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Special English Edition, Volume 6

Foreword by the Director-General of The National Insurance Institute of Israel • New Trends in the Welfare State: The Public-Private Partnership • Pension Plans: The Fourth Tier - Part-time Work and Partial Pensions • Israel's Health System Since the National Health Insurance Law • The Future of Long-term Care in Israel • Integration of Services for the Elderly: A Proposed Model • Personal Social Services in Israel: Main Issues and Dilemmas • For-Profit and Nonprofit Human Services: A Comparative Analysis • Foreign Workers in Israel: Their Eligibility for Welfare Programs and their Accessibility to Social Services • Juvenile Delinquency in Israel and its Treatment: Background, Policy and Future Trends • Legislation and Court Judgements: Social Security Legislation Enacted in the Past Four Years.

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Journal of Welfare and Social Security Studies

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CONTENTS

Foreword	Jochanan Stessman	5
New Trends in the Welfare State: The Public-Private Partnership	Gur Ofer	9
Pension Plans: The Fourth Tier - Part-time Work and Partial Pensions	Dov Pelleg	34
Israel's Health System Since the National Health Insurance Law	Revital Gross, Bruce Rosen, and Arye Shirom	67
The Future of Long-term Care in Israel	Rachelle Kaye	98
Integration of Services for the Elderly: A Proposed Model	Jochanan Stessman, Robert Hamerman-Rozenberg, Yoram Maaravi and Aaron Cohen	124
Personal Social Services in Israel: Main Issues and Dilemmas	Joseph Katan	137
For-Profit and Nonprofit Human Services: A Comparative Analysis	Hillel Schmid	161
Foreign Workers in Israel: Their Eligibility for Welfare Programs and their Accessibility to Social Services	Uri Yanay and Allan Borowski	180
Juvenile Delinquency in Israel and its Treatment: Background, Policy and Future Trends	Meir Hovav	206
Legislation and Court Judgements *Social Security Legislation Enacted in the Past Four Years*	Ruth Horn	231
List of Participants		235

FOREWORD

The National Insurance Institute of Israel is happy to present to the professional community and to its regular readers issue no. 6 of the *Social Security Journal* in English. As in the past, the volume includes selected articles which appeared in recent Hebrew editions of *Social Security*. These articles highlight some topics now on Israel's social agenda.

Although a welfare state, in Israel, as in other Western democracies, one may hear many voices advocating a market economy.

Gur Ofer surveys in his paper the experience of the welfare state and its lessons, the social and economic changes that are taking place towards the next century and the novel perceptions concerning the interaction between public services and economic growth. He examines how the welfare state adapts its major services (such as education and health) to these changes, and discusses implications relevant to Israeli society and goals. The approach is pragmatic rather than ideological as far as the means to achieve a certain goal are concerned. Ofer maintains that there is less of a conflict between efficiency and equity than is usually assumed. The traditional goals of the welfare state are fully accepted and will remain an indispensable complement to the two foundation stones of the modern state: a free democratic society and a market economy.

Various developed countries are presently engaged in profound reforms in their pension schemes. The main cause of this is heavy financial pressure on the schemes anticipated according to demographic projections for 30-50 years ahead. Two possible solutions are "targeting" - reduction of the schemes to cover only the most needy and leaving other workers without Social Security cover - and postponement of formal retirement.

While pointing to the disadvantages of these alternatives, Dov Pelleg proposes adding a fourth pillar to the pension system (the first pillar being the basic pension the workers get on retirement, the second - pension related to wage or income, and the third - commercial private savings and insurance), the worker will pass gradually to part-time work between the ages of 55-80 (or till age 75) and will receive a partial pension to supplement his income. This will add years of work to the national economy and to each individual, and less expenditure will be needed to meet the higher life expectancy. This proposal calls for adequate training for older workers and continuous renewal of basic education.

Revital Gross, Bruce Rosen and Arie Shirom provide a broad overview of

the National Health Insurance Law (NHI) and its effects. Their presentation begins with a summary of the factors which motivated the passage of the law, the law's objectives, its principal components, and the changes it mandated in health care financing and delivery. Next the law's historical development and key amendments are reviewed; the general trend has been towards greater government regulation of the sick funds. NHI has not succeeded in achieving one of its major objectives, i.e. ensuring financial stability in the health care system. On the other hand, it has achieved many of its other objectives, including universal coverage, freedom of movement across sick funds and redistribution of monies across sick funds. The article calls for continuous efforts to monitor the impact of NHI as the law itself continues to evolve.

The aging of the population all over the world, including in Israel, requires significant changes in the structure and composition of health care services, and in particular, the expansion of services for the dependent population. In Israel, as in many other countries, there is a sharp institutional and legal division between sickness and dependence on care. The lack of integration among the various services required by the dependent population has created a situation whereby frail persons in need of care are likely to become victims of controversies and lack of coordination between various financing agencies. With a view to learning from the experience of others, Rachelle Kaye reviews the systems for long-term care in three European countries that have developed and implemented relatively comprehensive solutions for the care of the dependent population: The Netherlands, Denmark and Germany. These systems are compared with one another according to uniform parameters, which provide the basis for the criteria used to evaluate the various alternatives examined for a solution to the problem in Israel. The conclusion reached is that the optimal solution for Israel is the enactment of an additional social insurance law for long-term care services for the frail, dependent population, with separate and specifically earmarked funding, under the responsibility and control of the sick funds. The latter are already charged with the provision of health care services within the framework of the National Health Insurance Law. This will ensure integrated coverage against the risk of sickness as well as the risk of dependence on care under the common roof of health insurance.

Reciprocal influences of health and social forces are recognized in the multiplicity and variety of services available to the elderly to maintain health and independent living at home. However, there are wide differences in the nature of these services, the utility of which must be measured equally by the dual standards of succor and cost, in the site of their performance, the providers and specialties involved. Jochanan Stessman, Robert Hammerman-

Rozenberg, Yoram Maaravi and Aaron Cohen review the variety of assistance programs available to the elderly in Israel showing how, in the course of their development, the health services fragmented responsibility and financing among various social and medical bodies. Recently a number of proposals to synchronize or merge the diverse agencies have been raised. The authors propose to take immediate steps for expanding the level of cooperation between the programs for long-term care, both institutional and at home, and point to the Long-term Care Insurance Law as an example of such potential cooperation. In this suggested model, this cooperation is an integral part of the commitment of the health services to their elderly clients.

Joseph Katan deals with personal welfare services in Israel, describing the central characteristics of these services in the Israeli system: involvement in a wide variety of needs and problems; the treatment of weak populations; the restricted involvement of consumers; the involvement of many organizations on the national and local levels; partial legal infrastructure; difficulties in reporting their output and in their measurement and evaluation; acting in a changing environment. These characteristics raise a number of issues and dilemmas and call for further discussion on the shape and direction of these services. Three of these issues are analyzed: the extent of centralization or decentralization; the extent of legislation; and the dimensions of privatization desired in these services. Different opinions and points of view are presented while a number of central principles, which should direct the design of these services, are pointed out.

In an attempt to better understand the dynamics of relations between for-profit and nonprofit organizations that provide human services, Hillel Schmid performed content analysis on research conducted over the past two decades. The following variables were considered: declared goals and objectives, clients, organizational strategies, organizational structure, human resources, costs of operation, quality of services and client satisfaction. This article emphasizes the importance of such studies, especially at a time when scholars recognize the need to study *how* services are provided rather than *who* provides them. The findings of Schmid's study have practical implications for policy-makers and clients alike.

For close to a decade, increasingly large numbers of temporary labor immigrants from outside the Middle East region - legal and illegal - have been employed in Israel, largely in the construction, agriculture and service sectors. The paper by Uri Yanay and Allan Borowski discusses this new (for Israel) phenomenon and highlights some of the related social issues. Primarily, it focuses upon the eligibility of these foreign workers and their families for

health, education and housing services. It also discusses their access to police and other local public services. The authors consider the eligibility for and accessibility to human services by Israel's foreign workers in light of the international standards set by various United Nations and International Labor Organization Covenants which Israel has ratified. They conclude by urging policy-makers to take the steps necessary to ensure that Israel more closely conforms to these standards, which should serve as accepted guidelines although they are not necessarily binding.

The article by Meir Hovav surveys the background and development of the Juvenile Probation Service and the Youth Protection Authority, the functions that they serve today and their directions for future development. The Juvenile Probation Service has moved beyond its traditional role of preparing pre-sentence court reports and implementing probation orders, to providing psycho-social evaluations on minors suspected of criminal offenses for Police Departments and District Attorney's Offices; to interrogating suspects, victims and witnesses in cases of sexual offenses and violence in the family; and to preparing reports for minors under arrest. In the future, it appears that the Service will strengthen the use of social intervention in the law enforcement network and increase the use of alternatives to imprisonment. The Youth Protection Authority has expanded its residential care to minors in acute distress who are not criminal offenders. This trend is expected to continue in the near future and to expand to special population groups, such as drug users.

It is our hope that the wealth of material appearing in this volume will help enrich knowledge in the field of social security and contribute to international cooperation in this field.

I would like to express my thanks to all the authors who agreed to have their articles published in this volume, to the readers who perused the articles and made useful comments, to the Editorial Board of *Social Security* - chaired by Mrs Irah Kahneman - and to the editor Mr Raphael Julius, for bringing the material to print.

Prof. Jochanan Stessman, M.D.
Director General
The National Insurance Institute

NEW TRENDS IN THE WELFARE STATE: THE PUBLIC-PRIVATE PARTNERSHIP

By Gur Ofer*

Introduction

The welfare state that developed following World War II, in part as a response to the alternative presented by the Communist regimes, has proved itself an appropriate humanistic and social complement to the market economy and democracy.[1] A large variety of social services and transfer payments financed by a progressive tax plan became an organic part of the rapid economic growth process in the developed countries which began in the 1950's. In addition to the contribution to growth, social services also ensured a more equal distribution of the fruits of economic growth. The financing of welfare state services required a significant expansion of the state budget and the public sector. The percent of the GDP allocated to services increased from 15% in the 1950's to 20-25% and more in the 80's and 90's. Correspondingly, the sector providing public services also expanded. The large variety of services included education, health, housing and income transfers for senior citizens, children, the unemployed and other low-income groups.

The concept of the welfare state is based on two basic principles: universality and equality of transfer payments and services. The principle of universality is first and foremost a desirable social principle: a progressive system of taxation finances services to each according to need. This principle also carries an obvious political advantage: universal benefits ensure widespread political support for the system. It also eliminates the need for means testing, which is complicated and usually imperfect, as well as denigrating. Providing the same service to everyone is preferable, not only because it is universal and egalitarian, but also because it ensures an appropriate level of service since it is the majority of voters who are the beneficiaries (services to the poor are poor services). Provision of social services by the government at the same level for all contributes to social solidarity and cohesion and to the citizen's feeling of

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1. There is an extensive literature on welfare policies and the crisis of the welfare state. A list of the sources used in preparing this lecture is appended to the end of this article.

belonging. Provision of services in kind instead of financial support was preferred, partly out of paternalism and partly to ensure appropriate usage of public resources.

