized standards and measures of effectiveness or quality reduce the monitoring to such observable behaviors as attendance, reported hours of work, and client complaints.

The inability to measure effectiveness or quality can also be exploited by agencies to the detriment of either the client or the home-care worker. For some organizations this vacuum serves as a stimulus to reduce the quality and quantity of the service due their client by law. Workers, sometimes

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32. Litwak (n. 28 above).
33. Albert O. Hirschman, *Exit, Voice and Loyalty*, Cambridge, Mass.: Harvard University Press, 1970.
34. Michael Lipsky, *Street-Level Bureaucracy*, New York: Russell Sage Foundation, 1980.

with the tacit understanding of their agencies, may take advantage of their clients' dependence and fail to provide the required number of service hours, accompanied by fallacious reports on services rendered, enables some providers to reap undeserved profits and some workers to supplement the minimal wages and benefits they receive. The absence of an effective control apparatus in an industry operating at a low margin of profit invites unscrupulous practices.[35]

One way to avoid this situation is to delegate more responsibility to workers, thus making them participants in addressing clients' needs. Research has shown this strategy to be positively and significantly associated with worker satisfaction, trust in management, belief in the equity of rewards allocation, positive attitudes toward the organization, and low levels of turnover and absenteeism, which, in turn, influence the stability and quality of the worker-client relationship.[36]

However, workers' participation in service delivery decisions must also be coupled with frequent on-site inspections, close supervision, and frequent communication with the elderly and their families. These are not common practices in the home-care industry because of the costs entailed and the lack of sufficient resources or incentives for providers to invest in such a control system.[37] Such incentives arise when there are outside demands for accountability, when the agency seeks a competitive advantage by emphasizing the quality of its services, or when it has a strong client-oriented professional ideology. Hospital-based agencies, for example, are more likely to invest in such a control system because the elderly they serve are potential hospital patients.[38] Similarly, an agency that provides a wide array of services to the elderly recognizes that the quality of the home

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35. Fine (n. 27 absove).
36. S. Alexander and Marian Ruderman; "The Role of Procedural and Distributive Justice in Organizational Behavior", *Social Justice Research*, 1 (1987), pp. 177–198; J.E. Dittrich and M.R. Carrell, "Organizational Equity Perceptions, Employee Job Satisfaction, and Departmental Absence and Turnover Rates", *Organizational Behavior Performance*, 24 (1979), pp. 29–40; Robert Folger and M.A. Konovsky, "Effects of Procedural and Distributive Justice on Reactions to Pay Raise Decisions", *Academy of Management Journal*, 32, no. 1 (1989), pp. 115–130; R.J. Bullock, "Participation and Pay", *Group Organizational Studies*, 8 (1983). pp. 127–136; J. Greenberg, "Determinants of Perceived Fairness on Performance Evaluation", *Journal of Applied Psychology*, 71 (1986), pp. 340–342.
37. Harrington and Grant (n. 10 above).
38. Joel Handler, *Law and the Search for Community*, Philadelphia: University of Pennsylvania Press, 1990.

care can generate business for the other services it provides. Professionally dominated home-care organizations also tend to invest more in monitoring and supervision, in keeping with their service ideology.

The most common practice is to use clients and their families as monitoring agents to substitute for or to complement the monitoring activities of the provider organization. Indeed, workers are often evaluated by the number and type of complaints received. Such a strategy has the obvious advantage of reducing administrative costs.[39] In opting for this method, however, an agency relies on a reactive monitoring system that, again, shifts to clients at least some of the responsibility for system failures. Undoubtedly, when an agency adopts an active monitoring strategy coupled with an active partnership with its clients and their families, both the clients and the agency benefit. Research has also shown that, to the extent that clients are involved in determining their care plan, they tend to cooperate with agency management and to be highly satisfied.[40] Findings indicate that many agencies are soliciting clients' views on quality of care as an important components of defining and evaluating quality.[41]

Unstable Work Force

Home-care organizations rely almost exclusively on an unskilled, non-nursing, female labor force, which profoundly affects their service delivery systems. Most studies indicate that home-care workers are predominantly women with a low level of education, earning a minimum wage.[42] Less than half the workers are married, and a significant proportion are from ethnic minorities. Most work less than full-time, and their earned annual income falls appreciably below the poverty level, As a class of workers, they do not belong to unions and have little job security, few fringe benefits, limited training, and no opportunities for advancement. These characteristics typify workers in a highly peripheral service industry.[43] As noted above, such

39. *Ibid.*
40. Schmid and Sabbagh (n. 23 above).
41. L. Woerner, "Client Perspectives on Quality Care", *Caring*, 8, no. 6 (1989), pp. 47–51.
42. Rebecca Donovan, "We Care for the Most Important People in Your Life: Home Care Workers in New York City", *Women's Studies Quarterly*, 1–2 (1989),pp. 56–65; Feldman (n. 13 above); New York State Department of Social Services, *Strengthening the Home Care Work Force in New York State: A Study of Worker Characteristics, Recruitment and Retention*, Albany: New York State Department of Social Services, 1990.
43. James N. Baron and Andrew E. Newman, "For What It's Worth: Organizations, Occupations, and the Value of Work", *American Sociological Review*, 49, no. 4 (1984), pp. 454–473.

industries tend to consist of small agencies that operate in a localized and highly competitive market and that are particularly vulnerable to short-term market forces.

Moreover, as women and minorities, home-care workers are employed in a "tainted" market in which employers devalue their work and depress their wages because their jobs are female-and race-stereotyped.[44] As noted by James Baron and Andrew Newman, sex and race stereotypes devalue pay, especially when jobs are nonunionized, traditionally associated with gender and race (i.e., low-skilled occupations), and when performance measures are ambiguous — all attributes of home-care jobs.[45] Especially noxious is the fact that home care in general lacks monetary value because of societal assumptions about sex roles.

Home-care workers do find their work intrinsically satisfying due to the opportunity to provide concrete help and to the flexibility and autonomy it affords them.[46] At the same time, however, the low wages and benefits and the lack of any job security or future career developments trap them into a status of economic marginality from which few can escape, unless they leave such jobs. Not surprisingly, there is a high degree of worker dissatisfaction with working conditions, and a very high turnover rate — estimated to be between 30 percent and 60 percent per year. It is precisely such economic marginality that makes the attachment of the women to such work so precarious and thus undermines the stability and continuity of the home care on which the elderly depend.

Through their labor management practices, provider organizations contribute to the tenuousness of home care. Fiscal viability necessitates tight control over labor costs leading to increased workloads per worker, wage and benefit cuts, and the employment of part-time and contract workers ineligible for employee benefits.[47] Recruitment and retention become serious organizational problems under such conditions, inevitably affecting the quality and continuity of care.

Providers also encounter the ongiong problem of their more talented

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44. Barbara Bergman, "The Economic Case for Comparable Worth", in: H. Hartman (ed.), *Comparable Worth: New Directions for Research*, Washington, D.C.: National Academy Press, 1985; Marta Tienda, Shelly A. Smith, and Vilma Ortíz, "Industrial Restructuring, Gender Segregation, and Sex Differences in Earnings", *American Sociological Review*, 52 (1987), pp. 195–210.
45. Baron and Newman (n. 43 above).
46. Feldman (n. 13 above).
47. Szasz (n. 12 above).

and skilled workers leaving for better employment opportunities in other services, often developing their own clientele independent of the agency. Ironically, investing in training may hasten such exit unless the provider can offer greater inducements in terms of wages, benefits, and working conditions — which, as noted earlier, may undermine profitability.

Research on demonstration projects to improve the quality of work life of home-care workers shows that a better benefits package, systematic training, supportive supervision, job enrichment, and guaranteed work hours contribute to job satisfaction and reduce turnover.[48] Nonetheless, without continued external sources of funding, such demonstration projects cannot be sustained because they are too costly. In principle, nonprofit home-care organizations should have a more stable and better-trained work force because they can augment their revenues with charitable contributions and government subsidies and invest their surplus in training, supervision, and better wages and benefits. The extent to which they actually reinvest will depend on the availability of such surplus, their commitment to professional ideologies, external and internal checks against the use of surplus for organiszational self-maintenance, and managerial largess.[49] In contrast, for-profit providers will invest in their work force only to the extent necessary to maintain their competitive advantage.

Studies also noted that an agency's ability to provide home-care workers with guaranteed work hours is an important factor in retention and job satisfaction.[50] This is not surprising, given the precarious financial status of home-care workers and the potentially devastating effects of loss of work hours. Guaranteeing hours requires that provider organizations have a relatively stable demand for extended home-care services and, especially, a sufficiently large replacement pool of clients who need and can pay for services. Agencies that cater to self-paying clients or to those eligible for extended hours of services have a greater capacity to guarantee stable work hours. Similarly, agencies that can provide full-time employment to their home-care workers are less likely to experience difficulties in recruitment

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48. Feldman (n. 13 above).
49. Henry Hansmann, "Economic Theories of Nonprofit Organizations", in: W. Powell (ed.), *The Nonprofit Sector*, New Haven, Conn.: Yale University Press, 1987.
50. Feldman (n. 13 above). According to Feldman, a significant proportion of home-care workers may not be interested in full-time employment but rather in steady part-time work — that is, 25 or fewer hours per week. New York State Department of Social Services (n. 42 above). This survey indicated that a major reason for choosing home-care work was convenient hours.

and retention.[51] Work-hour guarantees, however, are the exception rather than the rule in the industry.

Conclusion

The unskilled home-care industry is beset by fundamental structural problems that can adversely affect the quality of care on which an increasing number of elderly persons depend. One of the most troubling characteristics of the industry is its inherent instability. The environment of home-care organizations is characterized by an ever-rising demand for home-care services coupled with uncertainty in the availability of fiscal resources, a high degree of competition, and dependence on an unstable labor force. Its institutional environment is similarly characterized by a lack of rules and standards, minimal state regulations and control, and practically nonexistent measures of effectiveness. Together, these factors lead to rapid entry and exit of home-care organizations, to a high rate of organizational failure, and to a confusing array of organizational configurations among home-care providers.

Organizational survival in such a context takes many forms, but two distinct patterns emerge. One predominant pattern is to establish a market niche by providing very low cost care to as many clients as possible. To do so, organizations rely on a casual labor force; invest minimally in the training, wages, and benefits of that work force; and shift a significant share of the responsibility for maintaining and monitoring care to clients and their families. The other, less common, pattern is to establish a market niche through the professionalization of unskilled care, either by coupling it with other professional services or by embedding it in a professionally managed and controlled organization such as a hospital-based agency. Organizations following this second pattern invest in their home-care workers' training, wages, and benefits; develop professionally guided systems for assigning and supervising workers; and engage clients and their families as active partners in the care-giving process. One would assume that, under conditions in which trusting interpersonal relationships exist based on a mutual according of dignity, support, and empathy, the quality of care is appreciably better.[52]

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51. Balinsky and Shames (n. 25 above).
52. Nancy N. Eustis and Lucy R. Fischer, "Relationships between Home Care Clients and Their Workers: Implications for Quality of Care", *Gerontologist*, 31, no. 4 (1991), pp. 447–456.

From the consumer's perspective, the structure of the home-care industry presents a bewildering picture, making choices and decisions about care difficult and unpredictable. The consumer has minimal knowledge about the quality of care available from various providers, has few assurances about the continuity of care. and has little protection from poor or exploitative practices. The consumer is left to bear the costs of having to rely on an unregulated and unstable industry.

Our analysis points to several important policy implications. First, there is a need to stabilize the home-care industry. To do so will require a two-pronged strategy. (1) Governmental agencies must set stable reimbursement rates that are above the minimum wage and include payments for a basic package of fringe benefits such as health insurance, paid vacation, and sick leave. Indeed, payments for fringe benefits should be made contingent on agencies maintaining a full-time work force. (2) Governmental agencies must enforce industry regulations that include minimal requirements for training of workers, professional credentials of supervisors, and frequency of agency monitoring of workers.

Second, there is a need to integrate home care with other services to the elderly. Home-care services benefit from links with other services, and they become elevated in importance. Concomitantly, there is a need to increase the level of professionalization (e.g., social work, gerontology, and nursing) among the executives and middle managers of home-care agencies. Instilling professional norms and ideologies throughout the organization is an important mechanism to ensure protection of the well-being of the clients.

Third, there needs to be a considerable improvement in the training of home-care workers and the development of opportunities for advancement, such as entry into monitoring and supervisory roles. This further points to the importance of the integration of home care with other services. Finally, to the extent possible, the elderly and their families must become active participants in the decisions and monitoring of the home-care services. Home-care agencies should be given incentives to orient the elderly and their families to the services to which they are entitled and to actively engage them in the service delivery process. One option, for example, is to provide the elderly and their families with home-care vouchers, making the agencies more dependent on consumer satisfaction.

THE DEVELOPMENT OF UNEMPLOYMENT INSURANCE IN ISRAEL

by John Gal*

Introduction

The Israeli Unemployment Insurance Law took effect in 1973. This law was enacted more than two decades after an official government committee, formed shortly after the establishment of the state, recommended that unemployment insurance (UI) be included in the first stage of Israel's social security program. Yet in recent years, less than two decades after the law came into being, the Knesset has enacted a series of changes in the law aimed at significantly narrowing the criteria for receiving benefits by different segments of the unemployed population.

The idea of UI was first adopted in the middle of the last century by trade unions in different West European countries. In the early part of this century, initial attempts to establish state-run unemployment insurance programs were made. Today, unemployment insurance programs exist in over forty nations (Alber, 1981).

The goal of UI is to provide (at the very least) a basic income to all those who are willing and able to work, but are unable to find employment. In its modern form UI is aimed at enabling the unemployed to seek suitable employment, without suffering a significant drop in their prior standard of living. The sources of funding for the program differ, as do the administrative methods. However, UI is generally characterised by the fact that it is based on the insurance principle. Thus salaried workers, those who are liable to undergo periods of unemployment during their working life, are required to contribute part of their salary to funding the program.

As noted, despite the fact that the idea of UI received support in Israel during the initial years after statehood, it was adopted only two decades later and even then the process of enactment was difficult and protracted.

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In this paper, the development of UI in Israel since the idea was first raised, through its adoption, and up until the controversy surrounding UI today, will be described.

In the first section of the paper, the focus will be on the development of the idea of UI during the period between the establishment of Israel in 1948 and the enactment of the law in the Knesset in 1972. In the following section, we will describe the way in which the program was put into practice and the reactions to it. In the final section of the paper, alternative explanations relating to the development of the law will be examined. In particular, the emphasis will be on an attempt to explain why it took so long until UI was adopted and why this program generated so much opposition during the periods of growing unemployment in the 1980's.

From Support to Opposition: 1948–1968

The first attempts to deal with unemployment in pre-State Palestine were undertaken during a severe economic crisis in the mid-twenties. Seeking to alleviate some of the hardship caused by the unemployment situation, the representative bodies of the Jewish community provided financial support for Jewish workers unemployed for a period of over two months. During the thirties and forties, the Histadrut trade union federation also initiated a number of programs aimed at dealing with unemployment. The enphasis in these programs, however, was upon finding work for the unemployed and not upon providing financial support (Schindler, 1977; Daniel, 1987).

The notion of UI emerged during the first years of statehood, in particular during discussions over the welfare programs of the new nation. In 1948, mention of this idea can be found in the writings of Yitzhak Kanev, a key figure in the Histadrut and an expert on social security, and others (Kanevsky, 1948). Indeed, the guidelines of the first elected government included a promise to establish social institutions for the provision of assistance and insurance for the unemployed.

This position was also expressed in the plan for the Israeli social security system that was drawn up by an inter-ministerial committee headed by Kanev and presented to the government in 1950. In the committee report, there is a detailed proposal for UI and a lengthy justification for it. In its report, the Kanev Committee proposed that UI cover all workers and that the level of benefits be 50% of earnings for married workers with dependents and 40% of earnings for singles. The maximum duration of benefit payments, it was suggested, should be 180 days (*Kanev Report,* 1951).

It is, however, not coincidental that UI appeared in the very last place in the list of programs recommended to be adopted in the first stage of the social security system. Indeed, the committee proposed that relatively minor programs such as those aimed at providing insurance for farmers and economic support for the families of deceased persons be adopted *prior to* UI. These priorities reflected sharp differences of opinion over UI in the committee deliberations. While the Ministry of Industry and Trade representative supported the idea of UI as an alternative to severance pay, most of the members of the committee prefered to leave the adoption of UI to the distant future or, in the case of the representatives of the Treasury and of the Ministry of Labour, to ignore it entirely (Doron, 1969). The very inclusion of UI in the committee's recommendations was primarily the result of Kanev's insistence that the plan consist of a fullfledged social security system. In fact, the decision reached was to postpone the adoption of UI *indefinitely*.

Growing unemployment during the early fifties led to additional attempts to raise the idea of UI after the failure of the Kanev Committee to bring about the immediate adoption of the program. However, demands for adopting UI that were raised in the political arena (by the left-wing MAPAM and the communists) and in professional circles were all rejected by the government and by MAPAI, the leading party in the governing coalition.

While initially the government did not take an overtly negative stand against UI, this view became more clear-cut during the fifties. In 1953, Golda Meir, the Minister of Labour (and a leading figure in MAPAI), stated publicly that she regarded finding work for the unemployed as a better and more efficient means of dealing with the problem than UI (*Divrei ha-Knesset*, 1953, p. 1644).

Even when the levels of unemployment dropped and the potential financial burden of unemployment benefits lessened, this position of the government did not change. In speeches in the Knesset during the late fifties and early sixties, a number of Ministers of Labour emphasized the fact that their opposition to UI was a matter of principle. They adhered to a position that regarded labour as a central value of Israeli society and dismissed unearned income as morally unacceptable. This was a view that played a major role in the worldview of MAPAI and the labour movement, including the Histadrut. In fact, in a speech in the Knesset in 1957, Minister of Labour Mordechai Namir noted that within the Histadrut there is concern that UI "will have a bad effect upon the readiness of new immigrants to accept work that is offered to them" (*Divrei ha-Knesset*, 1957, p. 1508).

In general, the Ministers of Labour tended to prefer finding alternative solutions to problems of unemployment other than UI. This position found support in a series of reports by committees established by government ministers. In 1957, Ministry of Labour economist Avner Hovne submitted a document which concluded that the idea of UI was premature. In 1961, a committee headed by Oded Meser, Director General of the Ministry of Labour, was formed in order to examine the issue of UI. The committee concluded that "it is preferable to ensure a minimun income for unemployed workers by providing work, when there is a shortage of it, and to refrain from granting financial support that is not directly linked to the carrying out of some kind of labour in return" (*Meser Committee Report*, 1961, p. 2).

In fact, this position had already been put into practice by the government a number of years beforehand. From the early fifties onwards the government adopted a policy of relief work programs as a central element in its employment policy. Typically, most of these programs required that the unemployed worker participate in physically strenuous tasks in agriculture, afforestation, road building or archeological digs in order to qualify for benefits. While no legislation was passed relating to the program, the Israeli government provided work for thousands of unemployed persons yearly in a variety of relief work programs right up until 1969 (Gal, 1993).

During the first half of the sixties, calls for the passing of an UI law lessened due to a significant drop in the immigration rate and in the unemployment level (which hovered around the 3.5% mark during that period). However, demands to adopt UI were renewed during the severe economic recession that hit the Israeli economy during 1966 and 1967.

At the height of the recession in 1967, unemployment levels reached 10%. Moreover, the nature of unemployment differed during this period. This time the unemployed included not only new immigrants, as in the fifties, but also higher socioeconomic sectors of the population (Doron, 1969). Statistical data published at the time indicate that white collar professionals and clerks comprised 13% of the unemployed, their number reaching 8,700 in 1967. The decision-makers apparently understood that the work relief program was not a suitable solution to the needs of the white collar unemployed.

The government's initial reaction to the sharp rise in the number of unemployed was to decide upon the establishment of a committee to examine proposals for legislation guaranteeing employment and unemployment insurance. In January 1967 then Minister of Labour Yigal Allon nominated Knesset Member Moshe Baram as chairperson of an eighteen-person committee.

After forming the committee, and in reaction to a threat by MAPAM to leave the coalition, the government decided, in February 1967, to provide cash grants to the unemployed. The goal of the program was to ensure a basic income for the unemployed. However, the grants and the establishment of the committee did not lead to a significant change in government policy on UI. Doron claims that "an examination of the nature of the committee and its members indicates that the goal was to put off a decision rather than deal seriously with the problem". Indeed, the program to provide cash grants enabled the committee to defer reaching a decision on UI (Doron, 1969, p. 446).

In fact, it appears that within the committee there was fierce debate over the issue of UI. Among members of the committee there were those who strongly supported UI. For example, committee member Aharon Efrat, MAPAM representative in the Histadrut, published an essay at the beginning of 1967 in which he predicted that "...the adoption of UI is only a matter of time after the traditional opponents have been forced to take into account the regretable nature of the (unemployment) situation" (Efrat, 1967). Efrat was not the only member of the committee to take this view.

In October 1967, a sub-committee headed by Giora Lotan of the National Insurance Institute (NII) submitted its recommendations on UI to committee chairperson Baram. While the sub-committee reiterated the traditional preference for the provision of work as a solution to unemployment over UI, it depicted relief work as a necessary evil rather than as a desirable solution. Moreover, it recommended including UI in the framework of an employment law and suggested that job-seekers be eligible for unemployment benefits if "suitable employment" could not be found for them. The sub-committee recommended that the Minister of Labour would decide upon the criteria for "suitable employment" on the basis of the International Labour Office recommendations on the subject. This proposal, to allow an unemployed worker to refuse unsuitable work offers, marked a significat change of heart in the Establishment's approach to unemployment and the unemployed.

However, supporters of UI faced strong opposition within the Baram Committee. The disagreements over UI led to a lengthy delay in the publication of the committee's recommendations. Thus, while the recommendations of the Lotan sub-committee were submitted in October and discussed in the committee in November 1967, seven months elapsed before the final recommendations of the Baram Committee were submitted to the Minister of Labour.

While the influence of the Lotan sub-committee proposals can be

clearly discerned in the Baram Committee's final recommendations, closer examination of the document submitted by committee chairperson Baram indicates the major changes dictated by the opponents of UI. On the one hand, the committee accepted the notion of a combined law in which preference is given to the provision of work over the payment of unemployment benefits. On the other hand, unlike the Lotan sub-committee proposals, it recommended that relief work play a central role in the law.

The conclusions of the Baram Committee did not auger a real breakthrough in the UI debate. The committee's refusal to accept even the relatively conservative proposals of the Lotan sub-committee indicates an unwillingness to deviate from the views that had dominated discussion of UI until then. Once again the idea of work relief and the provision of work were prefered to UI.

Yet, at the same time, there is indication of development in the period between the recommendations of the Meser Committee in 1961 and the Baram Committee in 1968. For the first time, a government-appointed committee suggested including UI in the framework of employment policy. In addition, and despite the reservations, the committee approved the use of the term "suitable employment", therby indicating its acceptance of the notion that job offers must be suited to the job-seekers.

The results of the 1967 Six-Day War led to major changes in the Israeli economy. Among others, it marked an end to the recession, and it led to a significant drop in unemployment rates and in the number of participants in work relief programs. Concurrently, there was a real change of heart on UI despite the recommendations of the Baram Committee. This change of heart is very obvious in the recommendations of the Bar Yosef Committee that was established in March 1970.

In an economic accord between the government, the Histadrut and employers signed in early 1970, it was decided to adopt UI even if a formal decision on the matter had yet to be reached. As part of the accord, the three sides agreed to establish a UI fund based on the compulsory payments of workers (1% of wages) and employers (2% of wages).

After the political desicion-makers had taken this step, there still remained a need to flesh out the details of the program and establish the legislative and administrative means with which to implement UI. In order to deal with these details, a committee on unemployment insurance was established on March 18, 1970. Dr. Rivka Bar Yosef of the Hebrew University was nominated as chairperson of the fifteen member committee.

The legislation proposed by the committee was based on six basic principles.

UI, the committee stated, is intended to insure workers against wage-loss during periods of temporary unemployment of a frictional or cyclical nature. UI will be given as an insurance and not as a service and will be based upon the principles of social, not commercial, insurance. In additon, the committee decided that UI will be compulsory insurance and as widely based as possible. UI, it stated, is aimed at protecting the standard of living of the insured against any drastic reduction during the period of unemployment. Finally, the rights of the unemployed will be defined in such a way as to reduce as much as possible any negative work incentive (*Bar Yosef Committee Report*, 1970, p. 5).

Committee chairperson Rivka Bar Yosef described the law as a means aimed at "providing a temporary alternative to income from work". Speaking before members of the Knesset Labour Committee, she noted that the law included a number of new ideas. The first was the notion of universality, according to which "UI is a right which cannot be abolished. In other words, anyone who has worked and paid has a right, by law, to insurance against loss of work". Second, she noted, the insurance is not equal to all in absolute terms. Because the benefits are earnings-related, the unemployed will not be required to make radical changes in their lifestyle, rather to lower their standard of living to a certain degree. Third, a job-seeker need not accept every job offer, rather only "suitable employment" that takes into account his or her prior salary, education and work experience. Specifically, this definition includes three elements — a job offer that is suitable to the job-seeker's qualifications, a wage level that is not lower than the unemployment benefits that he or she is eligible to, and a position that is not too far away from the job-seeker's home. Finally, noted Dr. Bar Yosef, the law does not discriminate between men and women. All unemployed, irrespective of their gender, will have the same rights (*Labour Committee*, 1971, pp. 6–9).

In general, the Bar Yosef Committee proposals were accepted by the Knesset members. In March 1972, the UI legislation passed its final reading in the Knesset and became an integral part of the National Insurance Law. On the first of January 1973, Israel's UI program went into effect.

1973–1993: The Law and its Implications

The amendments to the National Insurance Law concerning UI passed during a period of full employment in the Israeli economy. To a large degree,

this situation did not change until the end of the seventies. During this decade, the number of job-seekers was small and the number of recipients of unemployment benefits even smaller. Speaking before the Public Committee for Unemployment Insurance (which was established in order to supervise the implementation of the UI program) at the end of 1976, the head of the Government Employment Service reported that the average monthly number of recipients of unemployment benefits in 1975 was only 450 (Haklai, 1976). In general, during this period UI was utilised primarily as a means to facilitate the movement of workers between workplaces.

Due to continuing full employment and the accumulation of a large amount of funds in the unemployment insurance branch of the NII, it was decided to gradually reduce the level of insurance contributions. In 1974, the level dropped from 3% of employees' salaries to 1.2%. In 1978, and again in 1980, the contribution levels were reduced to the level of 0.6% of wages. Yet a 1980 study undertaken by researchers at the NII found that the contribution levels were still too high and recommended that they be reduced even more (National Insurance Institute, 1980).

However, the employment situation began to change for the worst during 1979 and 1980. For the first time since the enactment of the UI law, there was a major increase in the payment of benefits. In 1980, the number of recipients of unemployment benefits rose by 236%. At the same time, there was a need to deal with a number of problems that began to emerge in the program.

One of the major difficulties was caused by the ever-rising rate of inflation. The existing system of indexation was not flexible enough to prevent a constant drop in the value of unemployment benefits from 1977 onwards. In 1979 the average value of the benefits was only 28.5% of the average wage, down from 42% in 1973 (National Insurance Institute, 1980, pp. 174–175). Under pressure from the Histadrut, the Public Committee for Unemployment Insurance decided to adjust the average income of the unemployed four times a year. At the same time, the differentiation between two types of unemployed was eliminated and benefits were paid to all the unemployed according to the higher rate. Finally, it was decided to calculate the applicant's average income on the basis of the 75 last days for which NII contributions were paid, rather than 150 days, as specified in the original law.

For the first time since the late sixties and the early seventies, the growth in the number of job-seekers and the consequential growth in the number of unemployment benefit recipients brought the issue of UI into the limelight. Reports on the worsening unemployment situation began to appear in

the daily press and first indications of criticism of the unemployed, who supposedly prefered benefits to work, began to appear. In an article published in August 1980, a journalist quoted senior officials in the Employment Service as warning against the "emergence of scrounging" among the unemployed (Kotler, *Maariv*, 1.8.80).

The focus of this criticism were the many discharged soldiers who comprised a significant proportion of the unemployed (National Insurance Institute, 1989, p. 13). Of the 42,142 benefits recipients in 1981, 10,000 were discharged soldiers. In the press, the number of reports of young men who refused to seek work and prefered to receive unemployment benefits grew. According to these reports, hundreds of discharged soldiers reported at the labour exchanges monthly and refused to accept the work offered to them by the labour exchange clerks (Dishon, *Yediot Aharonot*, 23.1.82).

It appears that one of the major sources of this criticism was the Employment Service, a semi-autonomous unit within the Ministry of Labour and Welfare. The Director-General of the agency, Baruch Haklai, expressed his criticism of the scrounging of the unemployed in 1980. "Once, not long ago" he said, "people fought over the right to work. Today they fight over money, over the right to receive unemployment benefits... we have to adjust to the job situation as it is today" (Kotler, *ibid*). The Employment Service waged a fierce struggle with the NII over the question of the level of unemployment. In contrast to the pessimistic figures published by the NII, the Employment Service tended to play down the level of unemployment. Haklai, who headed a public committee on UI, supported an amendment to the law which would require unskilled discharged soldiers to accept any job offered them (*Davar*, 25.1.82).

At the same time, discussions on changes in the UI law were being held in the NII and the Public Committee on Unemployment Insurance. Despite the fact that officials in the NII had reservations regarding the far-reaching changes in the law proposed by the Employment Service and the Treasury, the Director-General of the NII agreed that "certain limitations upon the eligibility of discharged soldiers to receive unemployment benefits were called for" (*Seminar in the Memory of Dr. Lotan*, 1982, p. 4). A number of proposals of this nature were subsequently approved by the Public Committee on Unemployment Insurance. One such proposal was to grant labour exchange clerks the right to offer job-seekers places of employment that were farther away from their homes than the 40-Kilometer limit set by law. It was also agreed that discharged soldiers would be required to accept any work offer. However, there was disagreement over the wage

level that would be part of the definition of suitable work for discharged soldiers (*ibid*, pp. 35–36).

Criticism of unfair exploitation of unemploymet benefits was also being expressed in the political arena. In a Knesset debate on the subject, one of the members claimed "that the UI law had become a means to get out of work" (M. Virshovsky, quoted in *Haaretz*, 1.6.82). Ministers in the government also raised the issue of the payment of unemployment benefits to discharged soldiers. The Treasury proposed changes in the law that would require every job-seeker to accept any job offer, limiting the payment of benefits to cases in which there were no job offers whatsoever (Porat, *Shaar*, 27.11.81).

In the Ministry of Labour and Welfare, there were attempts to formulate proposals that, according to the Deputy Minister in charge of the Ministry, Ben Zion Rubin, "would change the law and remove the limitation of suitable work in the case of young job-seekers" (*Avoda, Revaha Ve-Bituach Leumi* 390, 1982, p. 52). At the end of October 1982, Rubin submitted his proposals to the Knesset and they passed the first reading. The Deputy Minister proposed that the law be amended so that the period during which benefits would be denied a job-seeker who refused a job offer, would be lengthened from 30 to 60 days. He also suggested that benefits paid to discharged soldiers should not be higher than 80% of the minimum wage. In addition, it was proposed that when the jobs offered the unemployed were not suitable work, the NII would pay benefits that would make up the difference between the salary and 75% of the job-seeker's wage prior to unemployment.

During 1982 and 1983, there was a drop in the number of recipients of benefits, their number reaching 36,900 as compared to 42,152 in 1981. However, this drop did not last for long and in 1984 the numbers began to rise once again rapidly reaching levels that were higher than those at the beginning of the eighties.

Public debate in professional and political forums, and in the press, continued. During this period, a number of far-reaching proposals on UI were raised. One such proposal was made by Prof. Ruth Klinov. In it she advocated providing part of the unemployment benefits as a lump sum during the initial stages of unemployment, while the remainder would be paid over the period of unemployment proportional to the length of the period. The goal of the proposal was to provide an incentive for job-seekers to limit the length of their job search (*Seminar in Memory of Dr. Lotan*, 1982, p. 15).

An additional proposal was drawn up by an inter-ministerial taskforce on UI that was formed in 1986 by the Cabinet Committee on Unemployment

Policy. Nissim Baruch, then NII Director-General, was appointed to head the taskforce. On the one hand, the taskforce found "that the UI law is achieving its primary goal of ensuring the income level of the insured *during the period of job seeking*", and that additional limitations aimed at enhancing the incentives to work among benefit recipients would not contribute significantly to lessening unemployment levels.

On the other hand, the taskforce submitted a proposal that was described by representatives of the Treasury and of the Ministry of Economy and Planning as creating "a permanent state of relief work" (*Baruch Team*, 1986, pp. 6–13). The proposal, that was supported by a majority of members of the taskforce (yet strongly opposed by the Treasury and the Ministry of Economy and Planning), suggested that the government be required by law to provide work to inhabitants of regions strongly hit by unemployment. At the same time, UI payments would be suspended as would the rights of employees to UI. The unemployed would be required to accept any job offered to them. The proposal was justified on the grounds that under conditions of long-term unemployment, there are no employment opportunities. Therefore, it was seen as better to provide the unemployed with benefits and in return — require them to accept any work offered them by the government.

The opposition of the Treasury and the Ministry of Economy and Planning to the proposal was not so much a rejection of the idea of a return to the relief work approach to unemployment, but a result of their apprehension with regard the cost entailed in financing the program. Not surprisingly, this opposition ensured that the proposal was not accepted by the government.

After the number of unemployment benefit recipients stabilized at a relatively high level during 1986 and 1987 (around 58,500 recipients each year), the number began to rise rapidly once again in 1988. By 1989, the number of recipients of unemployment benefits was four times the number in 1980.

During this period, demands for changes in the UI law gained momentum. The daily press continued to publish reports on scrounging, and economic commentators demanded amendments of the law. An editorial in the prestigious daily *Haaretz* noted, that "the distortions in the UI law have been blatantly obvious for years — yet nothing has been done to correct them" (*Haaretz*, 28.7.89).

While in the early eighties it had been mainly representives of the right wing Likud who had called for changes in UI, during the late eighties representatives of the Labor (formerly MAPAI) party also joined in the campaign. In the past, Labor party member Ora Namir, Chairperson of the Knesset Labour

and Social Affairs Committee, had led opposition to amendments to the UI law. Yet, in 1989 she published an essay in which she claimed that "the law should be changed so that no one can abuse it" (Namir, *Davar*, 25.6.89). Another Labor Knesset Member, Deputy Treasury Minister Yossi Beilin, announced in the Knesset that there were certain "distortions" in the law that required remedial action (*Divrei ha-Knesset*, 1989, p. 3341). Indeed, apart from a handful of left wing Knesset Members and a number of experts in the field, there was a consensus on the need to add limitations to the law.

One pressure group that was particularly active in its calls for significant limitations upon eligibility to unemployment benefits was the Industrialists' Association. In a document submitted by the industrialists to the Minister of Labour and Welfare in 1984, they claimed that "UI undermines the motivation of the unemployed to accept existing job offers". The industrialists recommended cutting benefit levels and widening the gap between the minimum wage and the level of unemployment benefits.

Within the government and civil service, the Treasury and the Bank of Israel were the most outspoken critics of UI. In the annual reports of the Bank of Israel in the second half of the eighties, one can find support for the claim that UI encourages a lack of work thereby causing a rise in the levels of unemployment.

An example of the prevailing view in the Treasury on this issue can be found in a position paper on UI and the changes needed in the law, that was prepared by Treasury officials in 1989 and leaked to the press. The expressed goal of the proposed changes was to neutralize the negative work incentives in the existing laws. Among the proposals: Changing the maximum distance that a job-seeker be required to travel to work from 40 kilometers to 60 kilometers; requiring the unemployed (apparently unskilled workers under the age of 35) to accept any job offer; lessening the maximum amount of benefits from 80% of the prior wage to 65%; and changes in the criteria of suitable work (*Hadashot*, 9.2.89).

However, proposals for changes were discussed in other ministries as well. A committee of Ministry Director Generals headed by Ministry of Commerce and Industry Director-General Yoram Belizovski, that was established at the end of 1988, recommended that the amendments to the UI law that had been submitted to the Knesset by Deputy Minister of Labour and Welfare Rubin in 1982 be enacted as quickly as possible (*Haaretz*, 21.12.88).

One of the forces that played a significant role in lessening the demands for greater limitations on the eligibility for unemployment benefits during the

early eighties was the Histadrut. Yet, by the end of the decade, its position changed. In official publications, the Histadrut called for lengthening the duration of benefit payments in regions with high unemployment, but it also supported the proposal to enlarge the 40 kilometer limit upon the travelling distance of job-seekers (*Report of the Economic and Social Research Institute*, 1990, p. 5). Moreover, the daily press reported in 1990 that the Histadrut was also ready to accept the idea that job-seekers would be forced to accept any job offer under certain conditions (Arlozorov, *Hadashot*, 6.9.90). The change in the Histadrut's position enabled Labor party leader and Treasury Minister Shimon Peres to justify the Treasury's anti-UI position in the Knesset (*Divrei ha-Knesset*, 1989, pp. 3341–3342).

The trend in the early nineties is clear. A wide consensus for limitations in the UI law has emerged among political and bureaucratic forces and interest groups. One result of this consensus was the eventual adoption of changes in the law. In February 1991, the Knesset passed legislation which narrowed the definition of "suitable work" for under 35 year olds, enlarged the travel distance for job-seekers to 60 kilometers, set the disqualification period on those who refused suitable work at 90 days, and slightly limited the benefits due to unemployed who had earned salaries that were higher than the average wage. Two years later, in April 1993, the Labour government decided to add further limitations to the law, making it even harder for the young unemployed to recieve benefits. It also renewed the relief work program and managed to engage a few thousand unemployed new immigrants in archeological digs and tree planting projects in return for income maintenance benefits.

Discussion

An examination of the development of UI in Israel indicates that, apart from a period that lasted around a decade and during which there was full employment, the idea never gained much support among decision-makers in Israel. It was of course no coincidence that the law was not enacted until the early seventies. All prior attempts to pass UI legislation were rebutted by the political establishment. And as soon as the program was implemented on a relatively large scale, it was severly criticised. As a result, significant limitations on the eligibility to benefits of different groups, and particularly the young and unskilled, were enacted during the eighties and nineties.

Why has UI been so unpopular among the social and economic policy makers in Israel? The most obvious answer to this question is that the

implications of the law are so negative that its continued implementation, in its original format, would have been illogical. Indeed, many of the critics of UI have stressed the fact that it leads to unjust manipulation of resources, encourages laziness and contributes to the growing unemployment level. The annual surveys of the Bank of Israel emphasized this very point. Moreover, a number of studies undertaken in Israel and elsewhere have tended to prove the existence of a link between unemployment benefits and the level of unemployment (Ish-Shalom, 1984).

However, closer analyses of the influence of unemployment benefits upon the unemployment rate have shown overwhelmingly that the effect has been very limited and certainly cannot be compared to the importance of UI's social function — the ensuring of adequate living conditions for the unemployed (Yaakobson, 1989; Daniel, 1988), These findings would appear to indicate that the claim that UI has a negative influence upon unemployment is not so much the reason for opposition to UI as it is ammunition in the arsenal of the opponents of this program.

It would appear that there are four possible explanations for the negative approach of policymakers towards UI. The first explanation focusses upon economic considerations. This claim was initially raised in Knesset debates in the early fifties. The govrernment's refusal to adopt UI, it was claimed by opposition parliamentarians, was a result of purely economic considerations (*Divrei ha-Knesset*, 1954, p. 1643). During a period of immigrant absorption and unemployment, decision-makers opposed UI because they felt that the newly established nation lacked the economic resources necessary in order to finance a UI program. They believed that the limited resources could be better used elsewhere. Support for the claim that economics played a major role in views on UI can also be found in an examination of the reasons behind the establishment of the UI fund in 1970. At the time, Israel was undergoing a period of economic growth which was accompanied by full employment and a large increase in public consumption. The Treasury sought means through which to restrain private spending and UI was perceived as a good answer to this need, particularly when there was no threat of unemployment. In the eighties, also, it has been claimed that economic considerations have played a major role in the demands to place limitations on eligibility to benefits. With the growth in unemployment and the economic crisis, these limitations were portrayed as a means through which the willingness of the unemployed to accept low-paying and low-status jobs would grow, thereby saving government expenditure.

There appears to be considerable evidence that indicates that economic

considerations can indeed serve as an explanation of the positions taken by economists on UI. However, this explanation is far less convincing when it seeks to explain the views of decision-makers in the political arena. If the decision not to adopt UI in the fifties can be explained in economic terms, the reasons behind the continued refusal to enact this law in the early sixties, when there was a very low level of unemployment, were clearly not economic. The financing of benefits during a period of nearly full employment would have been negligible. Similarly, it would appear difficult to explain the negative views on UI during the eighties solely in economic terms. During this period, there were clearly alternative ways to restructure the labour market during a period of unemployment rather than to focus efforts primarily upon UI. While economic considerations evidently did play a role in the decision-making process regarding UI, it would appear that the decision to embrace these considerations or not was less a result of economic logic and more of the political, or moral, logic of the politicians.

Indeed, the second type of explanations focusses upon the ideological-political level and seeks to understand the formulation of social policy by examining the ideological approaches of the political forces from which decision-makers emerge. In the Israeli case, explanations of this type have tended to concentrate primarily upon the worldview of the MAPAI leadership before and after the establishment of the state. While MAPAI was a social democratic party, its leadership during the first two decades of Israel's existence was comprised mainly of Jewish immigrants who arrived in Palestine from Russia at the beginning of this century in order to establish an egalitarian society in their homeland, the Land of Israel. These pioneers viewed engaging in labour, and particularly manual labour, as a moral act with a collective value far above and beyond its instrumental value (Bar Yosef, 1972). Work was perceived as something that would ennoble people, restore their dignity, and heighten their sense of personal connection to the land and the fruits of their labour (Shapiro, 1974). Obviously, the idea that the payment of unemployment benefits might encourage people to stay in their homes rather than seek work was regarded as extremely anti-social and drew vocal opposition.

In addition to this value-laden view of labour, it has been claimed that the position of the MAPAI leadership during the fifties was strongly influenced by their attitude towards the new immigrants from African and Asian countries. These immigrants, hundreds of thousands of whom reached Israel penniless during the first years after Independence, were predominant among the unemployed. The European-born MAPAI leadership believed

that these immigrants lacked the will or the ability to join the workforce and that they would have to undergo a transformation in their lifestyles and mentality in order to integrate into Israeli society. It was assumed that under these circumstances unemployment benefits would encourage laziness among immigrants who lacked a positive approach to work, and in particular to productive labour. Thus the value-laden view of labour along with the prevailing attitude to the immigrants provided a solid basis for opposition to UI.

While this worldview undoubtedly played a role in the MAPAI ideology, an attempt to explain the MAPAI leadership's opposition to UI solely on this explanation is problematic. First, support for UI was, in fact, expressed officially by two MAPAI dominated bodies (the Histadrut and the first government) just before and after the establishment of Israel in 1948. Surely this support does not indicate the sort of outright opposition that is presumed by the ideological explanation. In addition, as noted above, various political and professional groups supported UI during the fifties. Not least amongst these were Knesset Members representing MAPAM, the left wing of the labour movement. The fact that this party adhered no less than the MAPAI leadership to the idealization of labour approach yet also supported UI, would seem to undermine the claim that MAPAI's opposition can be based solely upon ideology.

A third alternative explanation of positions on UI centers upon the high-level bureaucrats in the civil service who were directly involved in the formulation of welfare policy. An examination of the history of the discussions on UI indicates that these officials played a major role in consolidating the opposition to UI prior to the end of the sixties. High-level bureaucrats, all of them affiliated to MAPAI, dominated all the committees and forums formed to discuss the issue of UI during the first two decades after the establishment of the State. When positions changed and the idea of UI was finally accepted in the late sixties, high-level officials, in particular those in the Treasury, once again played a major role in pressuring government Ministers to support the proposal.

The role of high-level bureaucrats in policy formulation with regard to UI was very conspicuous in the eighties. Not only were all the committees and teams that suggested limitations in the law comprised mainly of these officials, but reports in the press also point to the active involvement of bureaucrats in the efforts to enlist public support for proposed changes in the law.

The power of these officials was a function of the fact that they were

the ones who presented the various policy alternatives to the Ministers reponsible for policy. Their expertise in the details of the policy issues is generally far greater than that of politically appointed Ministers. Moreover, in contrast to the Ministers, who tend to change portfolios, the bureaucrats remain involved in specialised policy fields over long periods of time. It is not surprising, then, that many of the proposals raised by various Ministers of Labour were very similar to those raised by their predecessors.