In addition to these central principles of universality and equal provision for all, the welfare state was meant to correct a number of market failures which prevent the market from providing services at the required level of quality and with reasonable efficiency. These market failures include: positive externalities in education; investment in human capital and some health services; the lack of opportunities to borrow in order to invest in education and health and to transfer income across life cycle periods; and the failure of the market in providing health insurance and health services which results primarily from asymmetric information among participants and adversely affects the weak and the sick and leads to overuse.

Finally, public assistance from an early age (child allowances, investment in education) limits the need for it later on. Many studies point to the high rates of return on such investments.

The achievements of the welfare state are many and it is hard to imagine a Western democratic state without this crucial social component. Both the former Communist states and the developing countries have recognized these principles and have sought to implement a similar model. Undoubtedly, the mixed approach is prevailing at this stage of history. It involves an ideological compromise between simple and more extreme economic and social theories, between the more intellectual and aesthetic theories and between free market theory with private ownership and central planning with total nationalization. This ideological compromise - an unpolished pragmatic approach which is sometimes forced to deal with social and economic problems through an appropriate combination of public and private efforts - is preferable, according to many, for its ability to balance between the principles of individual and economic freedom, economic efficiency, equal opportunity and poverty reduction. It is absolutely clear that within this general definition there is room for a variety of viewpoints and differences of opinion as to the appropriate way to combine these goals. Such a state of affairs is unavoidable and even desirable.

Since the model of a market economy combined with welfare state and democratic regime is essentially pragmatic (its goals, of course, being anchored in basic social principles), the relations between its various components and the policy measures meant to achieve them are not sacred and are subject to change. One reason for allowing change is the lessons learned from past experience. From time to time, there is a need to examine and make

adjustments in the system and even fine tune the balance between goals. Another reason for change is the fact that, contrary to claims that we have reached the end of history, history does continue and changes occur in all spheres of human activity. These changes justify adjustments in the model and policy measures.

The third justification for change is the important lesson learned from the collapse of extreme ideologies: the means used for achieving a goal should not be sacred. Their efficiency in achieving their goals should periodically be reexamined. In my opinion, the forces of the free market are not ideologically superior. However, I am convinced that in many cases, though not all, they are the most efficient means available. Similarly, government intervention is not intrinsically bad. The government has highly important tasks to perform, but its failures should be reduced to a minimum. In this century, we have witnessed several instances in which "people's property" became a justification for the exploitation of the population (and the denial of basic freedoms) and other instances in which unrestrained market forces have impoverished entire countries for the benefit of a few. At times, we forget that the goal of private enterprise is to maximize profits and not to organize the economy and perfect a competitive market serving the good of society. Similarly, politicians do not always identify with the goals they were elected to advance.

This essay is based on faith in the ideology of the welfare state. It attempts the following: 1) to examine the experiences of the welfare state in the second half of this century and the lessons to be learned from them; 2) to trace the relevant changes in all spheres of society and human activity, both in the recent past and in the next generation; 3) based on (1) and (2), to examine the options for necessary changes in the welfare state, with emphasis on the policy measures to be taken and the main objectives; 4) to briefly describe the welfare state in Israel and its specific problems and to apply the general discussion to Israel's situation. The methodology used in this essay is, I must confess, taken from economics. It describes reality as the attempt to achieve multiple goals within a constraint of general scarcity. A change in the mix of goals (usually on the margin) does not mean that any goal has a negative effect, but only that under the new conditions, a different goal has greater significance. The same applies to a change in the mix of policy measures. For example, the restriction of a universal service does not mean that it is defective but only that its cost now exceeds its benefits. Paul Wilding cites Keynes as saying, that the main difficulty lies not so much in developing new ideas, but, rather how to liberate oneself from the old ones (Wilding, 1996, p. 7).

Lessons and Changes Relating to the Developed Countries

1. Lessons Learned from the Welfare State Experience

Before we begin criticizing the welfare state, it is only proper to mention its impressive achievements. For the last two generations, it has provided a large majority of the population with a reasonable level of public services. It has also established a minimum standard of living while preserving a democratic regime with basic liberties, including economic freedom and economic growth. Among the problems created by the welfare state, one may list the following:

The significant increase in the public sector's share of GDP and the labor force negatively influenced macroeconomic equilibrium and growth rates. From the beginning of the 70s, a gradual increase in both inflation and unemployment occurred in most of the developed economies, with a corresponding slowdown in hitherto rapid economic growth. In some countries, high unemployment rates persisted and weaker elements of the population were marginalized and pushed into asocial and antisocial activities. The growth of the public sector and the emergence of budget deficits was, of course, only one reason for this phenomenon and, according to many, not an insignificant one. In addition, we witnessed the development of negative incentives resulting from high taxation and the structure of public aid programs. The growth of public expenditure for public services was a result of demographic developments and objective changes, as well as generosity in social programs and entitlements.

There was a tendency, which still persists today, to treat resources available to the government as a soft budget constraint and to gradually raise the level of expenditure on services to a point exceeding budget capacity. This creeping increase in welfare costs, a result of good intentions and political pressures, endangered the budgetary equilibrium.

The role of the government as service provider has turned out to be less efficient and less user friendly than anticipated. Government services were in many cases too uniform and of mediocre quality.

The anticipated level of equality was not attained. Most importantly, the welfare state has not succeeded in sufficiently reducing poverty, especially long term poverty. In spite of the uniformity and equality of services and even corrective discrimination favoring the weaker sectors, the achievements of education have been partial at best. Inequality persists as a result of the preference given to the middle and upper classes and the purchase of supplementary education by these classes. The difficulties caused by the prolonged slowdown also contributed to the increase in inequality in many countries.

Based on the experience of the welfare states, the development of economic growth theory, the experience of the developing countries and other components of economic theory, it is apparent that a new consensus has been reached among economists concerning the link between the level of social and welfare services and economic growth. Together with a much increased emphasis on the importance of a balanced macroeconomic policy for growth, the important contribution of investment in human capital, the human factor in general and even transfer payments to growth has come to be recognized. This contribution finds expression in the expansion of investments to the socially optimal level, the reduction in discrimination, which contributes to both greater efficiency and greater equality, and the increase in growth resulting from a more equal sharing of its fruits. Herein lie economic, social and political incentives.[2] There is also a high return to investment in education and welfare services for children even by the accounting of the public sector since expenditures for welfare services in the next generation will be reduced and tax revenues will increase.

Finally, the experience of the second half of the twentieth century has shown that growth itself is unsurpassed as an instrument for reducing poverty. There is still disagreement over the relation between growth and income distribution. According to Kuznets' curve, the beginning of rapid growth is accompanied by increased inequality that decreases at a later stage. If Kuznets is right, the experience of rapid growth in the welfare states following World War II enabled the development of the welfare state and to some measure explains it. From the economist's point of view, the tension between equality and efficiency is reduced to a large degree. Some welfare state services contribute to both equality and efficiency. An improperly functioning welfare state is liable to reduce both.

Just as economic theory has adopted a more positive approach to the contribution of social services, there are signs that members of the social lobby have recognized the contribution of growth to the solution of social problems and conversely, the possible damage to social goals from further expansion of welfare state services. They need to be convinced that some of the dilemmas they face can be resolved by adjusting the policy measures and the public-private partnership of the welfare state.

The combination of economic and social goals with the double task that

2. Anatoly Giddens, Dean of the London School of Economics and a close advisor of British Prime Minister Tony Blair, calls the new welfare state the state of social investment. The change in name speaks for itself.

welfare state services fulfil, should form a new basis for social solidarity and create a readiness to help weaker groups. The changes proposed in this essay follow logically from the lessons enumerated above, as well as from recent demographic, social, technological and economic trends that will continue into the twenty-first century.

2. Changes in Society and the Economy

The changes we discuss below apply to the average or characteristic member within the group of developed countries (those that were until recently members of the OECD). Later we will define important differences within this group.

(1) Demographic changes. The most important demographic changes are the increase in the proportion of elderly population (over 65 years of age) and the decrease in the share of children (below 15 years of age). The demographic dependency rate for these two groups combined has gradually been rising and will continue to do so in the future as the percentage of children stabilizes and the number of seniors continues to rise. These demographic changes are the outcome of the decrease in birth rates and the increase in life expectancy.

(2) Sociodemographic changes. The main change in this area is the large increase in the rate of labor force participation among women and the influence of the resultant changes on the dependency rate and the institution of the family. The increase in the participation rate has moderated the increase in the dependency rate between providers and non-providers (of all ages) correÙ sponding to the increase in the demographic dependency rate. However, it has also diminished the ability of families to provide proper care for children and the elderly. Thus, the dependency burden on the public sector has increased. The phenomenon of families with many children has been replaced with that of single-parent low-income families, most of which are headed by women.

(3) Technological developments. Technology is progressing rapidly in many areas, especially the information industry. These advances have altered modes of production and brought about dramatic change in the industrial structure. Additional structural changes are bringing about the globalization of the world economy and the opening of economies to trade and the flow of investments and capital. These two changes promise increased growth, but at the same time require a major overhaul of educational and training programs. The rapid pace of these changes exacerbates structural unemployment and increases the need for retraining and career changes. The acceleration of economic growth and the necessary structural changes (as well as the process of globalization) increase inequality, at least initially. Computers and the mass media were originally intended as a means for achieving concentration and uniformity, political

control and central planning, the creation of a cultural global village and a perception of the human role as one uniform production line. At some point it became apparent that this revolution had a contradictory aspect to it: the ability to shorten production lines, manufacture according to personal order and broaden and variegate the spectrum of politics, society and culture. In the beginning Big Brother saw everything. Everyone was meant to watch the same television programs, see the same movies and wear the same jeans. Now there is a choice of hundreds of channels and thousands of movies. Using a computer, people can order cars and jeans according to their individual preferences before the produce is even manufactured. Stephan Shortell has dubbed this phenomenon mass customization; the world is in the process of transition from mass production to mass custom design.

(4) Economic globalization. The move towards global economic integration enables export-based economic growth. At the same time, it restricts the level of inefficiency tolerated in each country and determines standards for macro-economic stability and efficiency in providing social services. In addition to the conventional combination of decreased tariffs on merchandise and services, a trend is emerging towards deep integration, including uniformity of norms of social services, social legislation, etc.

(5) Socio-cultural changes. Finally, there is a long list of socio-cultural changes closely related to the above-mentioned changes and which follow from them (or perhaps even caused some of them). There is an increase in individualism and diversity of tastes and consumption habits. There is more individual and less collective consumption (the media), more consumption based on individual taste and less uniformity. There is a strong desire for the freedom to choose between service providers and for a high level of service. Society relates to the individual as more consumer rather than citizen; to his personal tastes rather than his status. Technology makes this possible and the consumer prefers the post-Fordian pluralism of mass customization.

All of the above transitions, whether already under way or anticipated, necessitate a reevaluation of some key elements of welfare state services.

The Reevaluation of the Welfare State and the Public-Private Partnership

The term reevaluation is used here in the context of a gradual process of transition as opposed to rapid change. In general, several desirable trends are beginning to appear regarding the size and structure of the public budget and the participation of the non-government sector in financing, allocating and providing welfare and public services. The policy recommendations outlined here are applicable to all countries and several are already being implemented

to various degrees in some countries. In the following section there will be specific references to Israel.

(1) Since welfare and public services are, in one way or another, public goods and are susceptible to a long list of market failures, ways must be sought to limit the scope of the public budget in other areas. The first priority in reducing the size of the public sector is for the government to cease its involvement in industries which clearly belong in the hands of the business sector. As a result of the technological revolution, much of the infrastructure should also be in private hands. This will allow the public sector more opportunity to concentrate on social services.

(2) Budget items should be reclassified according to their contribution to economic growth. The investment items remaining in the budget should be separated from the rest of the expenditures and the idea of a development budget should be revived. This budget will include the financing that part of investment in physical infrastructure which will remain the responsibility of the government, as well as investment in research and development and human capital (i.e. education).[3] The development budget will have different rules than the regular budget (and strict rules should be established which would allow financing through credit). In particular, legislation should be passed which would allow the transfer of resources from the former to the latter but forbid it in the opposite direction.[4] The institutional separation will facilitate the preservation of a growth-oriented budget structure in the face of political pressure during periods of cutbacks and elections.

(3) The financing of the main welfare and public services (social security, old age pensions, health and education) should be ensured. At the same time, this setup will clearly have to be subject to change according to the economic situation and be open to annual budget negotiations to some extent. In addition to ensuring the level of services, there should be a mechanism for professional review of the budget with respect to the development of needs and possible increases in efficiency. Services for which a separate payment is collected, such as social security and the health tax, should be included within a defined budget framework and, if possible, within a closed independent budget (with a fixed obligation of financing from the general budget). The provision of services should be conditional upon financing. Such a framework is not only desirable for the sector providing the service but also helps to control the size of the

3. The division of expenditure on education into investment and consumption is not straightforward, however.
4. In Israel, these rules can be set down within the law regulating the budget deficit.

budget. A predetermined obligation on the part of the government along with a predetermined mechanism for updates will also protect the budget from excessive demands.

(4) Transition from universal to selective services should gradually be made in certain sectors accompanied by a reduction in taxes and an overall reduction in the government's financing burden. This transition is also justified by the changes that have occurred in the economic status and composition of some target groups for universal services. For example, the improvement in the economic situation of the elderly (65 and older) in comparison to the rest of the population and the increase of inequality within this group justify a more selective approach to this sector and changes in the composition of services. Whenever possible, universal payments (such as child allowances) should be replaced with a system of tax deductions and direct payments should be made only to groups below the tax threshold.

An additional saving in public expenditure can be achieved by replacing the direct involvement in the financing and provision of services with the creation of conditions in the capital market for the financing of investment in education (and child upbringing). This would enable the transfer of a significant portion of retirement savings to personal savings plans in the non-government and business sectors (see below).

(5) Income supplement programs of various kinds (for the elderly, children, the unemployed, etc) must find new ways to minimize negative incentives, moral hazards and misuse. Old age, unemployment and disability benefits, income supplements and similar programs should include incentives for increasing participation in the work force, for a quick return to the labor force and for professional retraining. Child allowances should not encourage additional children in families unable to provide minimum care and education.

(6) It is necessary to reevaluate the entire range of services related to the period in the workforce and pension arrangements. First, there should be an adjustment to the reality of rapid structural changes, career changes during a worker's lifetime and the continual professional training required by these changes. The term "life-long learning" expresses this need for constant retraining, and also emphasizes the increasing importance of the timing of training so as to be synchronized with the needs of the workplace. Unemployment benefits should be combined with a program of continual training and integration into the labor market. This can be accomplished through, for example, the subsidization of work programs for the unemployed by means of employment vouchers. Early retirement plans should be eliminated and integrated, along with severance pay, into more long term retraining

programs. The retirement age should gradually be raised and the obligation to retire made more flexible. Within the pension system, the share of pension plans based on accumulated savings should be increased. Programs of income supplementation for families outside the labor market but with family members able to work should encourage a quick return to the workforce and even make (temporary) assistance conditional upon returning to the labor force.

(7) The allocation of funding for the provision of social services should increasingly be done through a system of vouchers, whether real or virtual, whose value will be established according to the needs of the recipients. Virtual vouchers will serve to allocate resources to service providers in cases where the individual has no choice between providers (for example, in elementary school education). Real vouchers will allow consumers to switch providers when freedom of choice exists (as in the Israeli health system). The value of the voucher may differ according to which sector the provider belongs to (a higher voucher in the public sector), such as between schools in the education system. In circumstances where there are several providers and freedom of choice, the system of vouchers enables a certain measure of competition, mainly in the quality of service, and increases the efficiency of the system. Choice could also exist between different providers within the same sector.

(8) All the measures listed above will provide only a partial solution to the problem of financing public services, the demand for which is increasing due to economic growth and rising incomes. The demand for diversity of services and additional choice also adds to the financial burden. Therefore, an increase in the private financing of these services should be considered. Public financing will continue to provide a generous basket of services in all these areas. Private payments will finance services beyond the basic basket in areas of retirement, health and education. Such private payments will be voluntary in principle, but will be regulated by law. In any case, the basic basket, which will periodically be reviewed, will provide a minimum level of service in each area. Private financing will be channeled mainly to the second (public) and third (private) levels of the pension system, supplementary health insurance (principally for choosing a doctor and private medical service), nursing care and additional educational services.[5]

(9) The provision of services, however financed, should be carried out through the non-government public sector. In this sector, the right balance exists

5. The method of integration differs between sectors, according to the characteristics of the sector and the structure of the existing service. This will discussed in more detail later in the essay.

between the correction for market failures and social sensitivity on the one hand, and competition among providers, a broad variety of services, a higher level of service and more options for consumers, on the other hand. In some cases, similar results may be achieved through decentralization within the public system (to local authorities), to areas of provision (education) by way of internal competition. The novelty in this proposal lies in the attempt to preserve the single provider framework, which will supply both public and private services even in the case that financing originates from several sources. The argument is that providing for everyone under a single plan, even with a degree of inequality, will better assure the adequate provision of the basic basket of services than a framework which separates between the two systems. Such a consolidated plan will also save resources. It is not a simple matter to combine private and public resources within one system; such a move requires creative solutions. Under these conditions, it is very important to maintain a relatively small private sector as an alternative provider of some services, partly as an incentive for efficiency in the non-profit sector.

The acknowledgment of the economic role of social services, the combination of public and private financing and the consolidation of services principally in the non-profit sector, form the basis for the transformation of the social contract, which has been the foundation of the welfare state. The social contract must absorb the lessons learned from the old welfare state and adjust itself to demographic, economic, technological, social and cultural changes. The old contract was based on a uniform provision of services for all, financed by a progressive tax system. The quality of service was guaranteed by the middle class, who controlled the legislatures and were the ones who required social services. A new layer of mutual guarantees should be added to this foundation: general responsibility, by means of the tax system, for providing an adequate basic basket of services to all. This will come in exchange for the possibility to diversify services, thereby increasing choice and allowing the private financing of additional services for those who can afford the cost.

The new social contract and the public-private partnership in financing and providing services will result in inequality in the provision of health services, pensions and education; however, it is doubtful whether this inequality will be greater than that already existing. Its advantage over the previous system is that additional public resources will be directed towards increasing the value of the voucher for the weaker groups (mostly in the area of education). In addition, a larger share of human resources and administrative energy in government ministries will be directed towards guaranteeing an adequate level of services in

these sectors in order to achieve a greater level of equality. In view of the fact that the demand for health, education and pension services is characterized by high income elasticity, it is not possible to ensure full public financing and, therefore, total equality for all classes. Thus, there should be a guaranteed basic basket of services for all, where the level of services will be measured by outcomes or results, and not by expenditures. More public funds will be spent on sicker people and on children needing more help in order to reach set educational outcomes. Public resources should be dedicated to ensuring that the basic basket will result in greater equality of results (and not merely equality of investment).

Changes and Reforms in the Welfare State in Israel and Worldwide

This section will discuss the implications of the preceding discussion on particular sectors of the welfare state and on society in Israel.

1. Israel as a Welfare State: Similarities and Differences

Israel belongs to the group of developed countries with respect to economic and social goals, per capita level of GNP, economic structure and culture. The structure and scope of the welfare state in Israel is similar in its main dimensions to that found in western and northern Europe. In 1995, the public sector in Israel spent approximately 25 percent of GDP on welfare services (not including pensions apart from social security). This figure is only slightly lower than the average in the OECD countries.

The demographic burden in Israel is somewhat higher and structurally different than that of the OECD countries owing to the high percentage of the young in the population which is expected to gradually decline, and the moderate increase in the percentage of the elderly, which is expected to continue in the future. In Israel, as in several southern and central European countries, there still remains some potential for greater labor force participation among women, as well as among men. If this potential is realized, the burden on income earners will be further reduced. As a country of immigrants, Israeli society bears a special responsibility for social and national cohesion, both within Jewish society and between it and the Arab minority.

The per capita GNP in Israel is lower than the average in most OECD countries; however, the strain on the budget is greater, owing mainly to defense expenditures (and interest on debts incurred for defense in the past). In contrast, the outlook for the future (assuming the peace process continues) is for higher rates of growth than those anticipated in the developed countries and some decrease in the burden of the defense budget. In addition to the peace

dividend, there are two other factors which will contribute to a high growth rate: the massive human capital which was brought into Israel from the CIS countries and the process of structural reform, which includes increased exposure of the economy to international competition, a process that has been ongoing since 1985 (albeit at a slow pace).

Ways must be found to lessen the relatively heavy burden of the welfare state on the public budget, perhaps even more so than in other countries. The positive outlook for the future development of the burden gives Israel some breathing space in order to carry out the necessary reforms at an early stage and properly plan them. These reforms can contribute to economic growth and will at least prevent disruptions to the process as a result of excessive strain on the budget.

The discussion of the various components of the welfare state will proceed as follows: elements of the demographic burden, beginning with those of working age and up to retirement, children and education and finally health.

2. Unemployment Benefits, Employment and Structural Changes

Since the energy crisis, a significant number of European countries have experienced chronically high unemployment rates. Despite the renewal of growth in many of them, unemployment rates have only moderately decreased (with the exception of Britain). The situation is so acute that the new growth process has been called growth without employment in the literature. The persistently high unemployment rates are primarily due to the ability of some families to survive without employment for a longer time (thanks to working women or previous savings), the negative incentives resulting from unemployment benefits, the traditional inflexibility of the labor market and the emergence of structural and prolonged unemployment (in addition to cyclical unemployment), which are usually associated with recessions (for example, see Wilding, 1996; United Nations, 1997). In a few countries, Israel included, cheap guest workers replace domestic workers and cause unemployment to rise.