However, it is not sufficient to point out the major role of bureaucrats in decision making on UI. There is still a need to explain the changing attitude of these officials towards this program. The answer to this, and to the changing position of the political leadership, can be found, perhaps, in the realm of political economy. Indeed, this is the fourth type of explanation of positions on UI (Atkinson, 1988).

According to this approach, opposition to UI, and to other social security programs, during the fifties and sixties was linked to the political leadership's desire for rapid development of the Israeli economy (Shalev, 1989). In order to achieve this goal, the government sought to ensure labour mobility and to reduce costs in the fledgling labour-intensive industrial sector. The introduction of UI would have undermined employers' access to the cheap and vulnerable labour power of the new immigrants from Arab and African countries.

The situation changed in the mid-sixties during the recession. As noted above, the number of unemployed from among the traditional MAPAI electorate of white collar and skilled workers grew significantly. It was clear that relief work would not provide an adequate response to the demands of unemployed white collar workers and professionals. It should come as no surprise then that MAPAI was ready to accede to the demands of the left and change its unemployment policy. Sticking to the old positions would have undermined political support for the party. Moreover, presumably many of the bureaucrats involved in policy making on this issue belonged to the very same white collar groups that were threatened by unemployment for the first time during this recession. It is easy to imagine that these social links influenced the attitude of these bureaucrats to UI and their readiness to introduce UI shortly after the end of the recession.

While the memory of the effects of unemployment during the recession influenced support for UI during the late sixties, the situation was very different during the eighties. During the seventies, there was a large increase in the white collar sector of the workforce, in particular of managers, professionals and academics. Despite the growth in unemployment levels

and the economic crisis in the eighties, the members of this sector were far more able to deal with the economic crisis than were lower socioeconomic groups. Moreover, the unemployment levels among these middle classes were far lower than those among other salaried workers.[1]

It can be assumed that the fact that most members of these middle classes did not generally face immediate threats of unemployment or of sudden drops in their income levels, and therefore did not need to resort to applying for unemployment benefits, contributed to the emergence of negative views towards the many young and unskilled recipients of these benefits. Under circumstances in which unemployment is common mainly among blue-collar groups and very specific cohorts, the emergence of stereotypical views among the middle classes that regarded discharged soldiers and unskilled workers receiving benefits as lazy and unwilling to work is not surprising. Support for, or at the very least — acceptance of, government proposals to place greater limitations on eligibility for unemployment benefits is but a natural result of these sentiments. Under these circumstances, the upper bureaucracy, which is a sector of the middle classes, has felt free to propose the adoption of economic policies which include limitations upon UI. Decision-makers in the political arena have sensed that statements advocating the placing of limitations upon unemployment insurance have not undermined their support among the middle classes but rather, have struck a sympathetic chord. The result has been the institution of changes in the UI over the last decade that have significantly limited the ability of the young and unskilled unemployed to receive unemployment benefits.

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1. During the eighties, the level of members of the middle classes among the unemployed ranged from a low of 12.8% in 1980 to a high of 14.5% in 1989. During this period, the middle classes comprised of between 26.4% (in 1980) and 30.4% (in 1989) of the workforce. Source: *Workforce Surveys 1980–1989*.

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ASSISTANCE TO CIVILIAN CASUALTIES OF HOSTILE ACTIONS

by Dr. Uri Yanay*

"...Those eligible for payments are eligible
not because they paid their national insurance
fees, but because they paid with their blood"
(P. Rosen, Minister of Justice of Israel, 9.10.56)

Introduction

The Jewish-Arab conflict in the Middle East claims many victims, including civilians who have been, and are still being injured in acts of violence. Israeli society is very sensitive to victims in general and to victims of this conflict in particular. This paper discusses the support provided to civilians who are not in uniform, but suffer injury as a result of a security-related incident.

During the pre-state period, many civilians were injured in incidents that were part of this conflict. The Jewish population and its national institutions provided various arrangements to ensure medical care and assistance to those who were injured. On a local basis, for families in which the main breadwinner was killed or injured, efforts were made to provide continued support to restore damaged property and to rehabilitate its owners.

In the absence of national governing institutions these arrangements were voluntary and local. Assistance was extended to casualties by the

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Although this paper is written in the masculine gender, it is also applicable to females. Data regarding the gender of the victims appear in the body of the text.

national institutions (the Jewish Agency, the Va'ad Le'ummi — the General Council of the Jewish Community in Palestine), voluntary associations (Women's organizations and volunteers), and also by local committees in various settlements. One can assume that there were differences in the assistance extended by various committees to residents hurt in security-related incidents. The resources available to each locality and local decision-making determined the amount of aid given to victims of such incidents during that period.

This paper focusses on the period after the founding of the state of Israel. In general, three periods of conflict (in which civilians were hurt) can be distinguished: The first period was during the War of Independence; the second, the period of infiltrators and Fedayeen; and the third, the period of Arab terrorism. In each of these periods, the state took upon itself the care of individuals hurt in security-related incidents, but the handling and the principles of assistance were different in each period. This paper will describe policy guidelines and the principles that shaped government response to civilian casualties during these three periods, and some of the programs and services designed for their support.

The developments in this service area are not characteristic of other welfare programs in Israel. While most social welfare and even insurance programs have been subject to cut-backs and belt-tightening, the trend here is of expanded rights, greater flexibility regarding those eligible, a larger eligible population, etc. It can be assumed that the more sensitive the public is to civilians hurt in security-related and terrorist incidents, the more attention is paid to their needs. This trend clearly reflects both the desire to compensate those who were hurt and also to maintain social solidarity (Doron, 1975, p. 72).

The First Period: The War of Independence

The decision in the United Nations in favor of partition and to end the British mandate in Palestine (November 29, 1947) brought about an increase in the number of violent incidents in Israel and the first stages of the war for independence. The declaration of independence of Israeli statehood on May 14, 1948 stepped up the acts of war. In the War of Independence, civilians were hurt in the invasion of Arab armies and also by acts of irregular Arab forces. Private property was also damaged in the war that erupted. The provisional government set up a special agency to handle cases of civilians who were hurt and to restore their property.

The Ministry for War Victims

The Ministry for War Victims was set up by the provisional government immediately after the founding of Israel and it operated for about three years, until 1952. The minister was Rabbi Yehuda Leib Hacohen Mimoun. The legal basis for the activities of the Ministry for War Victims was the Emergency Regulations (Repair of War Damage to Houses), 5709–1949. The mandate of the ministry was the care of war disabled and damaged property, evacuated populations, and provision of services to civilians hurt in the war.[1]

In order to distinguish between those injured before the founding of the state and those injured after the War of Independence, the ministry was charged with handling only those injured between November 29, 1947 and February 24, 1949, when the final cease fire agreement was signed. This 15-months period was defined as "The War". Anyone injured during and as a result of the war could apply to the Ministry for War Victims for assistance. It should be kept in mind that the ministry was established to deal with the civilian population only, not those mobilized. Soldiers injured during this period were handled by the Rehabilitation Department of the Ministry of Defense.

The Ministry for War Victims assisted civilians in a variety of ways: medical treatment, convalescence and rehabilitation, distribution of food, provision of loans, and dealing with damage to property, business and agriculture. The ministry had a staff of 45 working in the district offices of Jerusalem, Tel Aviv, and Haifa and gave services as charged by the Minister and following his directives.

War Casualties

The distinction betweens those drafted and those not drafted for the War of Independence was not an easy one. Among the civilian casualties were those who had volunteered for the war effort, even though they had not been drafted: These were youths who helped convey military intelligence, distributed food and ammunition to army posts, and volunteered to guard facilities or settlements. Among the casualties were those who triggered mines or who were hit by sniper fire or an erring shell while standing in line for food, water, or fuel. These were civilians, not soldiers, who were injured

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1. State of Israel, *Government Yearbook*, Jerusalem, 1949–50, pp. 140–141.

in incidents directly related to the war situation. As such, they were eligible for public assistance from the Ministry for War Victims. Every applicant for assistance from the ministry was obliged to prove, with the help of witnesses or other evidence, that the injury to him or his property was a direct result of the war or enemy action, and not any other cause.

Ministry Operations

The handling of property damage included help in repairing homes or acquiring basic amenities, assistance in the transition period, arranging funds for loans (depending on the branch of the economy) to war casualties, rehabilitation of commerce, industry and labor, assistance to the agricultural sector, and rehabilitation of settlements and various factories that were damaged during, and as a result of the war.

Most of the ministry's funding was drawn from the national budget. The Ministry for War Victims cooperated with the banking institutions to create joint loan funds at easy terms totalling 117,000 Israeli pounds (lirot) to be used for those injured.[2]

Until December 1949, 8,598 requests for compensation for damages were received by the ministry in a total amount of 8.6 million Israeli pounds, not including damages to the agricultural sector, estimated at 4 million Israeli pounds, which covered primarily compensation for personal equipment that was destroyed or fell into enemy hands.[3]

The services for war casualties included issuing of orders to repair houses whose damage did not exceed 15% of their value, and persuading tenants and landlords to repair structures. In addition, the ministry organized the distribution of supplies contributed by the International Red Cross to the evacuated Jewish population. The value of the commodities given to the ministry for distribution in 1949 reached a quarter of a million Israeli pounds.[4]

In early 1950, the Ministry for War Victims reported on its activities to the Knesset. According to this report, from establishment of the ministry through 1949, the Department for the Care of War Disabled extended support to 1,027 families of the injured or deceased, arranged convalescence and orthopedic aids for 185 people, provided constructive rehabilitation and

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2. State of Israel, *Government Yearbook*, Jerusalem, 1949–50, p. 141.
3. Bureau Report, *Knesset Record*, vol. 5, Appendices, p. 1982.
4. *Ibid.*.

vocational training to 182 disabled, and placed 326 injured people in jobs.[5] In the absence of reliable data about the population of injured and of property damage, it is doubtful whether the amount of coverage given by the Ministry for War Victims can be estimated, or its effectiveness evaluated.

Evacuees included mainly those from the old city of Jerusalem, Atarot, Neve Ya'akov, and agricultural settlements (primarily Gush Etzion). In addition there was a need to give support to families whose breadwinners were taken captive. In the framework of evacuees, 2,550 individuals were given assistance. Twenty-five thousand Israeli pounds were allocated for the subsistence of these families and for acquiring for them basic domestic equipment that had been lost. Evacuees from the old city were given monthly allowances.[6]

Abolishing of the Ministry Activity

Two factors brought about the abolishment of the government's Ministry for War Victims. The first was the enactment of the Property Tax and Compensation Fund Law, 1951, intended to deal with property damaged in the war. In a Knesset debate on February 5, 1951, Knesset Member David Pinkas, chairman of the Knesset Finance Committee, noted: "...It is unthinkable that in this war which we endured, individuals will suffer and the entire public will not bear together the damage caused to them".[7] The handling of property damage was thus transferred to the Ministry of Finance.

A second reason for abolishing the Ministry for War Victims was the feeling that the ministry was not geared to handle the problems of injuries and damages on a national scale. In criticisms of the ministry, it was claimed that the residents of Neve Ya'akov, for example, did not receive compensation "other than a measly sum that is not at all commensurate".[8] In a Knesset question, the Minister for Civilian War Casualties was asked how much was allocated by the ministry for damage from air attack on Tel-Aviv, and "Does the Minister believe that a house could be rebuilt with this amount?".[9]

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5. *Ibid.*.
6. *Ibid.*.
7. Knessewt Session 222 (51–52), *Knesset Record*, 8, p. 984.
8. Question in Knesset session, June 8, 1949, *Knesset Record*, p. 670.
9. Question in Knesset session 108, January 23, 1950, *Knesset Record*, 4, p. 11.

As early as June 28, 1950, the ministry was criticized in the Knesset, primarily for not bearing the burden of responsibility and because its administrative costs were very high relative to the assistance it provided. Aharon Zisling, Knesset Member for Mapam party asked: "Is it necessary to spend 40,000 pounds on administration to provide assistance worth 67,000 pounds?"[10]

Thus the government decided to disband the Ministry for War Victims and to divide up the responsibilities between two ministries: property damage would be handled by the Ministry of Finance in the framework of the Property Tax and Compensation Fund Law; and war victims would be handled by the Ministry of Social Welfare through the local welfare bureaus in each local authority. In contrast with treatment of the regular population, however, for whom welfare comes out of the local budget and the national authority according to a defined formula, the cost of supporting civilian casualties of the War of Independence was entirely borne by the national budget, i.e., without the participation of the local authority. The local welfare bureau was thus given charge of dealing with civilian war casualties, and fully reimbursed by the national government for those outlays.

In addition to this assistance from the national government, and in an effort to ease the lot of casualties of the War of Independence, municipalities, local authorities, and various institutions offered them assorted local benefits. These included exemptions from licenses and fees, municipal taxes, etc. Some benefits (intended primarily for disabled veterans and families of fallen soldiers) were also applied to civilians injured during the course of the war and their survivors. In each case, the decision was made by the local authority.

Transfer of Responsibility to the Ministry of Social Welfare

With the disbanding of the Ministry for War Victims in 1952, approximately 1,500 cases were transferred to the various local welfare bureaus, of whom about 900 were disabled in various degrees and 600 were widows and orphans.[11]

The rights of civilian war casualties were not prescribed by law, but over the years the Ministry of Social Welfare conveyed to the municipal welfare

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10. Knesset session 158, June 28, 1950, *Knesset Record*, 5, p. 1935.
11. State of Israel, *Government Yearbook*, Jerusalem, 1952–53, p. 142.

bureaus various administrative directives about the kind of assistance to be provided to civilian war casualties. Some of these were based on rights given to army veterans under the Invalids (Pension and Rehabilitation) Law, 5709–1949, and to families of fallen soldiers according to the Fallen Soldiers' Families (Pensions and Rehabilitation) Law, 5710–1950, and the regulations derived thereof. The Ministry of Social Welfare disseminated these regulations to the municipal bureaus, recommending that these services be provided to the eligible. It is important to note that the provision of these services to war casualties was administered in the same way as the provision of services to local welfare recipients.

According to the directives issued at that period by the Ministry of Social Welfare, claims made by a civilian disabled in the war or a family of a civilian killed in the war must be proven eligible based on a standard means test. These claimants also had to prove that their injury took place during and as a result of the War of Independence. Collecting such evidence is very difficult, especially for someone needy who has no connection with army authorities. He frequently has no details of the injury (or the circumstances of death), which means that he cannot prove that the victim was indeed a casualty of the war.

The combination of security-related events and handling by the welfare bureaus was very complex. There were cases in which someone was injured in the War of Independence when he was a child or youth, and the injury was at the time not serious. As time passed, the effects of the injury became apparent, earning ability diminished, and medical treatment was required. To be recognized as a victim of the War of Independence, making him eligible for assistance and medical expenses related to the injury, the claimant had to meet the aforementioned conditions. If he failed to do so, he was denied the right to assistance in the framework of the special arrangements to victims of the War of Independence offered by local welfare bureaus.

To receive a monthly allowance, every disabled war victim had to prove that his income was insufficient to live on, and that he was unable to earn enough to sustain himself or to rehabilitate himself. The level of assistance given to war casualties was relatively high, higher than the support provided to other welfare recipients at the time. A person with 100% disability was eligible for a monthly allowance, linked to 86% of the salary of civil servants at level 10 (the starting salary for a clerk) of the unified government salary scale. A lower level disability would entitle the individual to part of this amount — proportional to the percentage of his disability.

The minimal physical disablity that entitled a civilian injured in the War

of Independence to benefits was 25% medical disability. This was a relatively low threshold for medical disability compared to what was required of other disabled people who applied for assistance during this same period. A person injured in the war with a relatively low disability could come to the local welfare bureau for help, while regular welfare support for a person not injured in the war could be obtained only by those with greater medical disability.

Furthermore, anyone recognized as a civilian war disabled was entitled to medical treatment paid for by the government for any medical or health-related problem that originated from the war-inflicted injury. This included medicines, tests, x-rays, hospitalization, and auxiliary medical and orthopedic aids. The welfare bureaus were not authorized to offer such broad medical benefits to disabled civilians who were not disabled in the war.

Widows from the War of Independence who did not remarry and who had no other source of income were eligible for a monthly allowance linked to the salary of civil servants at level 10, unified government salary scale. Some disabled and widows were promised ambulatory medical insurance which was also given to other welfre recipients. Additional services were given through the Rehabilitation Service of the Ministry of Social Welfare at the discretion of the management of the service. This refers to assistance in housekeeping, aid in acquiring basic household equipment, reimbursement of travel expenses to work, convalescence, and sometimes also a loan for various needs such as purchase of a heater, wedding expenses for a grownup child, and the like.

It should be noted that even if the claimant could prove need and eligibility, it was the decision of the director of the local welfare bureau as to who received services and the type and amount rendered to the claimant and his family. Although it could be appealed before a local committee, this decision was the determining factor, even though the costs of this assistance were not borne by the local bureau.

On the other hand, the fact that assistance to casualties of the War of Independence did not financially burden the welfare bureau or the local budget, but was entirely covered by national resources, enabled the bureaus to give relatively broad support to civilian war casualties. Furthermore, the fact that they were "national cases" funded by the Ministry of Finance, enabled these disabled to go from town to town looking for suitable aid without the need to establish "residence", as required of citizens who apply for aid from any local welfare bureau.

The Second Period: Victims of Infiltrators and the Fedayeen

When the cease fire came into effect, hope rose that the war was over and it would now be possible to devote energy to conquering the desert, settling the land, and dispersing the population. Infiltrators into Israel were initially perceived as a harassment which was sometimes accompanied by theft, primarily of farming equipment and cattle. When the infiltrators began to cross the border into Israel armed with weapons and following several acts of violence, it became clear that some were *Fedayeen* — terrorist "suicide squads" — sent to sow fear and death in the civilian population. Some of the *Fedayeen* actions were daring and instilled insecurity in the border settlements established along the frontiers of the country as well as in settlements in its central region.[12]

With the rise of *Fedayeen* actions including murder and destruction, the public began to expect an appropriate response by the government to the distress of the new casualties. It was felt that leaving it up to the local welfare bureaus was not enough. The public expected a comprehensive national program that would address in an organized, institutional way the needs of the victims and their families. There are those who view the murder at Ma'aleh Akrabbim (March 17, 1954) as the first major incident that placed on the national agenda the need to deal nationally with victims and their personal and family needs. In this incident, infiltrators from Jordan attacked a public bus that was travelling from Eilat to Tel-Aviv, killing seven passengers. In another incident in early April 1956, *Fedayeen* killed four civilians and injured fifteen, leading to a manhunt for the terrorists in the south of Israel. Between 1950 and the end of 1956, a total of 264 civilians were killed in hostile actions and an additional 477 were injured. Between 1952 and 1956, 235 civilians and 245 soldiers were killed in such incidents. This hostile activity increased until the Sinai Campaign, causing casualties among both civilians and soldiers (*Atlas Carta*, 1978, Table 189).

In light of the number of casualties, the government proposed a bill intended to meet the needs of those injured in border attacks, the Border Victims (Benefits) Law, 5717–1956 (Bill 274 of July 29, 1956). The bill was tabled in the Knesset on the eve of the Sinai Campaign, October 9, 1956 and ratified on December 10, 1956.

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12. *Hebrew Encyclopedia*, Supplementary Volume A, p. 513.

Border Victims (Benefits) Law, 5717–1956

The Border Victims (Benefits) Law, 5717–1956, was designed to deal with civilian victims of security-related incidents in the frontier areas of Israel, whether they reside or work there. Upon tabling the bill in the Knesset, Pinhas Rosen, then Minister of Justice, said: "Fundamental to the proposed law is the concept that the State considers enlargetement of settlement in the frontier areas and encouragement of the settlers to be vital... It is unthinkable to foster settlement in the frontier without the public ensuring an appropriate compensation if people are injured as a result of exposure to the special danger entailed by settlement in the frontier... With passage of the proposed legislation, justice to those required to endanger themselves, and the framework is enlarged of laws that give expression to the State's concern for those about whom it should truly be concerned is rendered".[13]

In his address to the Knesset upon ratification of the law, Knesset Member Akiva Guvrin, then chairman of the Knesset Labor Committee, noted: "We are the only parliament in the world compelled to legislate a law like this. Since the cease fire agreements, infiltrators, especially the murderous *Fedayeen* groups sent across our borders by the fascist Egyptian tyrant, have injured 1,376 citizens of this country, 434 of whom lost their lives, in addition to property damage. Among the murderedd were women, children, and men, young and old, hard-working people, including new immigrants and Israeli youth who went to settle the frontier, to work the land and to make the desert bloom".[14]

Section 1 of the law defines as the eligible population "one who resides in a frontier area or who works or is employed in the frontier or who is in the frontier because of a function that he performs". According to this law, a frontier injury is defined as an injury incurred "in the frontier area or from across the country's borders by military, paramilitary, or irregular forces of a neighboring country or by an infiltrator as defined in the Prevention of Infiltration (Offences and Jurisdiction) Law, 5714–1954. To preclude doubt, the law explicitly states (parag. 1[1]), that it is valid only at a time when there is no state of war between Israel and a neighboring country.

According to this law (parag. 2), a "frontier victim" is eligible for medical treatment, convalescence, and medical and vocational rehabilitation according to the paragraph that deals with work injuries in the National

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13. Knesset session 166, October 9, 1956, *Knesset Record*, 21, p. 33.
14. Knesset session 201, December 10, 1956, *Knesset Record*, 21, p. 440.

Insurance Act. The Border Victims (Benefits) Law, 5717–1956, reflects a new social and legal conception of rights to an injured party. The main innovation of the law is the parallel drawn between frontier victims and work injuries. This change afforded a civilian frontier casualty far better rights than available to casualties of the War of Independence:

1. The right of the injured party to receive the benefit is not fundamentally dependent upon his economic condition. He does not have to pass a means test and does not have to prove his need of assistance. Even a person of means is entitled to rights under this program.

2. Authorization of injury is made by a "competent officer" to be appointed by the Minister of Defense. Although this officer is entitled to question the injured party and clarify the circumstances of the injury, this authorization eliminates the need for the injured party or his survivors to prove that the injury took place during an act of hostility (parags. 7 and 8 of the Law).

3. The Law provides compensation for injury, a disability allowance, and an allowance to survivors. The benefits afforded by this law to the injured party are linked (up to 75%) to his previous salary or income. If the injured party was not previously salaried, it is his right to receive benefits at a set rate which is relative and linked to the monthly average wage per employee post. This arrangement applies to both employees and the self-employed (parags. 3 and 4).