The rapid technological changes and the opening of economies to world trade have increased the need for structural change and retraining of the work force. Economies unprepared for these changes suffer from much higher unemployment rates. The way to efficiently treat this problem is to deal with its causes. The main solutions lie in tightening unemployment benefit programs in order to minimize incentives for abuse and making benefit payments conditional upon professional training. On a more general level, questions arise concerning the role of the labor market and the policy required to prepare for and support the structural changes in the economy. The political

establishment in many countries tends to protect threatened sectors and their workers. A more efficient policy must also include the means to support and expedite structural changes. One method of protection is early retirement. Even though early retirement should not be entirely eliminated, the additional burden on welfare services must be taken into account. In order to make it easier to switch occupations once or even several times over the course of a lifetime, it may be possible to replace early retirement with an accumulated fund to be used for retraining for a new occupation.

In Israel, unemployment rates are currently higher than in the past but are still relatively low compared to Western Europe. This year's increase in unemployment rates to 8 percent and higher stems (at least partly) from a temporary slowdown and it is unclear what level structural and natural unemployment rates will reach. It is likely that part of the difference between Israeli and European rates of unemployment is due to the delays in implementing structural change. As a small country with a long tradition of structural distortions, Israel has a high potential for growth if it can eliminate these distortions, open up the economy and implement the necessary structural changes. Thus, it is in Israel's interest not to delay, but rather to expedite these changes and to utilize some of the liberated resources to assist those hurt in the process. As discussed earlier, the most efficient means of doing this combines retraining for new occupations with a guaranteed minimum standard of living and, if possible, employment. It will probably be difficult to retrain some of the older workers in the sectors to be reformed. These people should be guaranteed a minimum level of income. Efforts should be made through the education system and professional retraining to minimize this problem in the future. There are indications that the structural changes in Israel are moving towards knowledge-intensive industry, perhaps even more so than in the rest of the world. However, one important exception is the tourism industry, in which Israel possesses an obvious comparative advantage and significant potential for growth. Both the long-term structural change and the present economic slump would have been more moderate had this sector been developing at peacetime growth rates.

3. Pension Plans and Income Transfers to the Elderly

The guarantee of an adequate income for the elderly will be the most significant strain on the welfare state in coming generations as a result of anticipated demographic developments. The baby boom of the 1950's exacerbates this problem. The percentage of the elderly in the populations of the developed countries will reach 20-25 percent and the relationship between the number of

years in retirement and the number of work years may rise by more than a quarter. Such a figure, or one even lower than that, necessitates a high rate of savings during the working years and it is obvious that the public sector cannot transfer the necessary sums through taxation. At present universal national insurance exists in many countries. It includes a first layer (universal budgetary payments) and often a second layer (pensions) which is financed by special salary taxes or by general taxation. In view of the expected strain on the budget, many countries are considering various plans for shifting part of the burden off the public budget by transferring some of the budgetary programs or those based on current payments (national insurance payments to the elderly financed from taxes on those currently working) to non-government programs based chiefly on the principle of accumulation by the individuals themselves. In addition, many countries are raising the mandatory retirement age or even canceling it. Similarly, the age for pension entitlement is being raised; the method of calculating pension rates is being tightened; and early retirement is being restricted. A few countries have instituted negative mortgages which involve a monthly payment in exchange for the sale of a home or its transfer to the buyer after death.

Together with the increase in the percentage of the elderly, there has also been a rise in their standard of living in comparison to the rest of the population. In some countries the standard of living of the elderly as a group is already higher than average within the population and the rate of property ownership is even higher. At the same time, there is increasing inequality of income and property within the elderly population. These two phenomena are explained partly by the existence of old age pensions which are usually universal and uniform (at least in the first layer), and partly by the broadening of participation in pension plans and the general rise in the standard of living in the developed countries. These developments reduce the effectiveness of the universal system. In some countries, the possibility of taxing pensions is being considered.

Retirement savings in Israel, as in many other countries, are based on: 1) National Insurance pensions which are financed jointly from current deductions and accumulation; 2) budgetary pension plans (for workers in the public sector), which by their nature are financed from current payments, and union pension funds which are based on accumulation of pension rights. Most of these funds are extensively subsidized by the government (both before and after the Fogel Commission) and still suffer from large actuarial deficits; and 3) pension funds, training funds and other types of savings plans which are managed by the private sector. Although managed like private savings plans,

they receive subsidies from the government in the form of tax breaks, both at the time of deposit and on withdrawal.

The social security pension payments became already partly tergeted through the institution of an income supplement and additional pension for the elderly for whom the national insurance pension is their (almost) only source of income. The economic situation of the elderly (compared to the rest of the population) is improving in Israel as well, although inequality is increasing. In view of this, National Insurance pensions should gradually be made more progressive by increasing the share of the income supplement. The universal pension should not be increased relative to the average wage level. As a result of the wave of immigration and other factors, the connection between salary deductions which finance National Insurance benefits and the benefits themselves has been lost. Since pensions are financed from workers' savings during their earning years, National Insurance should, as far as possible, return to being a channel for saving toward retirement. While making the designation of old age pensions more targeted, universal benefits financed from budgetary sources should be phased out. Changes should be considered in the tax system, including the health tax.

The second layer of pension plans in Israel is the Achilles' heel of the system which requires concerted action. Preliminary steps were taken based on the recommendations of the Fogel and Brodet Commissions, but these were only a start. The government must strive to base the second layer of pension savings on personal savings plans in non-government funds. These programs must replace budgetary pensions. These programs could receive some government subsidies, as is appropriate for long term savings and it is possible that some government intervention would be necessary in transforming the savings plans into annuities, upon retirement.

The trustization, as opposed to privatization, of the second layer can be accomplished gradually in view of the favorable demographic forecast and the fact that only half the present wage earners are entitled to a pension. This fact diminishes the double burden involved in the transition from a current fund to an accumulated fund. In the short term, the methods of calculating pensions should be tightened up and early retirement should be eliminated.

In the third layer of savings, it appears that placing emphasis on long term savings (with the assistance of the tax system) along the lines of the Brodet Commission, together with the establishment of a negative mortgage market (in Israel, many of the elderly are homeowners) will be sufficient. The elderly, like the rest of the population, have full health insurance, which for them is the most important of the social services. In contrast, nursing care is financed and

provided by the government, the non-profit sector and the private sector. Eligibility for public funding is determined according to a means test and nursing care insurance is available from insurance companies. Considering the increase in incomes among many of the elderly and the increasing inequality, this is an appropriate solution, which is consistent with the central argument of this essay.

In the majority of developed countries there is additional public assistance for those 65 years of age and older through national health insurance laws or similar arrangements. According to this law, the elderly pay a health tax (or an income tax) proportional to their income and receive close to full coverage for all their medical needs. In Israel, the elderly pay a fixed health tax which is lower than if it was collected according to income. Full or near full health insurance coverage for the elderly is of utmost importance to their well-being and standard of living. The picture is somewhat different with regard to nursing care, whether in their own homes, supervised residences or nursing homes. Only some countries have full insurance for nursing care and, in most cases, the division of expenses depends on the elderly individual's income level. This is also the situation in Israel where the elderly have partial rights to nursing assistance at home, according to the Long-term Care Law, or to public subsidization of nursing home care following a means test. There is an option to acquire long-term care insurance, usually with incomplete coverage, through the supplemental insurance plans of the sick funds and insurance companies.

Any cutback in the rights of the elderly at any given moment is interpreted by the public as cruelty towards a weak segment of the population. In the long run, every citizen will one day be old and any decision of this kind allocates taxes and public services in a different manner between the various stages of the life cycle. It therefore dictates private savings behavior up to retirement.

4. Child Allowances and Education

The main share of child support in developed countries is paid in the form of educational services or child allowances (in Israel approximately four-fifths of the entire budget for child support is in the form of educational services while only one fifth is paid as allowances). The child allowance is intended not only to assist large and single-parent families but also to transfer income by means of taxation from later to earlier stages of the life cycle. Social awareness of equality is high when it comes to children and the positive external benefits to society justify transfers from childless couples to couples with children. In developed countries, the phenomenon of poor families with many children is rare; however, there is an increasing number of children in single-parent

families headed primarily by women. Most child support is provided through credits or deductions within the tax system and there is direct support for children from families below the tax threshold.

In Israel, the child allowance is universal and is paid by the National Insurance Institute. Large and single-parent families receive larger amounts. There is an ongoing debate regarding the allowance for the first two children (its removal or taxation). Even though support for large families seems, *ex post facto*, justified from every point of view, it defeats its own purpose if it provides an incentive to a poor family with three or four children already to have more.[6] In my opinion, three changes should be considered: 1) A return to tax relief, instead of allowances, for children whose families earn enough to pay taxes; 2) For families below the tax threshold, the allowances for the third child and up should be replaced by a uniform allowance for large families, (for example, at the level now being paid to a family with four children); 3) Transferring part of the support for large families to income supplements and, perhaps education.[7]

5. *Educational Services*

Most of the arguments supporting more freedom of choice and non-government educational services have been mentioned above. Israel, as a society which must absorb large scale immigration, has not yet completed the task of integration and therefore it is justified that the government continue to supply educational services and maintain a common curriculum. However, despite its declared intentions, the state education system has not achieved equality in educational services and certainly not in educational achievements. Even worse, the weaker segments of the population do not even receive the minimal level of education and professional training required for socialization, proper social functioning and a feeling of belonging and it goes without saying that they do not receive sufficient preparation for production employment. This is a result of two factors: first, the allocation of resources to education is insufficient and second, educational achievements are dependent, among other things, on the family and social environment. While this factor reinforces the achievements of the stronger elements, it makes the task of the education system more difficult with the weaker elements. A third explanation is the ability of the more affluent to invest additional resources in education, both

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6. See Dayan, 1995.
7. In his new book (Barkai, 1998) Chaim Barkai also suggests transferring soldiers' pensions to support payments to soldiers through the defense budget.

within the school and in extracurricular activities in order to strengthen the educational achievements of their children. The extent of reverse discrimination in budgeting and school programs is not sufficient to compensate for these advantages.

Therefore, the question arises whether the notions of universality and joint provision are indeed justified. Is it possible to reallocate resources and attention in order to increase the equality of educational results? And if not, can a minimal threshold of educational achievement be attained? Or perhaps the social contract should be readjusted in this area as well. This would involve freeing up part of the universal resources (or of the required addition) through allowing more freedom of choice in exchange for partial private financing of education in better-off neighborhoods and directing these resources to education in weaker neighborhoods. An educational voucher, which would be larger for low-income families, will increase the inputs into schools and at the same time increase the resources directed to the families (and community) for aiding the learning process in the schools. The voucher will also enable members of the weaker sectors to transfer to better schools. The technological changes now occurring in computers and information networks are actually widening the gaps in education and training. Therefore, a concerted effort at corrective discrimination is needed.