4. Some of the benefits are in-kind and include coverage of medical expenses, convalescence (physical and psychological treatments), and medical and vocational rehabilitation (parag. 2).

The law is retroactive (parag. 17). The legislator allowed civilians injured in security-related incidents in the past to claim benefits according to this law. After ratification and publication of the law, a period of one year was allowed during which benefits could be claimed retroactively by all civilians injured in hostile acts as of February 24, 1949 (the date marking the end of the War of Independence), even though for the period prior to publication of the law, payments would not be made.

As noted, this law removed the handling of frontier victims from the local welfare bureaus and transferred it to the National Insurance Institute (NII) through its local branches. This administrative change reflected a changed perception of security-related casualties: no longer did they have to prove their need and entitlement to receive assistance, but were entitled to assistance from society even if they are not in financial need.

Issues Concerning the Treatment of Frontier Victims

Although the Border Victims (Benefits) Law institutionalizes the handling of these civilians, it has some fundamental shortcomings that evoked criticism.

At the time the law was tabled for its first Knesset vote, several basic questions were already being asked. One (by Mapam Party Knesser Member Ya'akov Riftin) addressed the definition of "frontier": "There have been some painful cases at a marked distance from the border; there have been in the past and there will be in the future". Knesset Member Moshe Aram (Ahdut Ha'avoda-Po'alei Zion Party) raised the issue of the injured party residing or working in the frontier: "If someone by choice volunteers to help in the frontier, do we tell him that the law for frontier casualties does not apply to him?"[15] It was decided that the definition of "frontier" would be geographical and put by the Defense Minister on a map to be deposited with the NII. The Defense Minister was authorized to change this map at his discretion in line with changing events.

Other questions arose concerning the "salary" of a self-employed person for purposes of determining eligibility for benefits in accordance with this law: How should the salary of a self-employed person, such as a farmer, who does not draw a regular salary as an employee, be set? And what are the rights of a housewife, who is injured or killed in a security related incident in a frontier area? Will her family be eligible for benefits even though she was not either a wage-earner or self-employed? Indeed, the status of a housewife in this program is not resolved. The progarm does not offer benefits for this segment of the population.

There were also those who wanted to change the law concerning eligibility. Knesset Member Olmert for the Herut Party phrased his criticism as follows: "A work injury should not be mixed with a frontier-related injury. These matters are entirely different... Today we are sending to the frontier not just pioneers, but families in place of the hundreds and thousands who have not expressed a wish to live on frontier settlements. These people are being sent to frontier settlements straight off the boat, and therefore we must not equate their cases with work injuries".[16]

Knesset Member Devorah Netzer (Mapai Party) agreed with this argument, adding: "Let this serve as encouragment to all the settlers, those already in the frontier areas and those arriving daily to settle there. These settlements

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15. Knesset session 166, October 9, 1956, *Knesset Record*, 21, p. 35.
16. *Ibid.*, p. 38.

and all those living on the frontiers of our country enable all of us to lead a normal and secure life".[17]

Pinhas Rosen, Minister of Justice, raised an important point during the first deliberation: "...Those eligible for payments are eligible not because they paid their national insurance fees, but because they paid with their blood".[18]

The Border Victims (Benefits) Law was administered by the NII and its branches, but the program was not contributive and the public was not required to pay for being insured. Funds for the program were fully paid from the national budget. The guiding principle was thus the comprehensive responsibility shouldered by the state for its citizens who live and work in the frontier areas who are injured in security-related incidents.

The Third Period: Arab Terrorism and Casualties of Hostile Acts

Following the Six Day War (June 1967), Israel's borders changed and acts of hostility increased. An increasing wave of casualties among the civilian population called for new ideas and conceptions. Formerly, most casualties occured in the frontier areas, but this terrorism was directed against urban centers inside the country, Israeli facilities ouside the country, and international air travel. Terrorist acts — by nature dramatic, indiscriminate and fatal — left many casualties in their wake in every population group.[19]

On September 26, 1969 the government tabled in the Knesset the Victims of Hostile Action (Pensions) Law, 5730-1970.[20] Yosef Almogi, then Minister of Labor, explained the bill in the first session of the Seventh Knesset on December 23, 1969. Referring to the existing arrangement, he noted: "The current Border Victims (Benefits) Law, 5717-1956, was suitable essentially for the security situation that existed at the time, when hostile actions were primarily directed against the residents of frontier areas who bore the brunt of enemy attack... Although some border settlements are still under murderous attack by the enemy, the front has now widened to additional areas of the country and has even spread beyond the borders of the state".[21]

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17. *Ibid.*, p. 35.
18. *Ibid.*, p. 40.
19. *Atlas Carta*, 1978, Ongiong Security 1963-1967, War of Attrition.
20. *Official Gazette*, bill 860.
21. Knesset session 17, December 23, 1969, *Knesset Record*, 56, p. 285.

In his prefatory remarks to the law, the Minister of Labor added: "This bill reflects the existing emergency situation, and its goal is to ensure that civilians injured by enemy action or those dependent on them be afforded medical treatment, proper monetary compensation, and a reasonable standard of living".[22] The government proposed that the Border Victims (Benefits) Law, 5717–1956, be improved and that the new law apply to everyone harmed in a hostile action from the beginning of the Six Day War (June 5, 1967) onwards. The improvements are reflected in the widening of the eligible population, their rights, and the incidents covered by the law.

The need for the law and its importance were well expressed by Knesset Member Shlomo Rosen (Labor): "Because we are forced to live with terrorism and war for an extended period, we need a sense of solidarity among the entire Jewish population, a sense of security for each person that in time of tragedy, he will not be abandoned, that the public will take care of him. The sense of solidarity expressed in this law is one of the fundamental principles of our progressive State".[23]

Another approach to dealing with casualties of hostile actions that is related neither to the disabled nor to casualties of enemy action was presented by Knesset Member Yehuda Sha'ari (Independent Liberal Party). At the first reading of the bill, Sha'ari asked: "Hasn't the time come to offer general disability insurance?... Then we can simplify all the procedures and cover all the risks and even deal with borderline cases that are currently not covered... If a general law existed, perhaps the NII would not just pay the bills... it would bear the expenses".[24] This approach reflected fundamentally different principles. It denied the distinctions among various types of disability and claimed that anyone who is injured, for any reason whatsoever, can be covered by a contributive national insurance program that is comprehensive and inclusive. Sha'ari's approach was not well received. Elected officials wished to distinguish between victims of hostility and other disabled people. The reason for this was, perhaps, a desire to take into account public sensitivity toward victims of Arab terrorism and the desire to compensate them.

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22. *Ibid.*, p. 284.
23. *Ibid.*, p. 289.
24. *Ibid. Ibid.*.

The Victims of Hostile Action (Pensions) Law, 5730–1970

The proposed bill, the Victims of Hostile Action (Pensions) Law, 5730–1970. tabled in the Knesset by the government in late September 1969, expanded and made flexible the Border Victims (Benefits) Law, 5717–1956. The need to change the law was so urgent, that in presenting the bill to the Knesset, Minister of Labor Yosef Almogi felt the need to declare: "...In light of recent cases, there was an urgent need to implement the benefits in this bill even before it was enacted by the Knesset. In accordance with the decision of the Government, the NII is requested to implement the expanded payments as if the law were already in force".[25] The bill eliminated several limitations which had been part of the Border Victims (Benefits) Law:

1. The limitation on area was eliminated (frontier settlements according to a map of the Defense Minister, parag. 1 of the bill), and hence Israel and the territories held by the Israeli army after the Six Day War were included.
2. The bill was applicable to all visitors and tourists entering Israel on a visa or permit, not only to casualties who are citizens or residents of Israel (parag. 1[2]).
3. The bill covered all kinds of hostile activity, not only acts of infiltrators or a foreign army. Also, the concept "hostile actions" was interpreted rather broadly: In the language of the bill, "If someone is injured in circumstances that it is reasonable to believe was an injury in a hostile action, the injury will be viewed as a casualty of hostile action if not proven otherwise" (parags. 1, 3).
4. In place of a "competent officer" whose decision is final, it was now suggested that there be a "competent authority" to be appointed by the Defense Minister and the Labor Minister, whose mandate will be to define an incident as a hostile action. The decision by the competent authority can be brought to an appeals committee whose decision is binding (parag. 6).
5. The bill improved the level of benefits, but continues to link them to work injury benefits in the NII.
6. The bill expanded the definition of the injuring weapon to include firearms, mines, and explosive matter kept by Israeli residents for self-defense, the use of which (excluding illegal acts by an adult or criminal negligence) caused the injury.

Despite this extension, criticism of the new bill primarily concerned the

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25. Knesset session 17, December 23, 1969, *Knesset Record*, 56, p. 285.

nature and level of the benefits. Knesset Member Uzi Feinerman (Labor Party) claimed: "I find a defect in the benefits proposed in this law — the gap is very large between those suggested and the benefits given to army casualties... It would be correct and logical to equalize the benefits given to frontier and army casualties".[26] Knesset Member Ada Fineberg-Sereni supported this view, noting: "The individual who picks cotton in the area beyond the army patrol road, the Moshav member who milks the cows at night, the child who sleeps every night in a shelter — these are soldiers in every sense, and they deserve benefits just like army soldiers".[27]

These speakers expressed a consensus in the Knesset about the need to expand benefits to casualties of hostile actions, and to equalize them as much as possible to the benefits accorded army casualties and their families. After deliberations in the Labor Committee and the plenary, it was decided that the language of the bill (parags. 4, 7) would link the benefits paid to casualties of hostile actions with the benefits paid by the Ministry of Defense to army casualties according to the Invalids (Pensions and Rehabilitation) Law, 5709–1949, and with the benefits paid to families of fallen soldiers according to the Fallen Soldiers' Families (Pensions and Rehabilitation) Law, 5710–1950.

Indeed, in tabling the Victims of Hostile Action (Pensions) Law, 5730–1970, for the second and third readings, the chairman of the Labor Committee, Knesset Member Shoshana Arbeli-Almoslino, noted: "Linking these benefits with those of army casualties reflects both ethical and social justice: It prevents discrimination of the indigent and bases the benefits on equal rights for every casualty, regardless of income at the time of the injury".[28]

Knesset Member Arbeli-Almoslino also noted that, "Applying the law to tourists and temporary residents is intended to give a sense of security to the thousands of tourists, Jewish and non-Jewish, who continue to visit Israel despite the terrible propaganda". Concerning Israelis, the law ensures compensation to citizens and residents of Israel who were injured abroad by hostile actions: "...the murder of Israelis in Europe has more propaganda value than the killing of hundreds of soldiers in battle".[29]

The NII was charged with implementing the new law in the framework

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26. *Ibid.*, p. 286.
27. *Ibid.*, p. 292.
28. Knesset session 94, July 22, 1970, *Knesset Record*, 58, p. 2613.
29. *Ibid.*.

of its division for work injuries, i.e., in direct extension of the handling of frontier casualties by the NII and its branches, and utilizing the experience it gained in dealing with this population. The law also provided that the program be funded in its entirety by the national budget, as was the case for the previous law.

Because of the sensitivity concerning defining the type of incident in which an individual was injured, the law provided for two levels of appeal in this program. First, the individual may appeal to a committee regarding the decision of the "competent authority", appointed by the Defense Minister. The function of the authority is to confirm that the injury was "a casualty of a hostile action". In addition, the amount of compensation and the services granted can be appealed to the Labor Court, which handles claims arbitrated against the NII.[30]

In September 1993, the NII dealt with 1,282 casualties of hostile actions. Of these, 499 (38.9%) were women. The level of disability of 30 of the disabled exceeds 80%. The level of disability of two out of every three disabled (870 of the disabled, or 67.8%) is under 40%.[31] These data do not include families (dependents) of the deceased. If we add these families, the number of casualties of hostile actions (including dependents) handled by the NII reaches 2,000 disabled and family units (according to data from December 1992).

Implementation of the Law: NII or the Ministry of Defense?

The proposal to enact a law equalizing those injured throughout the country antagonized those who live in the frontier areas. They probably expected a special program that would set them apart, as had been the case in the past. Perhaps the intention of the residents of border Kibbutzim and villages was that the Rehabilitation Department of the Ministry of Defense would deal with them rather than the NII. On this basis, one can understand the reaction of the Labor Minister, Yosef Almogi, who responded: "The debate between the residents of the settlements and the Government has gone on for many years... They demand that [benefits in] the law for them be equalized to [benefits in] the law for army casualties. Financial considerations were not the decisive issue. Army casualties are a special problem: The age is different and the human material is different... We

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30. Knesset session 17, December 23, 1969, *Knesset Record*, 56, p. 294.
31. National Insurance Institute, *Statistical Quarterly*, 23:4, January 1993, Table XI/3.

cannot apply the law for compensating army casualties to civilians".[32] This issue was raised again at length in the deliberations of the Labor Committee, especially when the bill to amend this law was proposed in 1972.

Even though the NII was charged with implementing the Victims of Hostile Action (Pensions) Law, the question of implementation came up in the Knesset Labor Committee. In the first deliberation on this subject (January 3, 1973), H. Lachman, a representative of the NII, noted that the NII is handling 420 cases, of whom 270 were disabled as a result of hostile actions and 150 are their dependents. Most are residents of Israel, but some reside abroad (e.g., members of a group of pilgrims from Puerto Rico who were injured in the massacre at Lod Ariport, May 31, 1972). According to Lachman, most of those injured would have preferred that the Ministry of Defense handle their case rather than the division for work injuries of the NII.

The Knesset Labor Committee convened to discuss this subject on January 17, 1973 and again on February 4, 1973. Because of the fundamental importance of the discussion, the Director-General of the Ministry of Defense participated in the second discussion. The NII, demanded that casualties from hostile actions be transferred to the Ministry of Defense for a number of reasons. First, since the law creates some symmetry of rights between army casualties and casualties of hostile actions, there is no reason to separate them into two authorities: information (about rights, up-dates, etc.) is delayed between the two offices and does not arrive on time; the NII finds it hard to keep abreast of the benefits and rights given to army casualties; questions about rights asked by the NII of officials in the Ministry of Defense receive a variety of responses; the NII finds it difficult to take decisions about minors, the elderly, and widows who are eligible for benefits according to this law; the NII does not know how much discretion it has and what precedents already exist in the Ministry of Defense. Unlike the NII, the Ministry of Defense can respond quickly to urgent problems; it has internal committees and frameworks for taking decisions about exceptional cases, an indispensable tool which the NII lacks. And finally, claimed the representative of the NII, victims of hostile actions want not only symmetry of benefits between the two programs, as provided by the law, but also full public recognition at its base.

On the other hand, a representative of the Ministry of Defense claimed

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32. Knesset session 17, December 23, 1969, *Knesset Record*, 56, p. 293.

that the Rehabilitation Department of the Ministry is not set up to deal with children, the elderly or widowers, and is certainly not willing to handle foreign citizens. Throughout the world, it is normal for the army to deal with those in uniform, and not with civilian casualties. That is the special privilege of a soldier as opposed to a civilian. This uniqueness, which is important to the soldier and his family, should be preserved. Furthermore, the Ministry of Defense has a large budget and does not wish to add more budgetary commitments to it. Although the Ministry updates the rights of army casualties very frequently, said the representative of the Ministry of Defense, the system (with only four regional offices throughout the country) has to grapple with these changes. It is preferable that the casualties of hostile actions continue to be handled by the NII with its many branches scattered throughout the country. Finally, it was intimated by the representative of the Ministry of Defense, it is enough that the Ministry has an active committee to represent army casualties. It is not interested in adding another committee that would represent civilian casualties of hostile actions and their demands. This is an additional onus that the Ministry is not willing to take.

The question of which government ministry would deal with casualties of hostile actions engaged the plenary of the Knesset and its committees. On January 15, 1975, the chairman of the Labor Committee, Knesset Member Shoshana Arbeli-Almoslino, announced from the Knesset podium:[33] "...In July 1974, we recommended transferring the handling [of casualties of hostile actions and implementation of the law] to the Ministry of Defense. We received a positive response from both the Ministry of Defense and the Minister of Labor... The subject will be transferred no later than August 1, 1975".

But despsite this promise, casualties of hostile actions were still being dealt with by the NII, which took care to apply the updates of the Ministry of Defense and the frequent revisions made by the Rehabilitation Department concerning compensation and benefits to the disabled and families of the deceased as well as other services given to army casualties and families of fallen soldiers.

A Debt from the Past: Casualties of the War of Independence

Civilian casualties of the War of Independence continued to be handled by

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33. Knesset session 134, January 15, 1975, *Knesset Record*, 72/2, p. 1316.

the local welfare bureaus until enactment of the Border Victims (Benefits) Law, 5717–1956. When this law was passed, everyone injured between February 24, 1949 and the day the law went into effect was given an extension of one year to file an application with the NII to be covered retrospectively. Not included in this program, however, were those injured between Nobember 29, 1947 and February 24, 1949.

In the Knesset session of March 3, 1959, Knesset Members Schoffman and Riftin voiced their dissatisfaction with the assistance given to casualties of the War of Independence who continued to be poorly served by welfare bureaus.[34] Knesset Member Schoffman observed: "In Israel there are approximately 1,500 disabled civilians, veterans of the War of Independence and casualties of bombs and snipers. Until now, there is no systematic legal way to address their needs, and only by grace does the welfare bureau deal with these special welfare cases...". In the same spirit, Knesset Member Riftin asked: "The problem of civilian casualties from Israel's War of Independence has not been sufficiently resolved... Does the honorable minister intend to propose to the Knesset an appropriate law on this issue and, if so, when?" To this question, the Minister of Social Welfare, Perez Naftali, responded: "I agree that casualties from the War of Independence deserve special treatment, in terms of both assistance and rehabilitation... The Ministry of Social Welfare gives support to [these] families in amounts that far exceed those given to the needy in general...".[35] The Minister added: "I do not intend to propose to the Knesset a law that will define the rights of civilian casualties of the War of Independence. According to the data I have, the number of families still in need of special treatment for their injuries does not justify enactment of a special law... Enactment now of a special law, some ten years after the end of the War of Independence, would not be beneficial for the families, and therefore, as noted, I do not see the need for this legislation."[36]

In early 1963,[37] the Minister of Labor at the time, Yigal Allon, proposed a bill requesting that the Knesset "permit the consideration of claims regarding injuries in the past, even if the deadline for submitting the claim has been missed".[38] The Knesset approved this amendment (on March 12, 1963),

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34. Knesset session 610, March 3, 1959, *Knesset Record*, 26, p. 1264.
35. *Ibid.*, p. 1264.
36. *Ibid.*, p. 1265.
37. Knesset session 208, January 21, 1963, *Knesset Record*, 36, p. 864.
38. *Official Gazette*, 8:518.

allowing civilians who had been injured in security-related incidents in the past and had not managed to file a claim from this National Insurance program to do so now, even though they had not filed a claim during the given period.[39]

In 1964, Knesset Members Victor Shemtov (Mapan Party) and Benno Cohen (Independent Liberal Party) tabled a private members' bill called Benefits for the Civilian Disabled of the War of Independence, 1964, which sought to provide a legal basis for the rights of those injured between the declaration of the State (November 29, 1947) and the end of the War of Independence on February 24, 1949.[40] Knesset Member Shemtov noted that, "There is no need for great rhetorical efforts to point out that there is no justification for distinguishing between people who participated in the war effort of the War of Independence as civilians, and those who sacrificed themselves and were injured as soldiers". Hence, said Knesset Member Shemtov, "I believe that these civilians whose efforts and sacrifice I described to this assembly are deserving of treatment by right and not by grace, even if they are not welfare cases. Thus, sending them to the Ministry of Social Welfare does not solve the problem. In fact, it carries some insult".[41]

The Minister of Finance, Pinhas Sapir, reacted by saying that, "If this bill is passed, it will awaken thousands of disabled civilians to make claims upon the state although they have been rehabilitated and make an honorable living and already received compensation".[42] He suggested, therefore, that the bill be removed from the Knesset agenda. Knesset Member Benno Cohen still tried to persuade, saying: "I admit that these words [of the Finance Minister — U.Y.] disappointed me, because he sends those who were casualties of hostile actions to seek welfare. In other words, in his opinion their status is not one of disability by right, but dependent on the good graces of the institutions". The question of the right to assistance of civilians who were injured thus became a question of principle.

In an effort to convince, Knesset Member Cohen brought an example from post-war Europe: "Europe had the same problem and yet all the countries that fought in the war clearly paid their debts and took care of civilian victims of war just as they took care of the victims of the war in the armed services.

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39. Knesset session 229, March 13, 1963, *Knesset Record*, 36, p. 1412.
40. Knesset session 491, June 30, 1965, *Knesset Record*, 43, p. 2328.
41. *Ibid.*, p. 2328.
42. *Ibid.*, p. 2329.

I do not understand why we must distinguish between casualties in uniform and civilian casualties; the falling shells did not distinguish between them at all". And he added: "The cultural level of each country is also measured by how it meets its responsibilities to the victims of national catastrophies. This is one criterion of the cultural level of each country". Even though members of all political parties supported this bill, the arguments did not win out and, after a short debate, the bill was removed from the Knesset agenda.[43]

According to a memo of the Rehabilitation Service of the Ministry of Social Welfare (Shlomo Farkash, February 1976), 1,500 people were transferred at that time from the Ministry for War Victims to the Ministry of Social Welfare. Most of them were transferred to the care of the NII in the framework of the program for casualties of hostile actions. In early 1976, only 200 disabled and widows received any sort of services from the Ministry of Social Welfare, including a monthly allowance. Only 124 people (64 widows and 60 disabled) received a regular monthly allowance, after having established that their other income was insufficient. Medical services were provided to 120 disabled, with no income test. Approximately 30 disabled and widows received additional services approved for them by the Ministry of Social Welfare. The author of this memo explicitly claims that "A not negligible number of disabled and widows do not appeal to us for monthly allowance or assistance in medical and other services despite their situations of distress, as they do not wish to be welfare recipients". According to the author, this population will clearly claim its rights if they could be claimed through the Victims of Hostile Action Law. They were not covered by the present law because it went into effect after the War of Independence and did not cover civilians injured during this war.

In the Knesset session on February 21, 1977, Knesset Member Moshe Shahal claimed: "There are approximately 500 civilinas who were injured and classified at various levels of disability by the Ministry of Health. Most of these were children when they were injured. In the absence of a law that regulates the problems of these injured parties, this population is dealt with by the Ministry of Social Welfare... which gave support to a group of 133 disabled who were recognized as needy. This means that they receive assistance not because they are disabled, but because their economic situation justifies support".[44] Knesset Member Shahal therefore suggested

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43. *Ibid.*, p. 2330.
44. Knesset session 386, February 21, 1977, *Knesset Record*, 79, pp. 1623–1625.

that the Border Victims (Benefits) Law also be applied to those injured during the period between the declaration of the State (May 14, 1948) to the final cease fire (which took effect February 24, 1949). The proposal of Knesset Member Shahal passed on March 16, 1977 as Amendment 3 to the law.[45]

Amendment 3 to the Victims of Hostile Action (Pensions) Law, 1977, thus moved the effective date of the law and its rights for all civilian casualties of security-related actions back to the day the State was declared (May 14, 1948). This aging population was thus recognized as eligible according to the Victims of Hostile Action (Pensions) Law. Amendment 7 (ratified in the Knesset on August 18, 1982) cancelled the Border Victims (Benefits) Law while establishing directives for preserving the rights of these casualties (parag. 9 [2] of the law).

On March 26, 1982, an agreement was signed between the NII and the Ministry of Finance regarding allowances to casualties of hostile actions who were injured between November 29, 1947 and May 13, 1948. According to this agreement, allowances would be paid from the date this agreement took effect. To allow time for claimants to apply to the NII, the agreement set a deadline of August 31, 1987 to file claims.

Most of the population dealt with by the Ministry of Social Welfare was thus transferred to the NII. According to data from the Ministry of Social Welfare, only 12 casualties from the War of Independence were left in their care as of December 1992.

Summary and Discussion

This paper examines developments in the programs for care of civilian casualties of hostile actions after the declaration of the State of Israel. In general, three periods of hostile actions can be distinguished followed by three government programs for caring for these victims.

In Israel, as in most countries of the world, we witness the diminution of new social initiatives and cut-backs in existing programs. The crisis of the "welfare state" adversely affects many areas of life. Programs for education, health, and welfare for individuals and families are decreasing, payment of benefits is being reduced, pension plans are in a delicate actuarial balance. There is almost no social area over which the sword of budgetary cut-backs is not poised (Hasenfeld & Zald, 1985).

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45. Knesset session 387, March 16, 1977, *Knesset Record*, 79, p. 2039.

Despite this, and perhaps in reaction, the opposite trend is evident in Israel as reflected in improved programs, benefits, and services given to casualties of hostile action. Because of public sensitivity, this area appears *prima facie* to have significantly improved over time. These developments are outlined in this paper, and delineate a sensitive chapter in the evolution of welfare policy in Israel.

The development of programs to care for security-related civilian casualties reflects the growing social commitment to this population. Following the War of Independence, there was no commitment toward civilians injured in the course of the war. The increased frequency of security-related incidents, the more widespread, even beyond the borders of the state they became, the more at random the victims — residents, tourists and others — the more important it became to address the needs of this population. This care became comprehensive geographically and also covered more areas of life and need.

In addition to caring for the needs and distress of the casualties, the importance of compensating the victims beyond their expenses also became clear. The element of compensation is highlighted in the increasing level of the benefits, and the availability of a large variety of in-kind services provided without testing the personal resources of the claimant. The provision of assistance without a test of income or means and with no conditions whatsoever is characteristic of giving compensation (Marshall, 1985, p. 108).

The first period of care of victims was during the War of Independence and following it. At the time, civilian casualties were handled by a special government ministry established for this purpose. After the war, this ministry was disbanded and the care of war casualties was transferred to the Ministry of Social Welfare. The handling of war casualties by the local welfare bureaus was fundamentally similar to their handling of welfare recipients, although the funding for war casualties came entirely from the state coffers and not the local authorities.

The second period is characterized by transfer of the care of these casualties to the NII and establishment of the program under the Border Victims (Benefits) Law as part of the Division for Work Injuries. The assumption was that hostile activity would be focused on the frontier areas of Israel: villages, kibbutzim, and settlements along the borders. This program gave residents of the frontier areas the rights of those who work there, and from this point of view, it equalized the program of residents who were injured by infiltrators with programs for injured workers, and gave both the status of work injuries, with the broader rights that it entails.

The increase of hostile actions and their penetration into the center of the country and the urban centers overturned the basic assumptions of the program for frontier casualties. There was need for a program that would deal with any casualty of hostile activity, whether in the center or in the periphery, whether Israeli citizen, resident, or tourist. The Victims of Hostile Action (Pensions) Law created a legal framework for these arrangements. The law also equalized the rights of casualties of hostile actions with the rights of soldiers injured during or as a result of their army service. This coverage is better than that given as part of work injuries, which characterized the program that preceded it.

We can therefore witness the changes in the treatment of civilian casualties of hostile actions in terms of the range and depth of services caring for those needs. Several similarities and differences can be identified among the three described programs. The programs have three principles in common:

First, in all three periods and programs, the state reserved the right to decide which incidents are related to state security and which incidents and injuries are not. Such a decision by a "competent authority" is very complex. It is hard to get to this authority and to appeal its decision. This decision is taken on the basis of information (usually classified) available to the security services only. For example, someone could have been injured in an incident that appears to be a terrorist act, but the competent authority does not recognize it as such. The credibility of the competent authority is of critical importance. This is the only source of classified information required to determine if an incident was security-related. It is doubtful whether the security authorities are eager to define incidents as such, as this definition might damage their public image.

Second, for incidents that it defined as security-related, the state promised quite comprehensive assistance to casualties in each of the three programs. This included full medical and rehabilitative treatment and the provision of benefits to casualties or their survivors. The support was direct, ongoing, unconditional, and also included personal social services.

Third, in all the programs described, the national government undertook full funding of the assistance programs for these casualties. Local welfare bureaus and the NII did not bear the costs of assistance to civilians injured in hostile actions. The funding of the personal treatment, programs and payments was entirely covered by the state.

On the other hand, there were some differences between the programs. These are manifested in the improvement of the programs, expanding and deepening them.

In the first stage, when the programs were handled by the local welfare bureaus, every individual who applied for support had to prove personal need for assistance, residence, and eligibility. The claimant had to prove that he was injured as a result of a war-related incident. In the second stage, the claimant had to prove that the injury occurred at a time when he resided or worked in a frontier area. In the third stage, following passage of the Victims of Hostile Action (Pensions) Law, the applicant for assistance was not required to prove need, eligibility or to be means tested, and hence various limitations on the previous programs were lifted. The competent authority was the only party that could classify the incident as security-related. After this authorization, the injured party was eligible for assistance.

The assistance itself was broadened and deepened. The injured party no longer receives a welfare allowance or benefits linked to his previous salary. The program for assistance to casualties of hostile actions ensures broader and deeper coverage than any other program, and is similar to that given to army casualties. The program includes very broad assistance in money and in-kind: medical expenses, treatments, convalescence, physical and vocational rehabilitation, acquisition of an apartment, adapting it to the needs of the disabled, and more.

Among these improvements, the definition of family members eligible for additional support was also broadened. The assistance programs are sensitive to the needs of close family to the injured person. There is also room here for discretionary decisions: Family members more distantly related could receive assistance, *if there is evidence that the injured party helped them* with their livelihood or that their relationship was an important one.

The right to receive assistance also allows the claimant to appeal a rejection of his application, or to appeal a decision regarding the type of assistance promised or its level. Appeal mechanisms exist both as part of the program itself and also through the labor courts, where appeals can be filed.

This paper reviewed the development of programs dealing with civilian casualties of security-related incidents. With the exception of victims of the War of Independence who were injured during the war, all other victims were injured in periods not defined as war per se. The period of Operation 'Desert Storm' with its SCUD missiles falling on Israel was not defined as war, and the reader should be aware of this definition and its significance, as the programs described earlier might change during a war, including changes in the definition of casualties and the coverage to which they are entitled.

The process that characterized the handling of civilians injured in acts of hostility reflects a true improvement in policy, programs, and services to a group toward whose sacrifice society feels indebted (Doron & Kramer, 1991, p. 165). It can be assumed that if acts of hostility continue, and if these feelings continue toward the victims of hostility, the program will maintain its status, tools, and resources, and perhaps even improve.

But wouldn't it have been much much better if the need for this program diminishes altogether?

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THE ISRAELI PUBLIC'S ATTITUDES TOWARD THE NEW IMMIGRANTS OF THE 1990s

by Dr. Elazar Leshem*

A. Introduction

Absorption policy during the period of the mass immigration in the 1990s is characterized above all by the introduction of "direct absorption". Now the virtually exclusive initial track for the majority of new immigrants from countries of distress (other than Ethiopia), "direct absorption" is the antithesis to the service-intensive institutions ("absorption centers"), which were the primary initial phase for this population in the 1970s and 1980s. In "direct absorption" the new immigrant decides, shortly after his arrival and on the basis of his own considerations, where he wants to settle. As a result, a disjunction was created between the immigrants and the social services they require during their initial period of adaptation. The new system puts the onus on the immigrant himself — from his first night in Israel — to find the most appropriate solution for his own needs, without the "moratorium" provided by the sheltered environment of the absorption center (Leshem, 1992).

In addition, absorption policy gradually eroded the distinctive privileges and services which had been available to all immigrants. Instead, the newcomers were integrated into the same systems that serve the general veteran population based on quite similar criteria. Governmental responsibility for their absorption was transferred, in large measure, to the community and the local government (*ibid.*).

As a result of these changes, the new immigrant has to expend far greater resources to cope with a new environment in which he is engulfed by unexpected events, he must understand its structure and learn to navigate

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within it. This, just as his personal resources shrink enormously owing to the loss of support systems entailed in emigration (Saruk, 1992). "There is no doubt that the shock caused by the crisis of immigration exposes a person to diverse influences just when he is vulnerable and his resistance is weakened. This is when the new immigrant longs for information and support" (*ibid.*). Such needs could, seemingly, be met by the networks of complementary services for new immigrants, going beyond basic social security allowances, which had been developed by local governments, voluntary organizations, and immigrants' associations.

However, those bodies find it difficult to locate the relevant risk groups, and in practice they provide complementary services to a comparatively small proportion of the potential target population. Moreover, despite the large resources invested to raise their standards, they meet the immigrants' expectations in only a few spheres (Shye *et al.*, 1991; Fein, 1992; Menachem & Lewin-Epstein, 1992; Weil, 1993; Damian & Rosenbaum-Tamari, 1993).

The absorption of Soviet new immigrants in the 1990s indicates that the "transitional support systems" (Saruk, 1992) which in the initial stages assist the new arrivals to cope with the crisis of immigration and absorption — before they have acquired the tools to deal with them independently — *are based primarily on informal, extra-establishment support networks*, consisting of relatives and old and new friends from the home country (Damian & Rosenbaum-Tamari, 1990; Rosenbaum-Tamari & Damian, 1991a, 1991b; Fein, 1991, 1992; Menachem & Lewin-Epstein, 1992).

However, a long-term follow-up of the findings cited above shows that the importance of relatives and friends who are veteran immigrants soon declines, and the new arrivals turn instead for succor to friends and relatives who are part of the same wave of immigration. This is probably due to the erosion that occurs in the dense, asymmetrical relationships between veteran established immigrants and those who have just arrived (Katan, 1989).

However, reliance on other new immigrants who are themselves still in the initial stages of absorption entails considerable risk, such as getting incomplete and distorted information. Consequently, crucial choices and decisions made by the new immigrant during the period of "direct absorption" may be ineffectual and even harmful in terms of his adaptation and his perception by the new surroundings (Saruk, 1992).

It is therfore important to examine — based on studies of immigration absorption in recent years — the probability of the new immigrant's being integrated into transitional, informal support systems comprising neighbors,

friends, and volunteers who are native-born Israelis and longtime members of the community, rather than newly arrived compatriots. Israel, it should be remembered, is a combination of an immigrant state and a nation state which has always been open to virtually unlimited national immigration under the Law of Return (State of Israel, 1950).

We can monitor the attitudes of the veteran population toward the 1990s immigrants through a comparative analysis of five independent surveys that examined the attitude of the adult Jewish population (20+) in Israel toward immigration, in polls that covered a representative countrywide sample comprising 1,200 to 1,450 interviewees at five different periods:[1]

1. September 1986 (Damian, 1987): This survey was conducted during the period of very low immigration in the 1980s; only 9,505 new immigrants arrived in 1986. The findings furnish a starting point for examining the attitude of the general population at a time when immigration exercised only a marginal effect on the society and economy.
2. February 1990 (Shye & Dukhin, 1990): This survey was conducted shortly after the mass wave of immigration began. February 1990 saw the arrival of 6,699 new immigrants, and a total of about 25,000 had arrived since Septmber 1989.
3. December 1990 (Smith, 1990): When this survey was conducted the wave was cresting: that month saw the arrival of the largest number of immigrants since the influx began, 36,842 of the total of 213,000 who had already arrvied.
4. January-February 1992 (Hendels & Ben-Tsuri, 1992): By the time this survey was conducted the wave was beginning to recede. About 6,000 new immigrants had arrived since the beginning of 1992, and the total since September 1989 stood at approximately 400,000 (88 percent of them from the former Soviet Union).
5. March 1992 (Damian & Resenbaum-Tamari, 1992). The decline continues as this survey was conducted. About 6,000 new immigrants a month were arriving, on average, and the total since September 1989 was 406,000.

Charting the public's attitudes at these five points in time involves a comparison of unrelated national surveys conducted by different researchers at different dates. Nevertheless, we can extract from the surveys a fairly large group of nearly identical recurring questions and through them monitor the

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1. For puposes of comparison, and to understand the distinctive nature of the reactions to the immigration of the 1990s, we can draw on national public opinion surveys conducted on this subject since 1971 (Katz, 1971; Leshem & Adar, 1973; Zemach, 1975; Spiegelman, 1976; Cohen, 1977; Astman & Rosenbaum, 1980).

public's attitudes over the years. This group of questions is the basis for the comparisons and analyses that follow. To supplement the national surveys, we shall refer to the results of other studies conducted in the 1990s on the attitude of the veteran population toward the new immigrants, focusing on particular age groups or geographic regions.

B. Trends Emerging from Analysis of Identical Questions

The identical questions relate to three aspects of the veteran populations's attitude toward the 1990s immigrants:

1. The fundamental stand on immigration as a social goal: (a) its importance to the state; (b) its importance in relation to other national goals.
2. The impact of immigration on the economy: (a) how it affects the country's economic situation; (b) its effect on the employment prospects of the veteran population; (c) whether it aggravates the housing situation for the veteran population.
3. Personal-subjective commitment: (a) readiness to continue state aid to new immigrants even if this entails a decline in personal living standards; (b) readiness to volunteer to assist immigrant absorption.

As noted above, not all of these aspects appear in all five countrywide surveys. In what follows, we shall refer only to elements that appear in at least two surveys conducted at different times.

1. Fundamental Stand on Immigration as a Social Goal

The public's position was examined from both the absolute and relative standpoint in two questions (Table 1, Table 2).

Table 1 shows the existence of a solid consensus among Israelis, at the ideological-normative level, on the importance of immigration. However, the consensus has eroded over time: from 82 percent who perceived immigration as extremely important or very important in September 1986, and 83 percent

Table 1. "In your view, how important is immigration to the country?" (percentages)

Date of Survey	Extremely important, very important	In some degree	Not much, not at all	Don't know	Total
Sept. 1986	82	10	6	2	100
Feb. 1990	83	10	6	1	100
Dec. 1990	77	19	4	—	100
March 1992	71	20	9	—	100

Table 2. "Out of the following five population groups, which do you think should have first, second, third, fourth, and last priority in getting state assistance?"

— Large families (Hebrew: "families blessed with many children")
— Newly released soldiers
— New immigrants
— Young couples
— The elderly (February 1992 survey only)
— Returning Israelis (September 1986 and March 1992 surveys only)

Date of survey	Percentage giving first priority to new immigrants
September 1986	5.4
February 1992	12.0
March 1992	15.0

in February 1990, to 77 percent in December 1990 and 71 percent in March 1992. Morewover, as Table 2 shows, the attitude is largely declarative, since only a miniscule proportion of the public, both in 1986 and in 1992, thinks new immigrants should head the list of preferential target populations for social policy. Indeed, the majority of Israelis consistently ranks new immigrants next to last in the hierarchy, after newly released soldiers, large families, young couples, and the elderly; new immigrants are given priority only over returning Israelis (surveys of September 1986 and March 1992).

2. Impact of Immigration on the Economy

The public's perception in this sphere was examined in relation to three questions:

Immigration was perceived to be increasingly harmful to the economy as its scale grew. In September 1986, before the mass influx began, 18 percent of those polled said the veteran population faced difficulties finding employment because of immigration (Table 3). By February 1990, shortly after the mass wave began, this had risen to 34 percent, and in March 1992, with new immigrants continuing to stream in, a majority (61 percent) held this view. A similar pattern is discernible with regard to housing (Table 4).

A more comprehensive perspective of immigration's perceived impact on the economy is gained by examining the expectations of the veteran population as the mass influx began. In February 1990, 28 percent thought

Table 3. "In your opinion, to what degree does the veteran Israeli population face difficulties finding work because of immigration?" (percentages)

Date of Survey	To a very great degree, a great degree	To some degree	Not much, not at all	Don't know	Total
Sept. 1986	18	22	60	—	100
Feb. 1990	34	31	26	9	100
March 1992	61	30	9	—	100

Table 4. "In your opinion, to what degree does the veteran Israeli population face difficulties finding housing because of immigration?" (percentages)

Date of Survey	To a very great degree, a great degree	To some degree	Not much, not at all	Don't know	Total
Sept. 1986	22	22	56	—	100
Feb. 1990	33	33	27	7	100
March 1992	55	33	12	--	100

the wave of new immigrants would aggravate the economic situation (Shye & Dukhin, 1990), as Table 5 shows. In December 1990, 39 percent said immigration adversely affected the economy, and by March 1992 this negative viewpoint was shared by 58 percent. In this period, as shown by Damian & Rosenbaum (1992), 43 percent of the population thought the mass immigration was harmful to its living standard.

Table 5. "In your day-to-day life, do you feel the effect of the mass immigration from the Soviet Union on the country's economic situation?" (percentages)

Date of Survey	To a very great degree, a great degree	To some degree	Not much, not at all	Don't know	Total
Dec. 1990*	9	44	49	9	100
March 1992	26	16	589	—	100

* In December 1990 the question was: "To what degree has the mass immigration affected the country's economy until now?"

3. Personal Subjective Commitment

This was examined through two questions: readiness to make personal sacrifices for the sake of immigration, and willingness to volunteer to help new immigrants.

Tables 6 and 7 show clearly that Israelis were increasingly disinclined to make a personal commitment regarding new immigrants. This is seen in the growing opposition to state assistance for the newcomers should this affect the standard of living, and in less willingness to volunteer. Like the earlier figures, these data also suggest that the erosion of initially positive attitudes and the concomitant rise in negative attitudes was a function of the cumulative impact of the mass influx. Thus, in 1986 and again in February 1989, before and shortly after the influx began, respectively, a majority favored state assistance for absorption even if this affected living standards, and a willingness to volunteer a few hours a week was still evident. But as

Table 6. "To what degree do you think the state should continue to assist in the absorption of new immigrants even if this might affect your standard of living?" (percentages)

Date of Survey	To a very great degree, a great degree	To some degree	To a small degree	Don't know	Total
Sept. 1986	64	16	17	3	100
Feb. 1990	53	25	21	2	100
Dec. 1990	40	17	39	4	100
Feb. 1992	54	12	34	—	100
March 1992	33	24	43	—	100

Table 7. "Suppose you were asked to volunteer a few hours a week to help absorb new immigrants. Would you agree?"

Date of survey	Readiness to volunteer (percentages)
February 1990*	53
March 1992	26

* In February 1990 the question was: "Would you agree to accompany a family of new immigrants to help them in their initial stages of absorption?" The figure in table 7 refers to readiness to devote more than one hour a week for this purpose.

the number of new immigrants continues to spiral, that willingness gradually declined. Even if the February 1992 survey suggests a certain moderation in this process, the data for March show the trend continuing. By then the majority opposed state aid to the new immigrants if this meant a lower standard of living. Nor was the majority willing to volunteer to help the newcomers.

These data should be considered in conjunction with the findings contained in Tables 1 and 2, since this affords a useful opportunity to compare the public's attitude toward immigration on two levels: the normative-ideological and the subjective-personal. Table 8 compares the depth of the opposition to the national norm that advocates immigration, as reflected in Table 1, and to the idea of making personal sacrifices for the sake of immigration, as reflected in Table 6.

Table 8 shows that throughout the entire period under discussion a considerable disparity exists between the Jewish-Israeli public's declared stand in favor of immigration at the ideological-normative level, with only the most marginal dissension (ranging from 4 to 9 percent), and the public's personal readiness to make sacrifices or to become involved in helping absorb the new arrivals. Readiness to pay a price or become personally involved declines as the number of new immigrants increases, but the broad consensus on the importance of immigration remains virtually unchanged. The disparity between the normative level and the subjective level, seen emphatically in less willingness to volunteer for new immigrants (Table 7) — especially in Table 2, showing that Israelis put immigration absorption

Table 8

Date of survey	**Question:** "In your view, how important is immigration to the country?" **Stand:** *Not very, not* at all (percentages)	**Question:** "To what degree do you agree that the state should continue to assist in the absorption of new immigrants even if this might affect your standard of living?" **Stand:** *Opposed, or definitely* opposed (percentages)
Sept. 1986	6	17
Feb. 1990	6	21
Dec. 1990	4	39
March 1992	9	43

next to last among preferntial social goals — indicates that the broad national consensus on the importance of immigration for the country was, and remains, mere lip service.

C. Sectors of Sympathy and Hostility[2]

An analysis of all the surveys cited reveals that the attitude — positive or negative — toward immigration is not manifested with equal intensity by all sections of the public. Such reactions are expressed more strongly by certain groups, according to age, ethnic origin, education, and income.

The sector that is young, has little education and a low income, and is of African-Asian descent (especially the native-born Israelis among them) sharply rejects immigration absorption as a preferential national goal, stresses its adverse effect on the economy, and spurns personal involvement to assist new immigrants. By contrast, the older sector, with a high educational level and a high income, and European-American by descent, is strongly in favor of making absorption a preferential national goal, places less emphasis on its negative effects vis-a-vis the economy, and shows greater readiness to become personally involved.