The above changes can be implemented within the framework of the public education system by making school district boundaries more flexible, but there is no reason not to try other methods as well. In any case, the Ministry of Education will continue to determine the core of the mandatory school curriculum for the educational sectors it supports.

School for pre-kindergarten ages is not mandatory. It is based on graduated tuition and a public-private partnership similar to the general idea suggested in this essay for other social services. It is an accepted notion that the pre-school years are the most important ones in child development. During these years it is also hardest for women to go out to work. Thus, daycare centers and kindergartens are crucial for low-income families. Therefore, ways must be found to increase the enrollment of these children in educational institutions and to ensure that they receive a high quality of education. For other families, appropriate daycare should be provided. By their nature, most of these services will have to be financed publicly.[8]

In higher education, joint public-private financing should be combined with

8. These solutions are inappropriate for ultraorthodox communities. In the Arab sector as well specific solutions will have to be found.

differential tuition according to area of study and demand. At the same time, partially subsidized credit should be made available for higher education and ways should be found for integrating long-term socioeconomic criteria into the education voucher system. In this manner, it will be possible to increase the proportion of national resources invested in education. As mentioned above, part of these expenses should be viewed as investment, both in the public budget and in national expenditures.

6. Health Services

With the institution of the State Health Insurance law, a division of functions was made between the government and the non-government sector which was both just and efficient. The financing of health services has become more progressive than it was in the previous health tax framework. The decision as to the allocation of resources for health care has been removed from the family and is now determined on the basis of a family's health situation. This has improved both equality and efficiency. Medical insurance and service provision remain in the hands of non-government organizations which allows for diversity and encourages improvements in service. These organizations are financed from a fixed budget determined on a per capita basis (annual payments per person adjusted for age). This payment is, in essence, a personal voucher tailored for one's expected medical needs (there is an element here of insurance for unforeseen needs). An appropriate amount of competition between independent providers will ensure the level and quality of service and will allow consumers a measure of choice. Reform is still required in several other areas: First, an organized professional framework is necessary for defining the basic basket of services and its price, as well as for updatng the basket and the budget periodically. The relations between the State and the sick funds must be based on a fixed budget constraint, but should also be transparent and stable. The formula for updating the basket of services should be determined by developments in medical care and the adoption of innovative methods of managed care.

The second component is the transfer of state hospitals to the non-government sector by trustization (not privatization) and the formalization of relations between the sick funds and the hospitals. This process will complete the division of labor between the State and the non-government sector. The State will be responsible for health policy and financing of services while the non-profit sector will be responsible for service provision.

The third element is the transfer of the provision of services (and insurance) beyond those in the basic basket to the sick funds and hospitals. These services

will be provided with a much greater degree of choice between doctors and caregivers and will be directly financed by the public out of its own pockets or through supplemental insurance. Optimally these services should be provided within the public system by the sick funds and hospitals in a formal framework of supplemental insurance and private medical services. In this manner, public financing and allocation will preserve equality in the provision of the basic basket while allowing a degree of inequality in additional services. This is in fact desirable. The Israeli health system is very close to an optimal combination of the sick fund system initiated by Bismark and the state health care and insurance system developed in Britain following the Beveridge report. This system combines the best characteristic of each approach and avoids many of the disadvantages. In at least several other countries, health service reform is progressing along the same lines.

7. The Double Burden of Policy Changes

Certain policy changes in the welfare state system create a double load on the budget during the transition period. This is the case in the transition from budgetary and entitlement pensions to accumulative pensions: new savings are intended for those who are doing the saving and this leads to a deficit in the financing of old age pensions in the present. Past failures in the area of education create a burden in the area of income supplements, welfare services and other benefits for today's unemployed and other marginalized groups. At the same time, additional financing is needed to strengthen the education system for the weaker segments of the population in order to prevent a repetition of the same failures. In Israel, the double burden in the area of pensions is not as acute since national insurance covers only the first layer which is rather limited and also because only about half of the workers have pension plans or are entitled to budgetary pensions. The way to relieve the double strain is to spread the reform over a long period of time, as discussed above. However, any delay of far-reaching reform in the education system and professional training will produce results similar to those in the past. Victims of past failures should also not be forgotten and should be treated with generosity and consideration. At the same time, ways should be sought for achieving maximum productivity from these support programs (investments in infrastructure, mobility, intensive professional training and the combination of support to families with aid for their children's education). It should be remembered that the required investment in the education of the next generation is an investment with a high rate of return and should be regarded accordingly.

Conclusion

The welfare state must be preserved as the vital third component of a triad which includes the market economy and the democratic regime. In addition to its social function and its contribution to justice, the welfare system makes an important contribution to growth, equality and social solidarity. Some welfare services should be classified as essential investments in the infrastructure for growth. Similarly, certain government expenditures on welfare services, especially education, should be classified as investments and a contribution to government savings.

In addition to the list of policy measures enumerated above, I would like to emphasize the need to search for ways to combine public and private financing with joint provision of services, principally through the non-profit sector.

Financing and provision of services which is targeted and pluralistic, rather than universal and uniform, will contribute to social solidarity on a somewhat different basis than in the past. In addition to solidarity based on the universal provision of uniform services, a new approach should be adopted based on two principles: the acknowledgement of the contribution of investment in human capital and quality to economic progress and the interdependence (the existence of a public good) between all strata of society in achieving this goal; and second, the readiness on the part of the stronger elements of the population to contribute to the financing and provision of social services in exchange for more freedom of choice and their involvement in the financing and provision of these services. If in fact there is a desire to increase the importance of the individual consumer in the public-private partnership, then it will be difficult to build social solidarity based on the suppression of this desire. It is preferable to exchange it for increased willingness on the part of the stronger segments of the population to increase the private component of the public-private mix in the provision of services.

A prominent Communist leader gave his comrades the following piece of Machiavellian advice: Government goals are easily changed and therefore, from time to time, they are. What really needs to remain stable is the means for achieving them. The Communist regime has collapsed. It is up to the economists and social scientists to learn this lesson: let us adhere to the essential goals and adjust policy measures according to past experience and changes in society and the economy.

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PENSION PLANS: THE FOURTH TIER - PART-TIME WORK AND PARTIAL PENSIONS

by Dov Pelleg*

Introduction

In virtually all developed countries, pension plans are now undergoing reform or reassessment. The principal cause of this marked, consistent trend towards reform is the severe financial pressure - both present and (especially) projected - that such plans exert on their respective national economies, as reflected in grim actuarial forecasts based on major national demographic changes. One outstanding development of this type is the increasing percentage of elderly persons supported by their pensions compared with that of the working people generating the resource base required for national subsistence at any given time period.

As pensions demand decades of advance preparation, the pressure anticipated in another 20-40 years must be dealt with immediately if society is committed to the principle of social security, stipulating that once a person retires from his** job, he and his family should be guaranteed the same standard of living that they enjoyed previously (retirement is generally mandated by age, although the principle also applies in case of disability or death of the provider/retiree). In principle, the following guidelines are employed in addressing this issue:

1. *Denial of the above assumption and reduction of pensions, entailing a decline in standard of living following retirement:* This measure is generally implemented by a return to the "assistance" system, in which society, through the

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** Unless otherwise implied by the context, masculine pronouns refer to both males and females throughout this article.

government, tends only to the poor, whereas those living above the poverty line are to take care of themselves as they see fit, deciding whether or not to save money or acquire insurance to guarantee post-retirement income. Such measures are effected through targeting, i.e. channeling the government's limited means solely towards the most needy, with practical implementation accomplished through a means test. This approach, which we oppose, will not be considered in the present study. In such cases, pensions may lose their value if not updated according to inflation rates or income (wage) increases.

2. *Increasing formal retirement age:* This approach assumes that the increase will lead to deferral of retirement and consequently yield more work and less reliance on pensions. In practice, however, it emerged that despite the rise in formal retirement age, the actual retirement age in developed countries declined because of labor market conditions, rendering the solution ineffective.

3. *Substantive changes in work and retirement practices:* The proposed changes are planned so that working people will typically provide the economy with more productive work during their lifetime and curtail the period in which pension rights are exercised. Some observers expect more sweeping changes, altering the entire life cycle of working persons by replacing the conventional linear progression from education to employment to retirement with a combination thereof (that extends throughout one's lifetime, as elucidated below), in which the individual determines all steps to be taken, including savings to finance living expenses during non-working periods. The following description covers only a small fragment of this extensive concept: At an advanced age (around 55), employees may combine part-time employment with receipt of a partial pension, continuing this arrangement until they reach a far more advanced age (say 70-75). It is assumed that under such conditions, they will perform far more work to boost the economy, save more assets to prepare for non-working periods and curtail the period between retirement and life expectancy despite the constant rise in the latter, thereby achieving the designated objective.

Practically speaking, the relative burden that pensions impose on the GDP will decline in the future, as will the individual burden of retirement to pension for each working person, while the objective of achieving sufficient "rate of replacement" for employees and their families following full or partial retirement will indeed be achieved.

In Israel, the system that guarantees income for employees and their families following retirement for any reason whatsoever may be outlined as follows:

Tier 1 - National Insurance: Guaranteeing a minimum income for all citizens following retirement at a rate of 20% of the average wage. A proposal was

raised to increase this rate to 25% and eliminate the fine imposed on benefit recipients who worked during their first five years of eligibility, thereby encouraging people of advanced age to work. Subsequently, partial benefits will be disbursed during those five years.

Tier 2 - Pension Relative to Wages: Instituting mandatory insurance for all employees at a rate guaranteeing the desired "rate of transformation" when combined with retirement insurance benefits. This tier will be administrated through major public funds, managed by employees' representative organizations, in cooperation with employers and with government assistance. If the designated change in National Insurance benefit rates is instituted, a pension rate of 60-65% of the employees' wages (or income) will suffice.

Tier 3 - Savings and Private Insurance: Employees may select among various options, none of which guarantee security. Furthermore, statistics show that working persons in the bottom third of the income scale make very little use of this tier. Consequently, it is not taken into consideration in the forecast of the desired rate of transformation for retiring employees.

Tier 4 - Part-time Employment and Partial Pension: This innovation, the subject of the present study, calls for part-time employment up to a highly advanced age, preferably 70-75, combined with receipt of a partial pension from age 55-60, thereby maintaining the standard of living of the employee and his family throughout his extended lifetime. Institution of this fourth tier entails substantial changes in the labor market and in personal norms. Consequently, it will take some time, perhaps 15 years, until the system begins to yield results. Considering demographic and economic forecasts, this period would suffice to solve problems and maintain pension objectives. Once the Fourth Tier's feasibility is demonstrated, Second Tier pension objectives could be lowered without adversely affecting the rate of transformation.

Prima facie, the unemployment pressure that led to a decline in actual age of retirement would prevent implementation of the Fourth Tier. However, a more detailed analysis of the changes taking place in the modern labor market indicates that part-time work performed by experienced and appropriately trained employees well suits projected demands for labor, assuming that the percentage of older employees indeed increases greatly and that the economy will require this employee boost to maintain and increase the GDP.

Individual worker health at retirement age improves from one generation to the next, while jobs are becoming less physically demanding and more cerebral (research proves that older people suffer no significant decline in intellectual capacity until age 75 or later). Consequently, employees can contribute more at work and are usually very interested in doing so. Part-time work is known to

have only positive psychological, medical and social effects on working people, as noted by participants in all relevant research.

As such, the labor market appears capable of integrating the Fourth Tier, that appears very desirable for workers as well. Consequently, it emerges as the best solution to the problem of guaranteeing appropriate income following retirement without choking the national economy. In fact, the proposal fosters growth by adding working hands to the economy as required. Moreover, pension plan savings constitute the greatest source of capital for essential investments.

Demography and Economic Pressure

Increased life expectancy is an absolute and incontrovertible fact. Recent statistics reflect a rise of 1-1.5 years per decade in developed countries (OECD, 1996, p. 9). In contrast, the birth rate has declined considerably over the same period, so that several countries face the risk of an absolute decline in population over the next 50 years. The combination of these two demographic processes leads to a steady increase in the percentage of elderly persons (age 65 and up), especially the very elderly (age 85 and up in most cases; 75 or 80 in others).

One particularly significant demographic phenomenon pertinent to the present discussion is the post-World War II baby boom - the sharp rise in the birth rate in all developed countries between 1945 and 1960. During the second decade of the coming century, members of this generation will begin retiring from work, imposing heavy, long-term pressure on a much smaller working generation, entailing a particularly urgent demographic problem within the next 15 years. Consequently, it is important that all proposed changes mature as this generation starts to retire.

The demographic forecast for developed and affluent countries, including Israel, is disrupted by immigration. Rich countries attract immigrants from less affluent ones who want to improve their financial status and are willing to fill in holes in the labor market (consider, for example, foreign workers in Israel and throughout Europe). Moreover, some countries (e.g. Sweden, Germany and France) intentionally admit a controlled quota of immigrants to improve their respective demographic balances, generally preferring younger people with a much higher birth rate than that of the target country's own residents. As it is very difficult to account for immigration in demographic forecasts, its effects are usually ignored.

Returning to the issue at hand, namely the burden that pensions impose on the national income, it is interesting to derive dependency ratios from

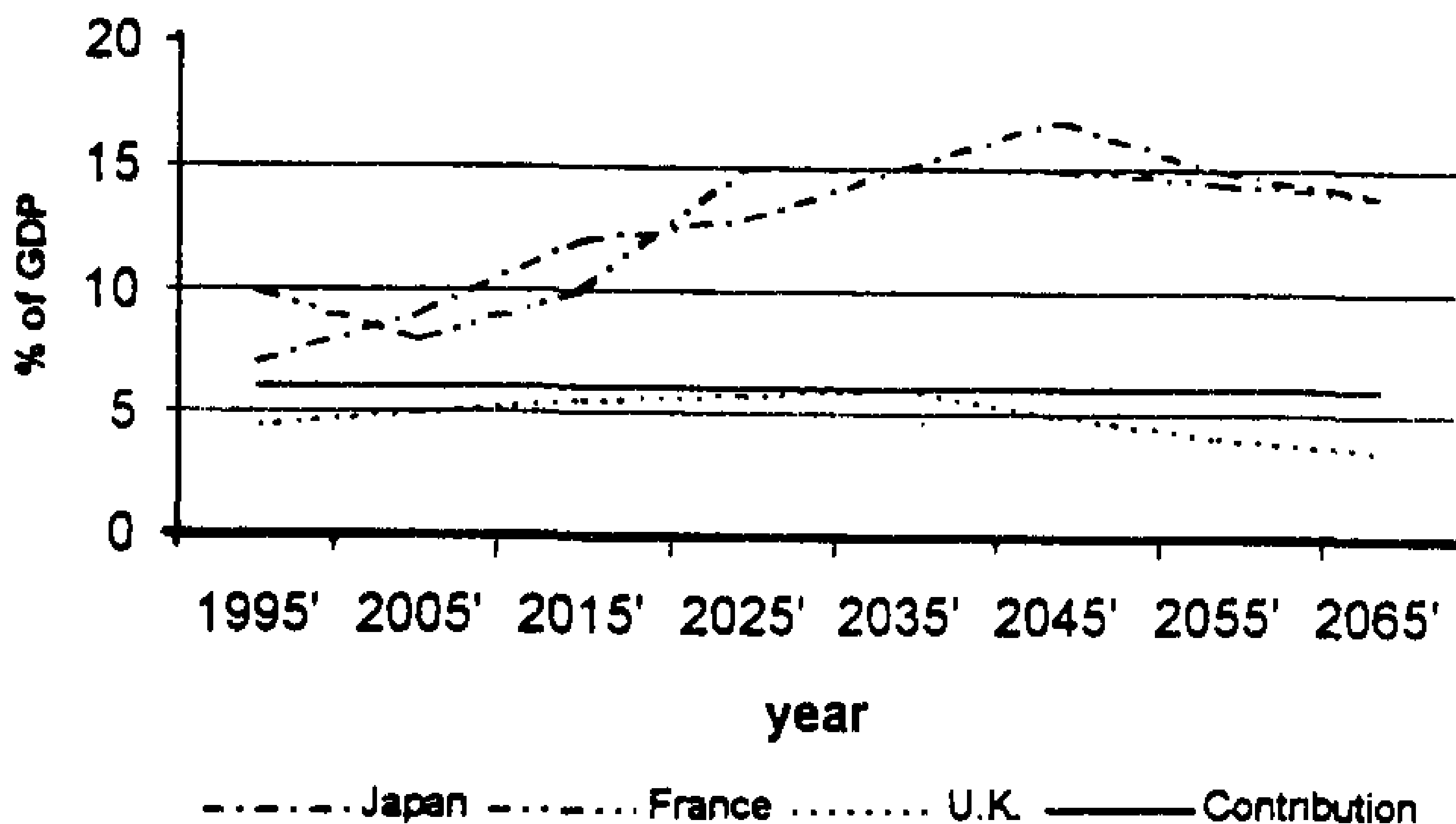
demographic forecasts. The simplest formula is the ratio between the percentage of citizens at an advanced age (e.g. over 65) and those of working age. Formerly, working age was believed to begin at 15, while today the tendency is to start at 20. A broader dependency ratio is the percentage of all non-working persons, including children and students, compared with that of adults of working age. When the percentage of elderly persons rises, that of young people below working age declines, reducing the economic burden concomitantly, a phenomenon taken into account by this latter ratio. However, as the period of education has been extended and now includes nearly universal post-secondary schooling, the change does not alter the economic burden.

This study addresses the economic burden as a function of demographic changes and not of demography itself. Assuming that per capita income rises constantly, and that retirees will be contented with less income than the increasing average income for the working population, the additional burden resulting from the rise in dependency ratio will not be as great as the ratio boost itself even if standard of living is maintained. Appropriate adjustments notwithstanding, however, the ratio is expected to rise sharply as a result of demographic changes, especially those engendered by the aging of the baby boom generation.

Forecasts of economic dependency ratios based on changes in demographic dependency ratios assume for convenience that National Product expenditure distribution patterns remain constant. However, one may certainly assume that the private consumption component may decline if society withstands the pressure of guaranteeing income for its elderly and as a civilized society accords sufficient priority to concern for parents and grandparents before allowing a marginal rise in standard of living for the working generation.

If the present pension regulations are retained (including changes already planned), vast discrepancies will result between pension payments and deductions that the national economy will have to cover. For example, consider the three different types of countries shown in Figure 1: Japan has the greatest gap and is an example of a country in which the dependency ratio will increase greatly; this gap is moderate in France (and several other European countries) and small in the United Kingdom (as well as the United States and Canada) because of a broader funded pension system and linkage to the consumer price index rather than average wages. Unfortunately, no long-range demographic forecast has been calculated for Israel, precluding prediction of trends in the economic dependency ratio (the Central Bureau of Statistics justifies this lack by extreme uncertainty regarding the future of immigration and consequently calculates its demographic forecasts for only five years).

Figure 1. Pension Plan Payments and Wage Deductions as a Percentage of the GDP



Source: OECD, 1996, p. 33

We conclude that economic dependency ratios are difficult to calculate because of the great uncertainty regarding very long-range future developments. As all long-range planning must posit conservative estimates, we assume that the ratio will become far more critical, demanding structural changes that solve problems without adversely affecting pension objectives and generate sources of capital for investment to enable continued economic growth.

The Labor Market

Until recently, it was customarily believed that conventional industrial workers, including factory employees in service positions, live their working lives according to a linear pattern: General or vocational education, followed by decades of work preferably in one occupation and even at one workplace and eventual retirement. According to this pattern, workers become weaker towards the end of their working life and look forward to retiring (sometimes even before official retirement age). Employers, too, are interested in timely or even early retirement at their own expense, as old workers (cf. Habib and Nusberg, 1990, pp. 123-143) are usually less efficient and more highly paid. Consequently, even before the sweeping changes in retirement age that began in

the 1960s, despite job stability and the rise in official retirement age, more and more employees are receiving proper Second Tier pensions, increasing the actuarial burden from year to year.

Over the past 2-3 decades, sweeping changes have taken place in technology, the labor market and organizational methods, exerting a profound effect on the issue under consideration (King, 1994, p. 2; OECD, 1996, p. 21). Technological changes, primarily computerization, have been introduced in most manufacturing and service processes at factories and the proportion of strenuous physical labor has declined as robots or mechanical control assume a considerable share of production and office work. This change requires workers with skills entirely different from those demanded previously. Workers now have to be capable of understanding and operating computers and of mastering automated and partially automated processes. Such activities are largely carried out by teams in which each employee is familiar with numerous aspects of the designated process. Workers must have many skills, most of them new and all constantly changing. An old worker will find it very difficult to adjust to these changes and consequently will find himself ejected from the work force as unemployed, disabled or prematurely retired. Even young people who complete their education find it difficult to enter the technological working world because they had not been prepared for it adequately; consequently, they too contribute to the great rise in long-term unemployment. The resulting structured unemployment is caused by incompatibility between worker supply and demand, rather than the absence of Keynesian demand (Habib and Nusberg 1990, p. 165; European Commission, 1996, p. 10).

Another extensive change has taken place in the market itself. The emerging worldwide goods market is largely open, while the capital market among developed countries is almost entirely open (Israel, too, is heading in this direction); customs duties have been virtually eliminated for industrial input and have declined drastically for finished products. Regional and interregional open markets have been created and the global labor market is opening up as well. Ease of transportation has largely facilitated migration (including the influx of foreign workers in Israel). This worldwide market enabled the development of outsourcing, in which plants may acquire input from wherever in the world it is least costly, eliminating in-house manufacturing. Veteran, skilled production workers find themselves redundant because their competitors in the Far East will do the same job at only one tenth of the cost to their local employers. The new technology, along with capital, passes to the cheapest *sources of labor, yielding far less expensive products and modern technology.*

The old worker who wants to continue working must acquire new skills or succumb to the temptation of early retirement offered by his employer.