1. Age[3]

An analysis of the surveys turns up a close correlation between the interviewee's age and his stand on the importance of immigration and its contribution to the economy, his readiness to make a personal commitment, and other related questions. The under-30 groups are more hostile, while older groups manifest sympathy, support, and commitment. Most sympathetic of all are the elderly retired. Four of the five surveys cited above found this connection (Damian, 1986; Shye & Dukhin, 1990; Hendels & Ben-Tsuri, 1992; Damian & Rosenbaum-Tamari, 1992), which was also evident in the 1970s (Astman & Rosenbaum 1980). The differences among the various age groups remain constant even in the period of general euphoria, at the beginning of the mass influx (Shye & Dukhin, 1990). The same findings also

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2. On the ascription of negative stereotypes to new immigrants from the former Soviet Union, see the Appendix.
3. Both Astman & Rosenbaum (1980) and Damian & Rosenbaum (1992) found the age variable to be a salient and major contributing factor to the explanation of the variance in most of the public's attitudes on absorption cited above.

stand out in studies of specific groups within the young population. We find evidence of hostility and violent friction between new-immigrant inductees from the Soviel Union and other soldiers (Bar-Kama & Ben Eliahu, 1991); Indifference by young kibbutz members toward new immigrants from the Soviel Union attending Hebrew language courses on the kibbutz (Mittelberg & Ben-Ari, 1992); a perception that immigration is harmful held by more than half of all 17-year-olds who are on the eve of military service (army's Department of Behavioral Science, 1991): and extreme negative stereotypes toward their new-immigrant peers from the Soviet Union held by students in Grades 10–12 in a cross-section of high schools (Horowitz, 1992).

2. Education[4]

According to Shye & Dukhin (1990), level of education, more than any other demographic variable, polarizes attitudes toward immigration: individuals with partial high school education (11 years of study) show less positive attitudes, while university graduates are very positive. The same correlation emerged in the survey by Smith (1990), conducted at the height of the mass influx, which found greater hostility among those with Grade 8 education or less; and by Hendels & Ben-Tsuri (1992), which found a more positive attitude among university graduates. Similarly, Damian & Rosenbaum (1992) found that those with a higher level of education are more aware of the importance of immigration, view it as a high-priority social goal, and are willing to make a personal commitment.

Similar findings had also emerged in the late 1970s (Astman & Rosenbaum, 1980). Still, it should be remembered that even among university graduates a hostile group with stereotypical preconceptions was found (Shuval, 1984), though it was proportionally smaller than the group with partial high school education.

3. Origins

All four countrywide surveys conducted in the 1990s, as well as the survey undertaken in the period of slack immigration (Damian, 1987), found a clear correlation between ethnic origin and attitudes toward immigration. Least

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4. Regression analyses carried out in some surveys found the education variable to be a salient and major contributing factor for the explanation of the variance in most of the public's attitudes on immigration absorption.

positive, and least willing to become involved, were native-born Israelis of Oriental descent, while the most positive were those of Western extraction. These disparities, which are pronounced from the very first survey, conducted in February 1990 (Shye & Dukhin, 1990), are consistent with a trend that was observed as early as the 1970s (Astman & Rosenbaum 1980). From the outset of the mass influx, native-born Israelis of Oriental extraction express less positive attitudes than others, and not only with regard to the issues reflected in the identical questions noted above. They are also less inclined to consider the mass immigration a contribution to the state, or to think that they will gain from it by acquiring a higher standard of living. On the contrary, a relatively large proportion of Israeli-born Orientals (28 percent) and of the Asian-African-born (32 percent) believe that large-scale immigration will be detrimental to their standard of living. A fairly large proportion of native-born Israelis of Oriental descent (41 percent) demands that veterans be given preference over newcomers in housing, whereas only 19 percent of Western-born Israelis insist on this.

In the countrywide survey conducted at the height of the mass wave (Smith, 1990), those born in Islamic countries (47 percent) maintain that the economic situation has deteriorated because of the influx, and Israelis from the Oriental communities were, again, more pessimistic about the economic prospects for the year ahead. This group also displayed a pronounced resistance to the idea of making personal sacritifces to help absorb new immigrants. Within the Oriental communities 47 percent — as against 29 percent among those of European extraction — said they would be opposed to further government assistance to absorb new immigrants if this meant a decline in their own standard of living. Here again, as in the previous survey, the Oriental communities demand that veterans be preferred over newcomers in the allocation of employment and housing, whereas those of European extraction tend toward a more egalitarian approach regarding new immigrants and others. Among members of the Oriental communities 44 percent — as compared with 23 percent of European origin — said veterans should be preferred over new immigrants in employment opportunities, if both candidates are similarly qualified. In the Oriental communities 59 percent thought that the conditions being provided to the new immigrants from Russia were more than the state could afford, against 40 percent holding this opinion among those of European origin. The same tendencies reappear in the countrywide surveys conducted in early 1992 (Hendels & Ben-Tsuri, 1992; Damian & Rosenbaum-Tamari, 1992) and in the survey conducted among pre-induction 17-year-olds (army's Department of Behavioral Sciences,

1991). In the latter survey, youngsters born in Europe-America displayed an emphatically positive attitude toward immigration and new immigration and new immigrants, the Asian-African-born were less positive, and the Israeli-born were in the middle.

In the same survey, 90 percent of the Western-born group considered immigration an important national mission, as against 81 percent of the Asia-Africa group: 79 percent of the former thought immigration has a positive influence, as against 60 percent of those born in Asia-Africa; 69 percent of the Europe-America group said they themselves showed a positive attitude toward new immigrants, as compared with 56 percent of the Asia-Africa group: and 51 percent of the interviewees from Europe-America thought that immigration does not have an adverse effect on Israelis, an opinion shared by only 39 percent of the Asia-Africa interviewees.

4. Income[5]

Three of the four countrywide surveys conducted on the 1990s found a correlation between income level and attitudes toward immigration and immigrants. According to Shye & Dukhin (1990), the higher one's income, the greater the recognition of immigration's importance, and the greater the readiness to make sacrifices in living standards so resources can be diverted for absorption, to pay higher taxes, to become personally involved, and to believe that immigration will enhance culture in Israel. Similar correlations were found by Smith (1990) at the height of the mass influx. Smith's findings showed that 53 percent of those with below-average incomes — a higher proportion than in any other group — were more inclined to think that immigration would aggravate the economic situation, and were least disposed to make sacrifices in their standard of living for the sake of immigration.

Hendels & Ben-Tsuri (1992) also found the same attitudes in the population with below-average incomes. The link with income also emerged in the survey of pre-induction 17-year-olds (army's Department of Behavioral Sciences, 1991): 92 percent of the youngsters whose parents had above-average incomes thought that immigration was an important national mission, as opposed to 70 percent of those whose parents had below-average incomes; 66 percent of the high-income group as compared with 56 percent of the low-income group thought they themselves showed a positive attitude toward new

5. This variable was not examined by Damian & Rosenbaum (1992).

immigrants; and 54 percent of the former, as against 36 percent of the latter, thought that immigration is not detrimental to Israelis.

*

It is no accident that a very high frequency of hostile attitudes, denial of immigration's importance, unwillingness to make sacrifices or to become personally involved, and so forth — was found in the surveys conducted since 1986 among the poorly educated (partial high school or less), the oriental communities — especially native-born Israelis whose parents are from Islamic lands — and within low-income groups. These findings are consistent with a statistical pattern that has in large measure recurred in all the surveys conducted since the early 1970s which were cited above. It also emerges that the social groups described above are not mutually exclusive. In other words, within the low-education groups there is a high representation of both lower than average income earners and of first- and second-generation members of the Oriental communities. In other words, within the Israeli population one can pinpoint a group that rejects immigration and new immigrants. This same pattern also exists at the other pole: the older, high-income population includes a high representation of university graduates and individuals of European-American extraction from the first and second generation. This particular group displays a positive attitude toward immigration and new immigrants in all the areas described above.

D. Causes of the Positive/Negative Attitude

Generally speaking, neither the surveys of the 1990s or of the early 1970s help explain definitively the correlations between demographic characteristics and attitudes toward immigration. At best, the research reports furnish information on statistical connections at the level of marginal distributions and cross-tabulations. More thorough, multivariable analyses were undertaken only by Astman & Rosenbaum (1980) and Damian & Rosenbatum-Tamari (1992). The surveys conducted by Damian (1986) and by Shye & Dukhin (1990) are also useful in this regard. Consequently, the conclusions drawn below should be considered tentative, requiring further examination.

1. Number of Immigrants

Fairly large sections of the Israeli Jewish society display a basic hostility toward immigration even when it is at a nadir. This is shown by the findings of the survey conducted in 1986 (Damian, 1987), the year which saw the

lowest number of new arrivals since the founding of the State of Israel — the tail end of the five "leanest" immigration years since 1948 (73,754 new immigrants arrived from 1981 to 1985: Central Bureau of Statistics, 1991). The results of the 1986 survey (cited above), as compared with the findings of the five surveys conducted since 1973, in relation to the annual immigration figures, lead Damian to conclude that the number of imcoming immigrants per year does not affect the public's attitudes toward immigration. An analysis of the trends in public attitudes during the 1990s (Tables 1–8), in relation to the number of new immigrants who arrived in the year of each survey, leads to the same conclusion. However, a comparative analysis of the 1990s surveys, in relation to the increasing numbers of new immigrants who arrived in the mass influx which began in September 1989, shows — in three of them (the exception is February 1992: Hendels & Ben-Tsuri, 1992) — *a constant exacerbation in the negative attitude toward immigration* and new immigrants, congruent with the cumulative increase in the number of new immigrants since the beginning of the wave. The survey conducted in February 1990 (Shye & Dukhin, 1990), in the initial stage of the wave (36,842 new immigrants from September 1989 to February 1990) turned up the most positive attitudes. The survey conducted that December (Smith, 1990), at the height of the mass influx (213,000 from September 1989 to December 1990) showed a hardening of the negative attitude in all areas; and the survey conducted in March 1992 (Damian & Rosenbaum-Tamari, 1992) revealed despite a falloff in the rate of immigration (406,000 from September 1989 to March 1992) — that the negative attitude had become even more pronounced. The findings of Hendels & Ben-Tsuri (1992), cited above, are also consistent with the trend indicated, other than in the area of readiness to accept sacrifices in one's personal living standard in order to assist the new immigrants (see Table 6).

Still, at this stage it is impossible to isolate the distinctive contribution made by the cumulative number of new immigrants in the mass influx to the variations in the public's responses at the different dates of the surveys. Presumably, the connection noted above is to some degree a function of the correlation — found in Tables 3, 4, and 5 — between the comulative number of new immigrants and the perception that immigration is bad for the economy. This viewpoint becomes more pronounced from one survey to the next, and the perception of the impact as positive or negative is related, in part, to one's anxiety regarding housing and employment (Damian & Rosenbaum-Tamari, 1992) — an aspect to which we now turn.

2. Sense of Anxiety Regrading Housing and Employment

The negative connection between the level of personal and family concern regarding housing and employment, and a readiness to divert resources entailing personal commitment and sacrifices for the sake of immigration was identified already in the 1970s (Katz, 1971; Astman & Rosenbaum, 1980). It is also evident in the 1986 survey (Damian, 1987) and in the 1990s surveys cited above, with the exception of Hendels & Ben-Tsuri (1992), which found a link only with concern about employment.

As Table 9 shows, much of the public, in all the periods surveyed, feels genuine anxiety about housing and employment.

At the same time, a multivariable analysis done by Astman & Rosenbaum (1980) and by Damian & Rosenbaum-Tamari (1992) shows that the connection between level of worry and level of approval/rejection vis-a-vis new immigrants makes only a a comparatively small, albeit significant, contribuition toward explaining the variance in attitudes toward immigration. This relates primarily to differences in levels of readiness to make personal sacrifices for immigration and in assessments of how the wave of immigration will affect various spheres in the Israeli society.

These trends, gleaned from countrywide surveys, are reinforced by community surveys. Thus Lipshitz (1992) found a link in Kiryat Gat between the level of public concern regarding employment and housing, and the public's assessment of the impact of the mass immigration in these areas and its opinion on whether the aid to the new immigrants was justified. The "weak" sector of the population, as defined by the researcher, is very anxious about housing and employment, and about the effects the influx of new immigrants will have. This group would like to see less aid given to

Table 9

Date of survey	**Question:** "How worried are you about your own or your close family's housing problems?" **Stand:** Worried, or very worried (percentages)	**Question:** "How worried are you about your own or your close family's employment problems?" **Stand:** Worried, or very worried (percentages)
Sept. 1986	36	38
Feb. 1990	47	49
Dec. 1990	45	47
March 1992	29	32

the new immigrants and a slowdown, leading finally to a complete halt, in their absorption in Kiryat Gat. Horowitz (1992) also found that the level of concern harboured by high school students (Grades 10–11) regarding their parents' employment is a contributing factor to the level of hostility they display toward the new immigrants in their classes.

3. Identification with the Israeli Society and its Values

Three surveys used an index geared to examine this feeling (Katz, 1971; Damian, 1987; Damian & Rosenbaum-Tamari, 1992). Katz based the index on readiness to accept economic sacrifices to further the society's goals and on adherence to Zionist values. The findings show a positive link between the general index of idenfitifcaion with the society and its values, and readiness to assist new immigrants. Damian (1987) examined the strength of the identification by means of an overall index composed of three parameters: linking one's destiny with the state's, national pride, and a sense of Israel's uniqueness. It was found that the overwhelming majority of those who identify strongly with their homeland have a positive attitude toward immigration, whereas among those with a loose sense of identificaion only a small proportion support immigration and think it is important for the country. Damian & Rosenbaum-Tamari (1992) used a variable composed of three elements identical in part to those in Damian's earlier survey (1987). These were: "link with the destiny of the State", "pride in being Israeli", and "centrality of the Israeli identity". This index was found to make a salient contribution toward explaining the variance in the public's assessment of the effect the wave of immigration would have on various areas. However, the contribution of this variable alone toward explaining the variance was found to be relatively low.

Besides the three factors noted above — the cumulative number of immigrants, the sense of anxiety regarding housing and employment, and the feeling of identification with the Israeli society and its values — one finds, especially in the survey by Damian & Rosenbaum-Tamari (1992), additional variables whose distinctive contribution toward explaining the shifts in the public's attitudes was also examined. We refer to aspects of the interviewee's personal situation, subjective elements such as "general contentment", "satisfaction with place of residence", "personal value orientation", and "sense of alienation". However, the analysis of that survey did not find that these variables could make a genuinely distinctive contribution toward explaining the variance in public attitudes. Indeed, the dominant variables in this regard are, as Astman & Rosenbaum (1979) and Damian & Rosenbaum-

Tamari (1992) found: age, education, and in the latter survey, (ethnic) origin. An analysis of the surveys cited and of the other relevant syrveys, conducted from the 1970s until the present, does not furnish a fitting explanation for the dominance of the sociodemographic variables which, as we saw, define the social groups that take positive or negative attitudes toward immigration. Seemingly, the "level of worry" over housing and employment, which is related to the sociodemographic variables, should eliminate, or moderate, their influence. However, as already mentioned, these variables make an independent contribution to the "level of concern" regarding housing and employment. Moreover, all the factors that were examined in the surveys cited above account for only a small part of the differences in the variance of the variables that characterized attitudes toward immigration in the surveys. It follows that the explanation for the positive or negative attitudes on immgration and for their sociodemographic focal points, defined according to age, education, income, and origin, must be sought in other variables which have not surfaced in the surveys conducted to date.

E. Conclusions

An examination of the Israeli public's attitude toward the new immigrants of the 1990s, as seen in the findings of the various studies and surveys conducted until 1992, points to the following trends:

1. A certain level of hostility toward immigration exists in Israel, irrespective of its scale of ethnic composition. This negative attitude probably has its source in an underlying fear of strangers and in defense machanisms that the absorber develops toward the stranger (Ben-Ezer, 1992).
2. The long-term consensus on the importance of immigration for the nation's existence is, for large sections of the population, merely declarative. In many cases the reality beneath the declaration is an unwillingness to become personally involved in absorption, either by accepting a lower living standard or by doing volunteer work. Indeed, the new immigrants are placed at or near the bottom of the list of priorities for state assistance.

In other words, Israel's distinctiveness as a nation-state that absorbs national emigration, as stressed in the Declaration of Independence, the Law of Entry, and the Law of Return (State of Israel, 1950), does not find its expected commensurate expression in attitudes harbored by the veteran population toward new immigrants.

3. This negative attitude cuts across all sectors of the population. However, it is especially potent among those with below-average incomes, the young

(under 30), those with a partial high school education, and among those of Asian-African extraction, especially the native-born second generation. In contrast, the favorable attitudes toward new immigrants, and readiness to make a commitment on their behalf, are found largely among older, university educated, high-income earners of European-American extraction.

These findings reinforce the conclusions of numerous studies by European social psychologists, who identified the parallel phenomenon as "poor white racism", i.e., a link between low educational and low income levels, and hostility toward immigrant groups (Lerer, 1992). In Western Europe this stance finds its political expression in the rise of radical right-wing parties and in violence directed at immigrants, especially those belonging to the social groups noted above (Borowski, 1993).

4. The negative attitude toward immigration, its perception as being harmful to the economy, and a reluctance to volunteer gain in intensity while the mass influx of the 1990s continues and the numbers of incoming new immigrants continue to increase.

This process is not a uniquely Israeli phenomenon of the 1990s. It was documented early this century (Park & Burgess, 1921) in the attitude of the American society toward immigrants. Three sequential stages were noted at that time: the initial stage of contact with the new ethnic group, accompanied by curiosity and overtures; leading to the second stage, marked by competitiveness and conflict between veterans and newcomers; and concluding with the third stage, in which the absorbing society accepts the existence of the new group within the social structure, even though its complete integration in that society will be a multifaceted, long-term process (Eisenstadt, 1976).

The findings of the surveys cited in this article indicate that the "honeymoon", the curiosity, and the feelers extended for closer relations between Israelis and new immigrants as the mass wave of immigration began, as reflected in the study by Shye & Dukhin (February 1990), were shortlived. From late 1990 the research shows (Smith, 1990) an exacerbation in the negative attitudes toward new immigrants. Later studies, cited above, show enmity and competitiveness escalating. The modulation is seen also in the growing difficulty of recruiting volunteers to help absorb the new immigrants (Cwickel & Leshem, 1992) and in the attitude of those responsible for providing services in the public administration (Leshem & Keinan, 1992). This shift was acutely reflected in the media's attitude toward the new immigrants, beginning especially in September 1992 (see Appendix). The extreme negative stereotypes adduced for new immigrants from the FSU

and on Ethiopian immigrants recall the stereotypes which the Israeli press foisted on the new immigrants from the Islamic lands from 1949 to 1953 (Lissak, 1987).

5. The root causes of the positive/negative attitudes toward immigration and new immigrants are not sufficiently clear. An analysis of the findings of the surveys turns up only partial explanations. The level of personal concern about housing and employment, and the level of identification with the Israeli society and its values make a distinctive, albeit relatively small, contribution toward explaining the variance in the attitudes of the Israeli public. These findings support the threat/competition theory developed by Sheriff (1966), holding that negative attitudes toward another group are caused primarily by a percieved conflict of interests between one's group and the other group — competition for jobs, schools, housing, and so forth. This in itself generates a negative perception of the other group and enmity toward its members. At the same time, as Lerer (1992) notes, the findings of empirical studies attempting to validate this theory regarding relations between a veteran population and a new-immigrant population were not definitive.

F. Summation

The findings from the surveys and the conclusions noted above suggest that among the veteran population mainly the older, educated, high-income, European-American sector can develop spontaneous, unplanned informal transitional support systems for new immigrants during the initial absorption stages. On the other hand, the "direct absorption" policy, combined with the new immigrants' financial distress, produce concentrations of new immigrants precisely in disadvantaged neighbourhoods and peripheral settlements (Lipshitz, 1992; Menachem & Lewin-Epstein, 1992; Ginzberg & Zemach, 1992), in close proximity to population groups possessing the sociodemographic traits that were found to be associated with a negative attitude toward immigration.

These trends, and the growing proportion of the new immigrants within the general population, require the authorities, at both the national and local level, to take concrete steps, not only for the sake of the new immigrants but for the benefit of the whole Israeli society. If not, "We can expect that Israel will have to cope anew with severe manifestations of marginality and social alienation" ("Elem", 1992).

The government with its various systems (education, welfare, etc.) at

both the national and the local level, can invoke a variety of models for intervention programs through which the community's resources can be exploited to assist immigration by activating nonestablishment elements (Kaminski & Bar, 1990; Kafri & Sharir, 1990; Ministry of Education & Culture/Shefi, 1990: Kaufmann, 1992; Ministry of Education & Culture, State-Elementary Social Education, 1992; Ministry of Education & Culture HQ of "Immigration in Education" conference, 1992; "Elem", 1992). Large resources were invested in the development of these programs, but their potential has been only partially realized.

APPENDIX

Immigration in the Israeli Media: Selected Headlines and Articles (1 September 1992 — 31 March 1993)

"The Black Sheep of the Russian Immigration — The marginal elements of the highest quality immigration in the country's history are absorbed well in local underworld"..."Import of prostitutes, locking up and rape of girls, blackmail, forgery of driving licenses, theft of mortgages, fraud..." (Aviva Shabi, *Yediot Aharonot*, 18 September 1992).

Absorption — Jerusalem '92. Two Russian girls, 14 and 15, tell about being prostitutes on the city's streets — more hair-raising evidence of the failure to absorb the Russsian immigration..." (Moshe Zigdon, *Jerusalem*, 18 September 1992).

The Russians on Violence Yuri Berchoff (retired electrical engineer): "For us, to fleece a bank, to defraud a bank is not an offense... Zorik Abrahamiav: "To rob a bank is a *mitzva*..." (Dorit Ben, *Hadashot*, 21 September 1992).

"We Came to the Land — Forgers and Immigrants" (Baruch Meiri, *Ma'ariv*, 2 October 1992).

"...The Ethiopians live east of the highway (at the Mazor site), the Russians to its west, and an invisible line made of fear of AIDS and other diseases separates the camps... The 24 children, all Ethiopians, have a kindergarten teacher with no hands — Hagit, from Bnei Brak. She's not a cripple, heaven forbid, but her hands are in her pockets, or behind her back. I don't dare touch them, she admits frankly, they have seriouss diseases that I don't know, and I'm not about to take any risks... One of the photographers asked the director of the site (called Hatzrot Yasaf), Arik Carmi, to pick up an Ethiopian child for a festive photo. Forget it, I don't touch them, he replied without hesitation".

"... Among the Russian new immigrants at Hatzrot Yasaf horific rumors are circulating about diseases of the Ethiopians..." (Shlomo Abramovitz, *Yediot Ahronot*, 2 October 1992).

"The Russian Mafia — The War Over the Russian Meat Market" (Gideon Meron, *Ma'ariv*, 11 December 1992).

"Half the driving licenses issued in Russia and Exchanged here for Israeli licenses are forged" (Weekly Newsmagazine, Israel Television, 25 December 1992. Two days later the spokesman of the Ministry of Transport stated that the actual figure was 3,000 forged licenses out of 120,000 requests that were submitted in 1991–1992).

"50 Percent of New-Immigrant Children Don't Want to Serve in the Army" (Israel Television Nightly News, 22 January 1993).

"*The Knife Is Passed to the Russians...* Only twenty years ago the papers carried headlines like: 'Moroccan seized during break-in', or 'Moroccan stabs neighbor in argument'. Nowadays, you won't see headlines like that in any paper. But when it comes to the Russians there are other rules. With them, anything goes. You can say and write that their physicians and engineers are bad, their academic degrees are worthless, they have no sense of belonging, they shirk the army, they are lazy at work, and they drive around in glittering cars looking for food in garbage cans, not to mention things like 'They aren't Jews'. How did the image of the immigration — which was briefly a great hope — deteriorate?" (Orna Kadosh, *Zman Tel Aviv*, 25 January 1993).

"Newest Immigrants, Oldest profession — Russian prostitution in Tel Aviv" (*Israel Television Weekly Newsmagazine*, 28 January 1993).

"*Good Immigration, Bad Immigration...* It's very easy to like the new immigrants from Ethiopia: culturally, they do not threaten us and they are certainly not perceived as competitors. Because few veteran Israelis have ever eoncountered Ethiopians other than through the media, what has emerged is largely a media image. The Ethiopian is a young brother, charming and gentle; whom we rescued in a spectacular operation that evoked the Israel of old... In the tragic role game that is conducted by the media, the 'Russians' are apparently condemned to play the counter-role: irate, demanding, judgmental, importers of prostitution, crime, alcohol, and road accidents. The facts, of course, don't matter. According to the police, the crime rate among the new immigrants from the former Soviet Union is lower than that among veteran Israelis, but a new immigrant who has committed a crime will always get headlines that mention his ethnic affiliation..." (Gail Hareven, *Ma'ariv* 31 January 1993).

"Poor Image for Immigration" (Gershon Gershon, *Ha'aretz*, 3 February 1993).

"At School They Call Us Stinking Immigrants... The principal of the Brandt State School in Jerusalem's Neve Ya'akov neighborhood said the new-immigrant pupils 'smell' and told the pupils in the class that the new immigrants 'want only to get things from us, but not to give anything'..." (Sarah Friedman, *Ma'ariv*, 23 February 1993).

"Reasons for the Alienation... Many well-intentioned Israelis who showed great enthusiasm at the beginning of the recent wave of immigration from the FSU were soon disappointed by the behavior of the new immigrants..." (Zahava Shaknai, *Ha'aretz*, 22 March 1993).

"Immigration as a Negligible Matter... Since we stopped being amazed at the 'intellectual' immigration, the new immigrants get exposure only when they steal, cheat, or open massage parlors. From a perspective of time, the information campaign conducted by the Ministry of Immigration Absorption under the slogan 'Smile and make them feel at home' seems pathetic, but it was the last attempt to evoke the sympathy of the veteran population. Since then the image of the new immigrants has gone from bad to worse, and suddenly they are presented as crooks and exploiters who have spread across the country" (Lily Galili, *Ha'aretz,* 22 March 1993).

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EXPLORING THE MULTIDIMENSIONALITY OF SOCIAL JUSTICE JUDGEMENTS

by Clara Sabbagh, Yehezkel Dar, Nura Resh*

Introduction

Issues of distributive justice, like: who deserves what, and on what basis; *should rewards be shared equally*, distributed on the basis of need, or allocated according to merit — play a central role in social life. The answers people give to these questions may be regarded as social justice judgements (SJJ), i.e., perceptions of how rewards should be allocated "justly", whereby individuals or groups will feel that they are receiving what they believe they are entitled to.

In the present study we conceptualize SJJ as multidimensional and particularistic, that is, as complex evaluations whereby several justice principles and the type of social reward allocated are considered simultaneously, and which vary from person to person and from situation to situation. Using Facet Theory and Smallest Space Analysis, we attempt to identify the dimensions that define SJJ, to map their content domains and to reveal the structural relationships between these domains. Our principal aim is to examine how the theoretical relationships between SJJ fit the actual judgements made by individuals when evaluating the relative importance of justice principles in allocation of rewards.

The Multi-dimensional Perspective of Distributive Justice

Two meta-theoretical approaches to the research of SJJ have existed in the social psychology literature for the last 25 years: equity theory

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and the multi-principle approach. The equity theory, first proposed by Homans (1961), Adams (1965) and Blau (1967), rests on two interlocked assumptions which ensue from the individualistic and meritocratic beliefs that characterize Western capitalist societies (Sampson, 1975; Deutsch, 1985). The first assumption is that every individual deserves an equal opportunity to compete for the attainment of social rewards. The second, the very essence of the equity theory, contends that people should be rewarded in proportion to their merits or contributions: the more effort you invest, or the greater your productivity or ability, the greater the reward that you deserve. It is the individual's responsibility to develop his or her talents and moral character, and it is the obligation of the society to reward those who have made greater efforts and are more capable or productive.

The equity theory assumes the existence of a single basic principle of justice that holds universally: people are guided by the equity principle whenever they judge the fairness of reward distributions, regardless of circumstances, the type of the reward to be allocated or type of social relationships. Research is thus concerned with the universal conditions that underlie SJJ rather than with their variability. See *inter alia*, the works of Walster and his colleagues (1973, 1978), who examined the applicablility of the equity principle to a wide range of social relationships (e.g., victim-aggressor, mutual help, business, intimate relationships).

Critics of the equity theory claim that it does not cover every instance of SJJ. They argue that equity is not the sole principle of justice, but rather may be complemented by other principles (Leventhal, 1980). Moreover, reservations have been expressed concerning the underlying assumption that the principle is universal (Deutsch, 1975; Sampson, 1975; Rubinstein, 1988). Such criticism has led to the development of the multi-principle approach, which conceives SJJ as multidimensional and particularistic.

According to this approach, there are several basic principles of justice, and their derivative, more specific, sub-pribciples known as "distributive rules", that individuals may employ separately or in combination in judging the fairness of allocation in different situations (Leventhal, 1980; Lerner, 1981; Reis, 1984). Each of these distributive rules is regarded substantively different and granting a distinct right for reward. While scholars oriented to the equity approach relate to different justice judgements as specific manifestations of the equity principle, the multidimensional approach views the equity principle as one of several justice principles, and each principle is viewed as a distinct type of investment or entitlement in a given situation (Walster, et al., 1973, 1978).

The multidimensional agrument also assumes that any theory of justice must relate to the type of reward intended for distribution, since justice judgements are meaningless if their differential benefit/harm to the individual is not taken into account (Galston, 1980; Walzer, 1983). According to this argument, there are several social rewards which are substantively different from each other, and no single justice principle is appropriate for distribution of every type of reward. For example, application of the equity principle to the distribution of welfare resources, basic education or medical services may be perceived as unfair.

The particularistic argument also presupposes that SJJ are relevant to the specific social context in which they are applied, and judgements that are appropriate in one context are not necessarily appropriate in others. Thus, the question is not what judgements are made by individuals under universal circumstances, but rather what judgements are made by individuals in specific circumstances (Walzer, 1983). The particularistic perspective of SJJ assumes that individuals are selective in their judgements, and that they may apply different principles in different situations. Similarly, different individuals in the same situations may apply different SJJ (Leventhal, 1980). These assumptions are rooted in social learning models which claim that SJJ are formed within the social contexts in which people live, and not as a function of psychological laws of human nature (Sampson, 1975). That is, social contexts and socialization patterns influence the individual's evaluation of the fairness of reward distributions.

This study does not explore the particularistic aspect of SJJ. Rather, it focuses on their multidimensionality.[1] In order to examine that multidimensionality, we consider the content domains of SJJ. That is, we attempt to identify irreducible classes of justice principles, rules of distributive justice that are derived from these principles, and classes of allocated rewards. Moreover, we point out the degree of proximity between elements in each class and attempt to explain their order of relations. This approach differs from existing theoretical research in that it attempts to encompass all three major principles of justice, as well as their distributive rules, within a single conceptual framework. It also includes classes of rewards as an integral part of the definition of SJJ — an aspect that has been usually neglected (Parsons, 1967).

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1. For a detailed examination of the issue of particularism, see Sabbagh, 1990.

Multiple Principles of Justice and Distributive Rules

Of the many principles of distributive justice referred to in the literature, three irreducible principles stand out as major principles under ordinary circumstances: equality, need and equity (Deutsch, 1975, 1980; Schwinger, 1980). From these principles, one may derive nine distinctive distributive rules: arithmetic equality, equality of results, equality of opportunities, equality of basic liberties, primary needs, secondary needs, effort, contribution and ability. Each of these rules, by itself, grants a right for reward. For instance, the rule of contribution dictates that people should be rewarded according to their actual contribution to society (or productivity) regardless of the effort invested, while the rule of effort states that they deserve to be rewarded for their effort even if their actual contribution is low (Slote, 1973; Nisan, 1989). Let us elaborate briefly on each of these three principles and their derivatory rules of distribution.

The principle of equality states that every individual, irrespective of personal traits, investment or contributions, has equally ligitimate claims to social rewards (Oppenheim, 1968). At least four distributive rules can be derived from the principle of equality. First, *arithmetic equality* calls for allocation of an equal share to all participants regardless of their contributions. This rule is intended to ensure that, irrespective of their income, power, authority, prestige, or talent, people will share essentially the same life chances. Taken to an extreme, this rule calls for a statusless society (Nielsen, 1979). Second, the rule of *equality of results* assumes that resources should be distributed differentially so as to allow disadvantaged persons to compete fairly with highly resourced individuals for rewards. This rule is applied when measures of affirmative action are used to promote disadvantaged groups (on the basis of gender, ethnicity or race) (Coleman, 1973). Third, the rule of *Equality of opportunities* states that every individual, regardless of social status, deserves an equal opportunity to compete for rewards. According to this distributive rule, every individual should have access to the same starting point, and his or her final position will depend solely on his or her use of resources (Coleman, 1973). This rule has been extensively applied in the field of education, and is manifested in the increased participation of lower-class students in higher educational levels. Finally, there is the rule of *Equality of basic liberties*, according to which individuals have an equal right to fundamental liberties (Rawls, 1971). This rule calls for a social order that affords each individual moral autonomy and an equal share of respect and honor. Whereas the principle of equality favors an equal share of rewards and opportunities,

the principle of need calls for distribution aimed at attaining a similar, not necessarily equal, level of welfare for everyone, regarding his special, sometimes psychological, needs. It aims to equalize satisfaction among people in terms of what they seek from life (Galston, 1980). The principle of need is related to norms of humanitarianism and social responsibility which deal with the welfare of the needy and demand that individuals sacrifice some of their own interests to provide for the basic needs of others (Schwartz, 1975). This principle is widely applied in social legislation and is pivotal in communal societies, like the Israeli kibbutz. Two distributive rules can be derived from the principle of need: primary and secondary needs (Galston, 1980). The rule of *primary needs* calls for reward distribution that satisfies basic and universal needs related to survival and normal physical functioning (for example, food, shelter, clothing, medical treatment). Complementing this is the rule of *secondary needs*, which dictates distribution according to higher needs related to the individual's intellectual, artistic, moral and emotional development, i.e., needs whose fulfilment makes life meaningful to the individual.

Both the principle of equality and that of need represent egalitarian justice. They both assume that individuals share common characteristics, such as basic needs, the ability to experience joy or pain, the ability to make rational choices. They both perceive individuals as having the same moral value and deserving the same fundamental respect (Dworkin, 1981a; 1981b).

In contrast to the egalitarian claims manifested in the principles of equality and need, the *principle of equity* legitimizes unequal distribution of rewards and requires a distribution of rewards which is proportional to the investments or contributions made by individuals. At least three distinctive distributive rules can be derived from the principle of equity: effort, contribution and ability. By the rule of *effort* rewards should be distributed on the basis of the conscious effort one makes, regardless of his/her actual productivity. In contrast, the rule of *contribution* calls for reward allocation according to one's productivity, even if achieved effortlessly (Slote, 1973; Nisan, 1989). Finally, the rule of *ability* calls for distribution on the basis of each individual's talents. This last rule is not as clearcut in terms of fair reward entitlement. Inequality between individuals in terms of abilities is a genetic given. It would be unfair for an individual to be rewarded more than another owing to innate traits for which he or she is not morally responsible. Consequently, the moral standing of talents is related to their outcome. In other words, ability should be perceived as a collective asset which can be realized in the interests of the community (Green, 1989).

Having defined the distributive rules deriving from the three principles of justice, we now consider the degree of their proximity to or distance from one another. We hypothesize that principles and rules of justice can be ordered along a continuum of uniform vs. differential distribution. Uniform distribution aims at equalizing the level of welfare among all individuals, whereas differential allocation legitimately unequalizes individuals on the basis of their efforts, contributions or talents. The principle of equality does not relate to individual traits (ascribed characteristics, effort, contribution, etc.) and demands uniformity at the starting point (equality of basic liberties and equal opportunity) or in personal welfare (equality of results, arithmetic equality). The principle of need can be understood in two ways: On the one hand, it can be applied in an attempt to compensate people with poor resources; that is, distribution based on need seeks to equalize levels of welfare among individuals. On the other hand, this principle has a differential aspect in considering differential characteristics of individuals as a condition for receiving rewards. The principle of equity is the most differential of the three justice principles. However, the three rules of equity (effort, contribution and ability) vary by the degree of their differentiality according to the extent of moral responsibility they entail (Perelman, 1970). For example, the rule of effort refers to a high degree of moral responsibility — the individual's internal values and morality, motives and intentions. Thus, effort has a more egalitarian meaning in comparison to contribution or ability, which are less subject to the individual voliton (Dar, 1991).

Multiple Social Rewards

Values of rewards are not intrinsic but rather culturally and socially determined. Social and cultural meanings of each reward are distinct; yet, some rewards are closer in meaning than others. Moreover, rewards that have similar social or cultural meanings are more easily exchanged. For instance, money can be exchanged for services, whereas love may not be obtained through the use of power. Each class of rewards is an "autonomous sphere of justice" in which one or more principles of justice are activated (Galston 1980; Walzer, 1983). That is, the social meaning attributed to the reward determines those principles that are likely to be applicable to its distribution. Principles that are applicable to one sphere of justice are not necessarily applicable to another. For instance, people may judge that economic rewards

should be distributed on the basis of merit, while political rewards should be allocated equally.[2]

The literature defines at least four classes of rewards that are distributed in every society (Weber, 1947; Galston, 1980).

Economic rewards (money), i.e., means to produce or aquire commodities and services for the individual's or society's utility.

Rewards of recognition (prestige), including esteem and deference. Reference is to rewards granted on a differential basis in token of excellence of exceptional traits, rather than to the fundamental respect that is the moral right of every individual.

Political rewards (power), that is, the opportunity to influence social activity or decision making. This does not necessarily refer to leadership qualities that require special skills, such as problem solving and implementation of policies.

Personal Development rewards (learning opportunities), i.e., opportunities to participate in activities and share resources that contribute to the development of one's vocational, intellectual, artistic, moral and emotional faculties which provide for the fulfillment of personal and societal needs.

Similarities and differences between classes of rewards has been given little scholarly attention. Foa and Foa (1980) examined empirical similarities and contrasts between reward types along two continua: degree of concreteness/symbolism and extent of particularism/universalism. With regard to the former continuum, money (and sometimes power) involves the exchange of some tangible activity or product, and hence is a concrete reward, whereas prestige and learning opportunities are more symbolic. The particularism/universalism continuum represents the extent to which the value of the reward is influenced by the specific relationships between the particular individuals involved in the exchange. Prestige and power are largely particularistic rewards; their value is relative, context-bound, depending upon the persons who bestow them. In contrast, money and learning opportunities are more universal in nature; they retain more or less the same value regardless of the persons and social contexts involved in the transaction.

Multidimensional Definition of SJJ According to Facet Theory

To provide for a formal conceptual framework for expressing the multidimensionality of SJJ and using it to formulate hypotheses about their

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2. For a description of empirical research on this issue see: Hoschschild, 1981; Tornblom et al., 1985.

empirical structures, we have applied Facet Theory. According to Facet Theory, the dimensions of the phenomenon which is under study are defined by the universe of items included in the proposed theory. The system for defining the universe of observations incorporated by the selected attributes is called a mapping sentence (Canter, 1985). This approach enables us to link the conceptual framework regarding SJJ with the empirical structure of their observations, and to examine the degree of correspondence between them. To define the SJJ we used two facets of content: (A) principles of justice and their distributive rules, on the one hand; and (B) types of social rewards, on the other, as well as one range facet (R). This produced the following mapping sentence:

An item belongs to the universe of SJJ if and only if it refers to the evaluation of subject (x) regarding the degree of consideration that should be given to the distributive rule (facet A)

[1. arithmetic equality
2. equality of results
3. equality of opportunities
4. equality of basic liberties
5. primary needs
6. secondary needs
7. effort
8. contribution
9. ability]

in the allocation of the social reward (facet B)

[1. money
2. prestige
3. power
4. learning opportunities]

by the judgement (facet R)

[1. it should not be considered at all
2. be considered a little
3. be considered somewhat
4. be considered a lot
5. be considered very much.]

This mappimg sentence was used to define the scope of the phenomenon of SJJ and to identify the relevant parameters for evaluating it. Similarly, it can serve as a criterion for producing and validating variables to study the phenomenon both on the conceptual and empirical levels.

Research Questions and Hypotheses

The hypotheses to be tested empirically deal with the following questions: Is the adolescents' perception of the structure of SJJ multidimensional? Are the principles of justice and distributive rules perceived as complementary or contradictory to each other? How are the nine distributive rules related to each other? How are the four social rewards related to each other?

The formulation of the hypotheses regarding the multidimensional structure of SJJ rests on the Smallest Space Analysis method (Guttman, 1968; Lingoes, 1973). This method enables to configurate judgements as points in a multidimensional space, where distances between the points represent the empirical relationships between judgements. The greater the conceptual similarity between SJJ, the higher the empirical correlation between them and the closer together they were in the multi-dimensional space. The theoretical relationships between the facets and their components thus determine how the space is divided into areas.

Hypothesis 1: Justice principles and social rewards are not dependent on one another. The concept "social justice" was defined on the basis of two conceptually independent facets — the facet of justice principles and the facet of rewards. Accordingly, this independence will be configurated in a geometric, three-dimensional space, where justice principles are perpendicular to social rewards.

Hypothesis 2: There is a distinction between various justice principles and distributive rules. The facet of justice principles was defined on the basis of nine distributive rules. Therefore in a two-dimensional representation of relationships between pairs of justice judgements, the space will be divided into nine distinct area.

Hypothesis 3: The relations between justice principles and distributive rules are ordered. The interrelationships between them were described in terms of a continuum. with uniform distribution of rewards on one end and differential distribution of the other. Accordingly, the distributive rules will be arranged as an axial facet, which will be graphically represented in one of the following tables.

The distributive rules in alternative A are arranged according to the extent to which the rule demands that different characteristics of individuals be taken into account as a condition for receiving a reward (i.e., emphasis on the distribution process). In contrast, the distributive rules in alternative B are arranged according to the desired outcomes of the distribution, i.e., according to the level of welfare which the distribution seeks to arrive at.

Order of distributive Rules (A)		*Order of distributive Rules* (B)
talents	*Equitarian Judgements*	talents
contribution to society		contribution to society
effort		effort
secondary need		equality of basic liberties
primary need		equality of opportunities
equality of results		secondary need
equality of opportunities		primary need
equality of basic liberties		equality of results
arithmetic equality	*egalitarian Judgements*	arithmetic equality

Hypothesis 4: The structural relations between the rewards can be described along two continua: degree of concreteness/symbolism or extent of particularism/Universalism. Accordingly, rewards will be arranged as a modular facet. This facet will divide the two-dimensional space into concentric areas which will be ordered in one of the following ways:

Order of Social Rewards (A)		*Order of Social Rewards* (B)	
Universalism	Money	Symbolism	Honor
↕	Learning opportunity	↕	Learning Opportunity
	Power		Power
Particularism	Honor	Concreteness	Money

Questionnaire and Sample

A full representation of the facets in the mapping sentence consists of 36 possible structuples[3] (9 disrtibutive rules x 4 rewards), only 16 of which were operationalized in the questionnaire.[4] For example, these are the

3. Structuple is a concept used in facet theory to define a unit made of an element in each of the content facets. The above structuple contains two facets — Facet A consists of 9 justice principles and distributive rules; and Facet B consists of 4 rewards. Thus, for example, Structuple A_7B_1 would say: "'The rule of effort (A_7) should be considered when distributing monetary rewards (B_1)".
4. The questionnaire included only 16 structuples for the following reasons: (a) in some cases, the principle was not relevant to the reward (e.g., distribution of prestige according to need); (b) some of the distributive rules appearing in the mapping sentence were not representative (or only partially representative, e.g., equality of opportunity, equality of basic liberties, equality of results); and (c) the rules governing need (primary and secondary needs) were not distinguished.

operationalizations of the four scructuples regarding the distribution of economic rewards:

Content of Item	*Structuple*
1. There should be as equal as possible distribution of money among people.	A_1B_1
2. People with greater needs should receive more money.	A_5B_1
3. People who invest greater efforts should receive more money.	A_7B_1
4. People whose work contributes more to society should receive more money.	A_8B_1

The relative importance accorded to different SJJ was recorded by the questionnaire among 6,880 eighth and ninth graders in a national sample of 47 Israeli urban junior high schools (Dar, Resh & Erhard, 1989).