A third major change affects organization and administration: Computerization has enabled control of work and production processes with far fewer junior executives, thereby rendering middle management partly superfluous. Work is conducted by teams of skilled employees in flexible positions that are more involved than ever before in organization, control and even development. In major and even intermediate-sized corporations, entire management echelons are eliminated and thousands of people in such positions become redundant and likewise opt for early retirement, most of them already at a somewhat advanced age. Modern organizational and administrative methods demand an extensive educational background, including computer literacy and constant, rapid absorption of constantly changing, plant-specific professional knowhow. Old workers (sometimes even those as young as 45) who enjoyed respected work status and good pay suddenly drop out because there is no constructive alternative, joining the ranks of the unemployed or forced into early retirement.

Market structure has changed as well: Major and intermediate-sized industrial corporations are greatly reducing their employee complements, with most new jobs created in "services" - a broad and highly varied field ranging from mass consumer services demanding little employee skill and consequently paying low wages (e.g. the McDonalds chain) to highly professional services required in various occupations, requiring extensive knowhow and offering salaries accordingly. This structural change has a profound effect on trade union organization: Unions are becoming smaller and weaker and are losing their ability to protect wage and retirement agreement terms, rendering it easier for employers to pension off veteran and costly employees and thereby lower the actual age of retirement.

Change has also been observed in the gender ratio among employed persons: More and more women are entering the labor market to increase family income and at times even to stand in for a spouse laid off from work because of the above changes. There are more and more single-parent families; in most of them, the head of household and breadwinner is a woman. Many women enter the labor market at a young age and then leave it fully or partially at age 25-40 to devote themselves to care of children or aging parents, then return subsequently. Such women encounter several severe problems relevant to the present issue: The pension rights they accrue are only partial and generally insufficient for achievement of conventional pension objectives. Furthermore, most are unsuited for the new technological market and consequently apply for

simple and highly unstable service jobs. As such, they eagerly await retirement as early as the law and pension regulations allow.

This section addresses three principal issues in greater detail:

1. *Training and Studies:* Major, frequent technological changes demand constant vocational training throughout one's working life (OECD, 1996, pp. 20, 25, 65). Furthermore, modern training is becoming more and more complex and consequently requires major augmentation of employees' basic education. The issue of market failure enters the picture as well, primarily regarding enhancement of basic general education: Employers do not consider it worthwhile to invest in employees who may resign if the market requires their skills. Both general and specialized training contribute much to the national economy. European countries offer various types of assistance and allocate considerable resources for both basic and on-the-job vocational training, such as the Adapt and Objective Programs announced and amply financed by the European Commission (European Commission, 1996, pp. 8-18).

Small and intermediate-sized plants have the most difficulty insofar as training programs are concerned, as they are concerned about future ties with employees and organizing for training, as most new jobs in industry and services emerge in enterprises of these dimensions.

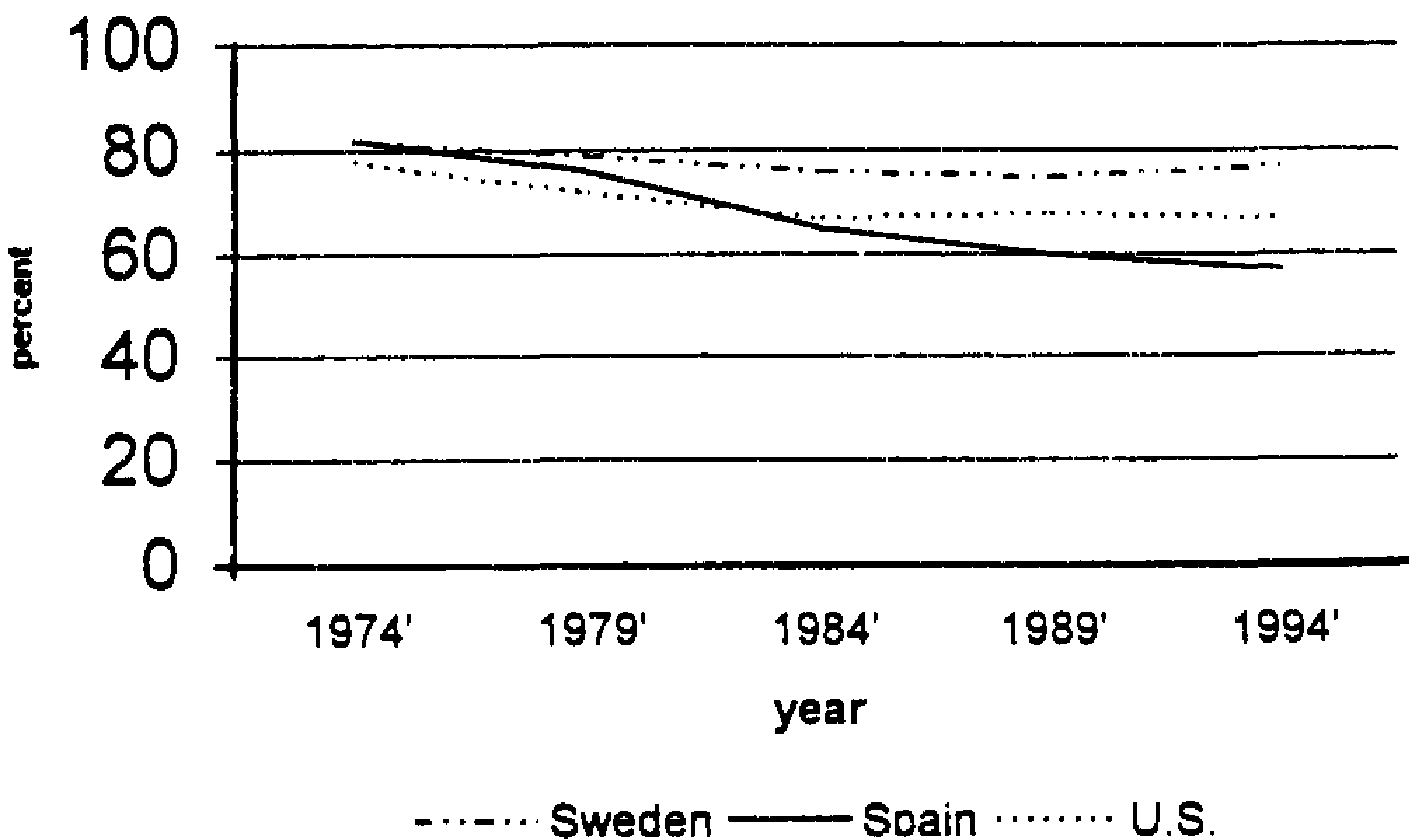
This issue is particularly relevant to our discussion, as there is no chance whatsoever that older, veteran employees will continue to work efficiently unless they are trained appropriately. Moreover, old workers often have to change jobs and even occupations to continue working. Such extensive turnover is standard in Europe, while Israel has far more professional and workplace stability because of pension arrangements and severance pay. Societies and nations are interested in having employees continue working, while individual employers are not. Consequently, the state itself must become involved extensively and intensively in providing basic and vocational training for old workers. These measures acquire particular significance as the baby boom generation matures. Investment, especially from public resources, is essential if we want this generation to continue working.

To encourage vocational training, especially on-the-job training, the expenses entailed should be recognized as tax-deductible for employer and employee alike. Moreover, if employees opt for external training with the intention of changing jobs, they should be entitled to severance pay and termination of employee-employer relations according to labor agreements and relevant legislation. Such changes will facilitate the decision to participate in a fundamental and extended training program, thereby enabling mobility to new jobs more suitable for the employee's age group.

2. *Part-time Employment:* Part-time employment has gained considerable momentum over the past three decades, taking various forms according to circumstances and conditions: Fewer working hours each day; fewer work days per week; unpaid vacation for family matters or training; contract work at home (office automation); flexible or partial working hours, etc. Part-time work enables employees - especially women - to accumulate the pension rights they still lack and is of particular significance to older workers (Habib and Nusberg, 1990, p. 20). It is convenient for the individual as it provides the best possible response to personal problems, but is also advantageous for employers, as it enables greater flexibility in organizing work and even controlling its quantity according to changing market needs. Part-time work is considered an efficient method of solving unemployment problems, as detailed below. Most part-time employees are women, as such work is highly amenable to integration of family obligations with the desire to earn a living. Unemployment hits old workers especially hard, as there is a reasonable risk that once the market improves, they will not be able to return to work after severing contacts, while part-time employees can return more easily to full time jobs.

Entrenchment of partial employment in the market facilitates advancement

Figure 2. Average Wage Profile by Age as a Percentage of Overall Average Wages



Source: OECD, 1996, p. 71.

of the proposal raised herein: Part-time work for veteran and older employees, combined with a partial pension. Part-time work by older men and women embodies and intensifies all the above advantages: Application of accumulated knowhow and experience without having to work full-time, that may be difficult for the employees in question; integration and balance with family needs, including care of the elderly and of grandchildren; flexibility and involvement in workplace organization; greater loyalty, entailing fewer unexplained absences (despite numerous absences for health reasons). Insofar as the labor market is concerned, all conditions are present for institution of the proposed Fourth Tier.

There is a marked difference in wage profiles between Anglophone countries, in which there is a sharp decline in wages towards the end of working life, rendering it easier to employ old workers in part-time positions and European countries, in which wages rise constantly or remain stable for employees of an advanced age, rendering part-time work difficult because of the high cost to employers.

Studies of early retirement (King, 1994, p. 9) show that people of advanced ages are interested in part-time work and that most of those who accept early retirement and return to work do so on a part-time basis. Part-time work after early retirement generally entails a decline in income and in status at work (King, 1994, p. 66). Ensuring continuity through gradual, orderly transition to part-time work can foster better conditions for the employee and maximize benefits for the employer. Another study (Zipkin, 1993, pp. 25 ff.) indicates that about one third of retiring persons in Israel near formal retirement age want to continue working; 92% would like to work part-time (i.e. up to 20 hours a week, roughly half a full work week). Data originating in the United States display a very similar picture. The principal obstacle to implementation of this proposal is the fine imposed on National Insurance benefits and pensions for retirees who work full-time.

Statistics provided by Israel's National Insurance Institute (hereinafter: NII) (Morgenstin, Nimrodi and Schmelzer, 1997, p. 9) indicate that only 17% of those who reach the age entitling them to old-age allowances postpone their retirement. This rate has not changed since 1978 (this observation may be somewhat misleading, as the unemployment rate was very high in the next survey year, 1993). A considerable percentage of people in this age group (39% of men and 29% of women) work part-time for wages below the cutoff point for allowances eligibility. Wage levels have risen markedly since that time.

The NII's ceiling for receiving old-age allowances is 57% of the average wage for a single worker and 76% for married workers with dependents. It may be

assumed that raising or even eliminating this ceiling would increase participation in the work force - especially in part-time work - among people of this age group.