Results

A. Egalitarian vs. Equitarian Judgements

In order to examine the extent to which justice principles and distributive rules are perceived as complementary or contradictory, intercorrelations were calculated among the 16 SJJ (Table 1). The table shows that the condition of the first law of attitudes did not apply to every pair of items.[5] Although in most cases the correlation coefficients between justice judgements were positive (ranging from 0 to .50), a few negative correlations were also obtained (ranging from −.13 to −.01), and they are not accidental. The negative correlation can be interpreted to mean that certain SJJ are perceived as contradicting each other.

Analysis of the positive correlations reveals two groups of items, each of which has a common content object: One group consists of egalitarian judgements based on the principle of equality and need; the other group consists of judgements based on the principle of equity (effort, contribution to society and abilities).

Negative correlations were obtained between judgements based on the

5. The first law of attitudes examines whether behavior in accordance with attitudes (or justice judgements as a particular manifestation of attitudes) is directed towards a "common content object" (Guttman, 1981; Levy, 1985). According to this law, the correlation between any pair of items and a common object among a population that has not been sampled artificially, will be monotonic and marked as positive or equal to zero, but will not be marked as negative.

Table 1. Pearson Intercorrelations between SJJ (x 100)

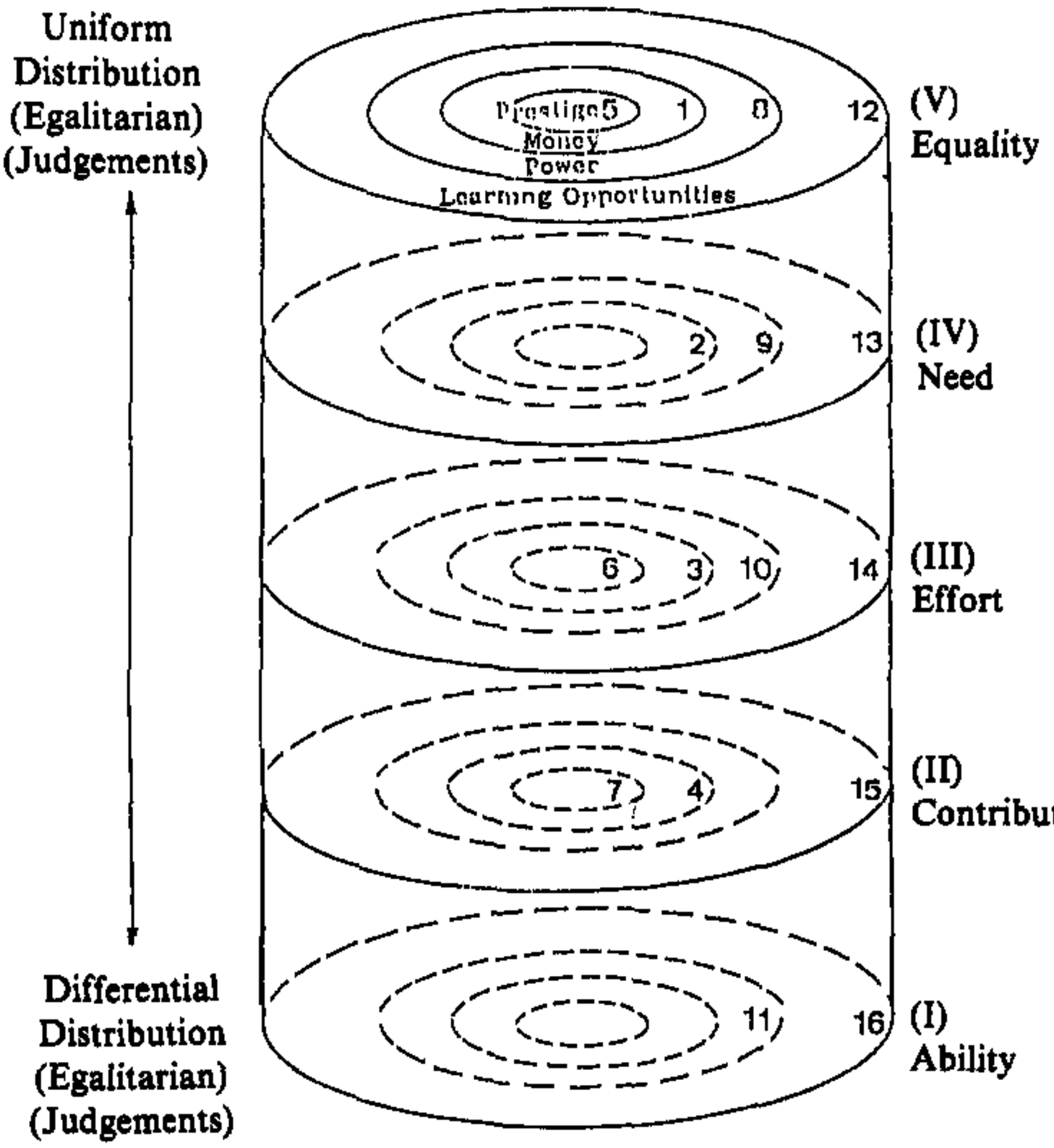
A.	**Money**														
1	Equality														
2	Need	33													
3	Effort	-4	2												
4	Contribu.	-13	-6	26											
B.	**Prestige**														
5	Equality	32	19	1	-4										
6	Effort	17	17	28	17	-1									
7	Contribu.	-2	7	25	36	-10	37								
C.	**Power**														
8	Equality	30	19	11	5	32	16	8							
9	Need	29	30	6	-1	31	11	6	30						
10	Effort	5	13	24	22	5	34	30	2	11					
11	Ability	-3	7	23	28	-3	24	37	-6	-1	50				
D.	**Learn. Opp.**														
12	Equality	24	17	8	0	28	19	3	32	17	11	2			
13	Need	23	27	7	-1	25	16	7	18	38	14	6	26		
14	Effort	10	16	25	15	9	29	23	12	16	29	22	13	19	
15	Contribu.	6	12	15	26	4	19	28	8	13	22	25	1	12	32
16	Ability	1	9	20	25	-1	24	28	8	7	25	33	1	12	28	28
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		Money				Prestige			Power				Learn. Opport.			

principles of equality or need, and judgements based on ability or contribution to society. That is, the principles of equality and need are perceived as contradicting the rule of allocation based on ability or contribution to society. It is noteworthy that this phenomenon is more salient in the case of money and prestige (items 1, 5) than it is in the case of power and learning opportunities.

B. The cylindrex Representation of SJJ

The SSA shows that the intercorrelation matrix of SJJ can be represented in a three-dimensional cylindrex (Figure 1). Four dimensions were needed in order to obtain a good correspondence between the facet components and the space diagram regions (the coefficient of alienation = .064). The cylindrex itself holds three of these, with the rest of the projections constituting "noise" or noncorrespondence. In other words, the relationship between the empirical structure of observations and definition of facets in the mapping

Figure 1. The Cylindrex Structure Obtained from the Intercorrelation Matrix of Social Justice Judgements (Schematic Representation)*



* The numbers indicate the 16 items that were operationalized

sentence is expressed in the cylindrex diagram, where each region of the cylindrex corresponds with elements of one of the two facets: (a) the facet of distributive rules; and (b) the facet of social rewards.

The facet of distributive rules runs along the cylinder's axis, while that of rewards lies along its base. The axial partition divides the space vertically, with each region representing a different principle or rule of justice; the modular partition creates concentric circles, with each reward in a separate circle. Thus, the facet of justice principles and distributive rules is perpendicular to the facet of rewards, and indicates that they are independent of each other.

The cylindrex in Figure 1 is constructed schematically, along three

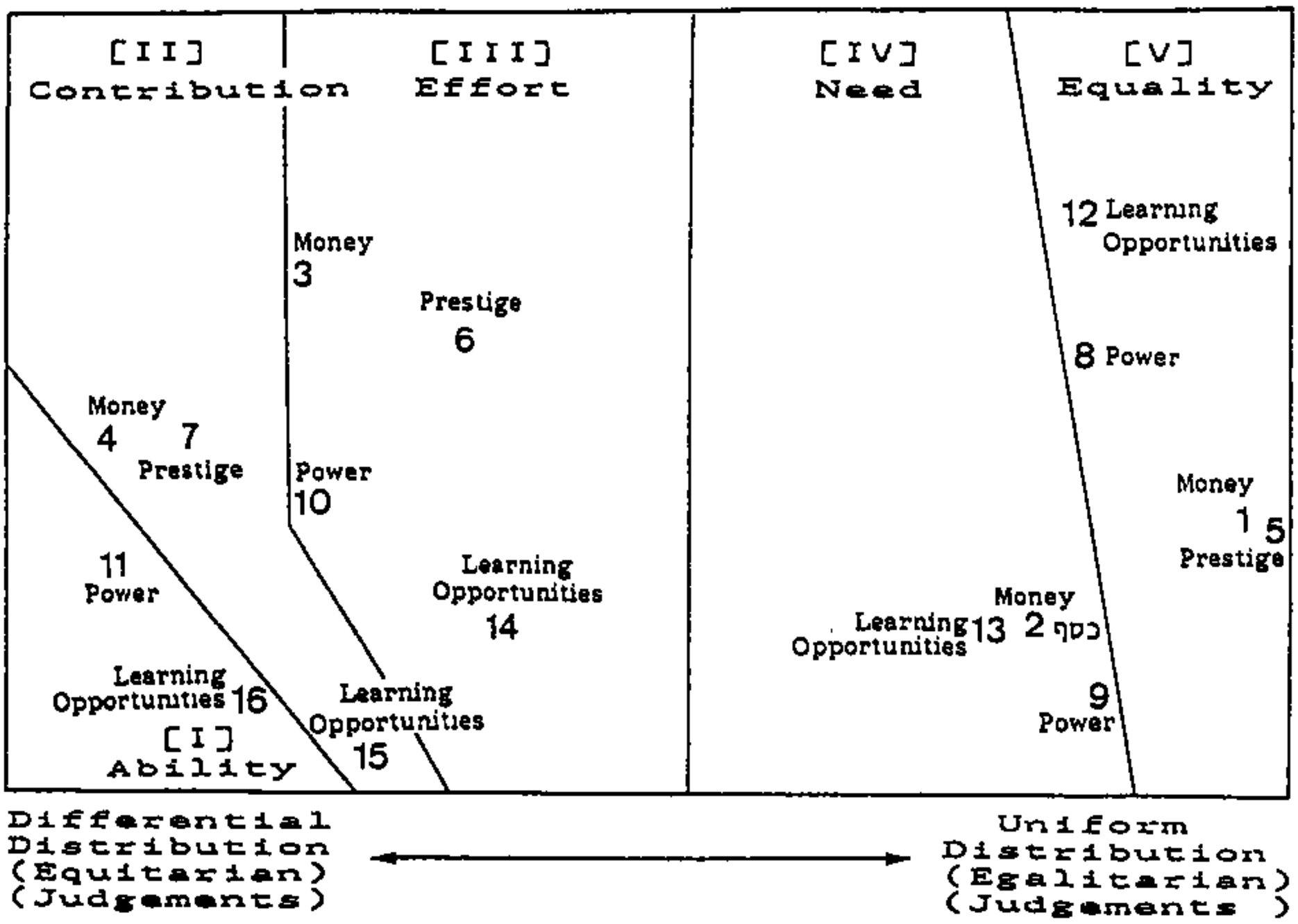
dimensions of the SSA areas which are presented in Figures 2 and 3. The following is a detailed discussion of the analogy between the cylindrex and the content facets of the mapping sentence.

C. The Order Relations of Justice Principles and Distributive Rules

A more detailed analysis of the SSA diagrams (Figure 2) reveals that the axial partition distinguishes clearly between two classes of judgements: egalitarian, on the basis of equality and need, and equitarian judgements. The former provide for distribution of rewards that will equalize starting points or levels of welfare; the latter legitimate inequality and support differential rewards. Moreover, there is a clear distinction between the three principles of justice — equality, need and equity. There is also a clear distinction between the distributive rules based on the principle of equity (effort, contribution to society and ability). The distinction between the distributive rules underlying the principles of equality and need will not be discussed in this paper, since items empirically measuring the distinction have not yet been defined.

As figure 1 shows, the facet of distributive rules partitions space into

Figure 2. The Facet of Principles of Justice and Distribution Rules. The Axial Partition (Projection Vector 3 and 1)



five distinct layers, arranged one on top of the other. Each layer represents a distinct principle of justice or distributive rule. The first or lowest layer (I) includes items that relate to the rule of ability; the second layer (II), items related to the rule contribution; the third layer (III), items related to the rule of effort: the fourth (IV), items related to the principle of need; and the fifth or upper layer (V), items relating to the principle of equality.

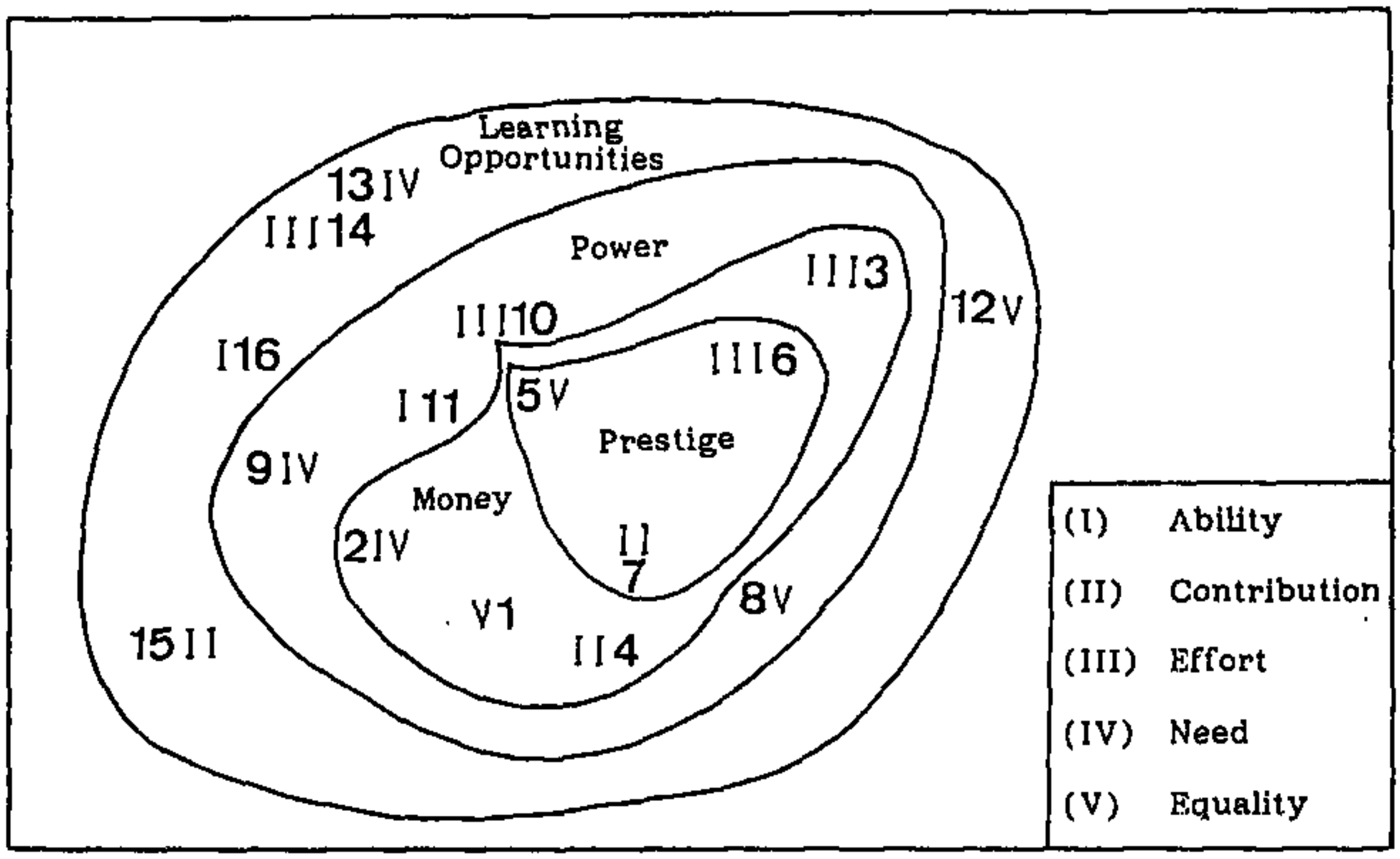
Moreover, judgements fall along a continuum of uniform vs. differential distribution, ranging from egalitarian judgements to judgements of distribution by ability. From a slightly different perspective, we can interpret these same order relations along a continuum of conditional vs. unconditional distribution. Egalitarian judgements involve the most unconditional distribution — individuals do not have to invest anything in order to receive rewards — whole equitarian judgements entail the most conditional distribution, in exchange for individual investment or contribution.

The principle of need is located between the principle of equality and rules related to the principle of equity because of its vague character. On the one hand, the principle of need supports differential distribution of rewards ("the person in need gets more"); and the same goes for the principle of equity ("people who make an effort, contribute and have greater ability deserve more"). On the other hand, however, the principle of need strives towards equality of personal welfare, unlike the principle of equity which advocates personal inequality. It should be noted that our way of examination may have increased the vagueness of the principle since no distinction was made between primary and secondary need.

D. Social Rewards and their Order Relations

Figure 3 portrays a modular partition (circular order) of items. The circles at the base of the cylindrex show a clear distinction between the different types of rewards: prestige, power and learning opportunities. Similarly, justice judgements regarding prestige are found in the innermost circle, followed by the circle containing judgements regarding money; and the outermost circle encompasses judgements regarding learning opportunities. Thus, the further we go from the center, i.e., when one moves from judgements regarding prestige to judgements regarding money, then to judgements relating to power, and lastly to those regarding learning opportunities, the average association between justice judgements diminishes. This means that SJJ referring to prestige are less differential, i.e., when the prestige of the respondents is involved, there is a tendency to attribute appproximately the same degree of importance to all of the distributive rules; however, when

Figure 3: The Facet of Social Resources.
The Polar Partition (Projection Vector 3 and 4)



money, power of learning opportunities are at stake, the justice judgements are based more differentially on various distibutive rules.

While the hypothesis regarding the distinction between the different rewards was corroborated, the order relations between them do not support one of the two original hypotheses, according to which rewards fall along the continuum of particularism/universalism or symbolism/concreteness. At this point, these order relations cannot be satisfactorily explained.

Discussion

Our empirical analysis examined the hypothesis that SJJ are multi-dimensional, and described the empirical structure of their interrelationships. The analysis was based on the assumption that the structure of perceptions of the criteria defining just rerward distribution can be represented in a three-dimensional space. Similiarly, this structure will express the interrelationships between the content aspects of justice judgements as theoretically conceptualized. The empirical structure of SJJ was, in fact, multidimensional.

Examination of the interrelationships between SJJ revealed two classes of

judgements: "egalitarian" judgements (equality and need); and "equitarian" judgements (effort, contribution to society and ability). Judgements based on the principle of equality were found to contradict judgements based on equity and, to a lesser extent, judgements based on need. The contradiction between egalitarian and equitarian judgements derives from the extent to which rewarding is perceived as contingent or uncontingent on personal attributes or productivity. The contradiction between equitarian judgements and judgements based on need lies in the outcome of distribution: The principle of need calls for an analogous welfare among individuals, whereas the principle of equity justifies inequalty.

These negative correlations would seem, at first glance, to contradict the First Law of Attitudes. Levy (1985) suggests that a further condition, which would characterize the content of the items, be added to the Law. This condition calls for a distinction between complementary and contradictory aspects of the object towards which attitudes are being expressed. In our case, it was found that judgements based on the principles of equality and need are complementary aspects of "eglitarian" judgements, and that judgements based on the principles of effort, contribution to society and ability are complementary aspects of "equitarian" judgements. In contrast, it was found that egalitarian and equitarian judgements are contradictory aspects of the concept of justice.

The following, more specific, conclusions can be reached from the analysis:
1. In defining SJJ, consideration of principles and rules of justice is insufficient; rather, the rewards to be distributed have to be taken into account as well.
2. Equality, need and equity were perceived as three distinct principles of justice, and the equity principle was broken down into three distinct rules of distribution — namely, effort, contribution and ability. This suggests that each of these principles and rules of justice grants a distinct right for reward. The structural relationship between these principles and rules of justice can be explained by a continuum of uniform vs. differential distribution.
3. Money, prestige, power and learning opportunities were conceived as defining four autonomous spheres of justice, in which specific principles or rules of justice hold.

The proposed conceptual framework for analysis of SJJ is meaningful for the principles and rules of justice examined in this study. However, there is a need to examine whether it is equally applicable to other combinations of SJJ. For instance, would the structural organization of the distributive rules be modified if additional SJJ relating to the principles of equality,

need and equity, not operationalized in our questionnaire, will be included in the analysis; or if items irrelevant to the universe of the rules examined in this study — e.g., a rule calling for an ascriptive distribution of rewards — are added to the analysis?

Further study is essential in order to evaluate the generalizability of our findings. First, the structure of SJJ should also be examined separately for each of the justice principles in a more elaborated system of operationalized distributive rules. Such a study would enhance our understanding of the interrelations between justice principles and distributive rules, and lend more validity to the order relations between them as proposed in this paper. Second, it is necessary to examine the validity of this structure of SJJ among different subpopulations of the same sample (according to gender, intelligence, and socioeconomic status), as well as among different populations in the same society (such as adolescents raised on kibbutzim or in religious families). It is also important to investigate the similarities and differences in the SJJ systems of adolescents in comparison with other age groups — e.g., adults and children. Third, the validity of the conceptual framework should be examined from a cross-cultural perspective. The definition of distributive rules and the justice principles underlying them was based on literature dealing with Western, democratic societies. The question remains whether the findings are relevant to other cultures. For instance, if the logic govrening complementary and contradictory rules is correct, the findings should be replicated in other cultures. A cross-cultural study would enable examination of the similarities and/or differences attached to specific SJJ. It could also reveal whether the meanings of SJJ are consistent in different groups and cultural contexts, and distinguish universal SJJ from those that are culture-specific.

Several directions may be suggested for applying the present framework in the sphere of education and socialization. One possible direction is to study the relationship between SJJ and individual behavior. For instance, does a certain behavior distinguish individuals who attribute more importance to egalitarian judgements from individuals who ascribe greater importance to equitarian ones? Another direction is to examine whether conceptions of justice differ between social institutions and contexts of socialization. For example, are SJJ in the family similar to or different from those at school or in the peer-group? Are judgements among youth movement members more egalitarian than among non-members? Research in these directions is likely to throw additional light on the interplay between social contexts and SJJ.

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