The fines levied on national insurance or pension benefits for working retirees constitute the principal obstacle to part-time work (King, 1994, pp. 38-39, and international research cited therein). In Israel, for example, civil servants and employees of workplaces that receive public funding aged up to 60 lose up to two thirds of their pensions; those aged 60-65 lose one third. Such fines are imposed extensively in the United States; in Europe, they were reduced or partly eliminated to encourage part-time work. Old workers, who are physically limited, are also more selective in choosing jobs in terms of the personal status they offer. The market maintains a norm of bias against older workers, rendering it very difficult to find jobs through employment agencies or personal contacts. In Israel and several European countries, workers generally own their own homes and are consequently limited in terms of job mobility. The business cycle, with its employment rate fluctuations, encourages old workers to leave the labor market during slumps; subsequently, they find it difficult to return to work during peak periods for the reasons enumerated above.

In conclusion: The current state of the market makes it difficult for people of advanced age to work part-time. Continuity at work and changes in training and function assignment would facilitate realization of part-time employment.

3. *Unemployment:* Developed European countries suffer from very high unemployment rates, sometimes reaching an average of 11% of the work force. To date, no methods have been proposed to address this powerful source of social and economic pressure. Among the millions of unemployed persons, one may discern several clusters of long-term (over a year) unemployed for whom the problem is clearly structural, i.e. incompatibility between available workers and market and employment demands, rather than the absence of macroeconomic market demands (Pelleg, 1995). One such cluster consists of older workers (over age 50) who have a very difficult time finding work when dismissed from their previous positions. Those who are willing to switch and work in consumer or treatment services (primarily women) find work more easily, while the remainder stay unemployed for several years.

Unemployment rates also increase as more and more women enter the labor market; in some workplaces, they replace current employees. It will take time until the market can accommodate this increase, as it exceeds the pace of economic growth. This too is a structural problem for which a partial solution will be found eventually.

Table 1. Participation in the Work Force from Age 55, by Sex

Years	55-59	60-64	65-69	+70
	Age group			
Men				
1992	77.3	61.1	28.0	13.1
1993	76.6	60.8	28.4	13.9
1994	76.7	61.2	26.5	13.5
1995	76.6	59.3	28.3	13.2
1995*	77.0	59.7	28.5	13.2
1996	76.0	59.0	26.0	12.6
I-III 1997	72.0	57.2	25.0	10.5
Women				
1992	40.9	19.4	7.7	4.3
1993	41.2	19.7	8.8	3.8
1994	43.1	50.5	8.9	4.1
1995	43.9	21.1	10.2	4.2
1995*	44.2	21.5	10.2	4.2
1996	44.7	19.9	7.2	4.2
I-III 1997	46.6	20.6	8.2	4.0
Total				
1992	58.2	38.4	16.3	8.2
1993	58.0	38.7	17.1	8.1
1994	58.9	39.3	16.5	8.2
1995	59.5	38.8	18.1	8.0
1995*	59.5	38.8	18.1	8.1
1996	59.6	37.9	15.6	7.7
I-III 1997	58.6	37.6	15.6	6.7

* According to the new definition.

Another cluster comprises immigrants from developing countries. While many accept simple jobs that do not interest local residents, there is still some displacement of local workers because foreign workers are willing to work for lower wages.

Older unemployed persons tend to opt for disability (loss of ability to work) benefits, early retirement at the employers' expense - encouraged by the state - and even total withdrawal from the work force. Fifty years ago, for example, some 50% of persons over 65 remained in the work force. Today, the

percentage has dropped to 7%. For men, a steep decline in work force participation begins at age 55; among women, the decline is less marked because most women work part-time and need to accumulate more working hours to become eligible for pensions (Habib and Nusberg, 1990, p. 11; OECD, 1996, pp. 66-69). A decline in work force participation has been noted among older people below official retirement age in Israel as well, gaining momentum during periods of severe unemployment (King, 1994, pp. 11, 26).

We have observed a constant decline in the participation of men in the Israeli work force and a rise in the participation of women. Similar processes are evident in other developed countries. In Sweden, the phenomenon is somewhat less marked because of the country's active work policy that prepares old workers for changes in the labor market.

Some unemployment problems are alleviated by part-time work. At the initiative of the state or of the employers themselves (such as the measures taken by Volkswagen of Germany in 1995), for a designated brief period of time, the work load is divided among more employees by shifting to a 3-4 day work week or offering longer vacations, with the employee's consent, for general training and education.

All these factors lead to a decline in the effective age of retirement, a trend that has gained in intensity over the past two decades. On this background, our proposal appears to contradict labor market realities. However, a more intensive analysis reveals that solution to structural problems may alleviate the situation considerably. Although unemployment is assumed to be an intermediate-range phenomenon, we are addressing the issue in the long range, in which two of the factors analyzed above may affect the situation decisively:

(a) Basic training for older people, filling in gaps in general education to provide an infrastructure for vocational training. Such measures will facilitate adaptation to technological and organizational changes, as demonstrated in the United States, Japan and the United Kingdom, where current unemployment rates are lower than in continental Europe because they initiated some of these measures somewhat earlier.

(b) Willingness to work part-time in a flexible organization, thereby restoring old workers to the labor market if they adjust to occupational demands.

Consequently, our proposal - or at least the first part thereof: part-time work until a very advanced age appears feasible in the long range despite present unemployment rates. The forecast of developments in the United States, for example (Habib and Nusberg, 1990, p. 171), shows that in the long range, 20

million workers will join the work force, filling in the vast gaps engendered by a rise in the demographic dependency ratio.

Retirement from Work

The expression retirement from work is subject to interpretation (Zipkin, 1993, p. 36): Does retirement begin only on full and final termination of work or does the term also apply when retiring from one's regular job with an option to return after a designated period of time? Present market conditions allow for various types of retirement.

Studies list several factors motivating retirement (Zipkin, 1993, pp. 40-41): Involuntary reasons such as personnel cutbacks or declining health (some survey respondents may have listed these reasons as a cover for others), or voluntary ones such as more leisure or job change. About one third of retirees at formal retirement age, in Israel and the United States, indicated they would like to work in alternative formats, while a decisive majority of those retiring at earlier ages said they wanted to continue working.

Obviously, age of retirement (in all its various forms) is the most significant variable in addressing the increasing economic pressure of guaranteed post-retirement income (Sheetal, Jaeger and Jaeger, 1996, p. 32), as the demographic processes described are almost entirely beyond human control. Consequently, in most developed countries, the earliest pension system reforms included postponement of formal retirement age for all working persons, as well as equality between the sexes, thereby postponing retirement age for women as well.

Table 2 indicates the age of actual retirement in Israel, in which formal

Table 2. Actual Retirement Age in Israel, 1995

	Women		Men		All Retirees	
Retirement Age	Percent	(000)	Percent	(000)	Percent	(000)
Total	100.0	102.2	100.0	106.1	100.0	208.3
Up to 40	10.5	10.8	0.2	0.2	5.3	11.0
40-49	6.9	7.0	1.1	1.2	3.9	8.2
50-59	27.8	28.4	8.9	9.5	18.2	37.9
60	16.2	16.6	5.1	5.4	10.6	22.0
61-62	10.3	10.5	5.9	6.1	6.0	16.7
63-64	7.4	7.5	7.0	7.4	7.2	15.0
65	4.5	4.6	34.1	36.1	19.6	40.7
66-69	7.8	7.9	18.3	19.4	13.2	27.4
70+	7.9	8.0	19.2	20.3	13.6	28.4
Unknown	0.7	0.7	0.3	0.3	0.5	1.0

Source: Israel Central Bureau of Statistics.

retirement age is 65 for men and 60-65 for women. Part-time work may also be undertaken until retirement: 70% of men retire at the formal retirement age or thereafter while nearly half the women do so at the designated age (60). In other words, there is extensive opportunity to defer retirement until the present formal retirement age, even before considering a uniform retirement age for both sexes or across the board postponement. In Europe, retirement age is lower than in Israel because of the pressure exerted by extensive unemployment and structural problems in the labor market of relevance to old workers.

The basic forecast predicts an actuarial deficit measured as a percentage of the unchanged GDP. Immediate institution of the proposed changes will provide only a partial solution. Formal retirement at age 67 solves many of the economic problems affecting most countries. On the average, the proposal presented herein will essentially bring about retirement at the desired age, as transition to part-time work from age 55-60 is very gradual and extends up to age 70-75.

It soon became clear that a direct rise in formal retirement age does not necessarily lead to deferred retirement in practice. On the contrary, we have noted that changes in the labor market over the past few decades engendered a decline in actual age of retirement. Raising the formal retirement age adversely affected retirees' income, as most people opted to retire early. Consequently, the declared objective of maintaining standard of living following retirement is not fulfilled. This is also the reason for labor organizations' strenuous opposition to retirement age deferral, although they too admit that the plan is feasible and perhaps even desirable for individual working persons. The organizations exerted all efforts at introducing substitutes by extending

Table 3. Effect of Changes in Retirement Age on Contribution Gaps, in GDP Percentages

	Basic	Announced retirement age increase	Retire at 67 in 1995
Industrial countries	1.8	-0.5	-1.4
U.S.	0.8	-0.3	-0.3
Japan	3.3	-0.8	-1.6
Germany	3.4	-0.4	-1.2
France	3.3	-0.4	-3.7
U.K.	0.1	-0.4	-1.1
Sweden	0.9		-1.0

Source: IMF.

occupational disability criteria and entitling older people to unemployment compensation.

Several countries began taking steps towards the elimination of formal retirement age, presenting it as discrimination against employees according to their age rather than their work skills. Such measures, adopted in the United States and under consideration in some European countries as well, can encourage flexibility in retirement age, as mandated by the greater variation in labor market suitability and the personal situation among older workers. It is highly doubtful that a Second Tier pension system could be conducted without stipulating some formal retirement age, although introduction of the present proposal as an interim stage, combined with major deferment of the full retirement age, could solve the attendant problems. Perhaps the retirement age so determined would vary among different occupations and even different workplaces instead of remaining uniform according to respective national laws. Such variation would blunt the sting of discrimination claims, as it engenders greater compatibility between supply and demand in the labor market. The resulting flexibility will require a different kind of wage deduction, determined according to detailed actuarial calculations for each industry or service, as is practiced by the construction industry in Israel, in which an additional employers' deduction is levied for occupational disability.

The decline in retirement age is effected primarily through early retirement plans at the employers' expense. Consequently, it has no tangible effect on pension systems, whose statistics show that retirement takes place by the book (for a detailed discussion of early retirement, see King, 1994). Several European governments set up special funds to help employers finance early retirement, thereby assumingly reducing the scope of unemployment among younger people. In England, for example, the JRS Fund was established for this purpose in 1977. It was eliminated in 1989, when unemployment declined, primarily because of the change in approach towards work by older persons once the results of early retirement were discerned. The option of advancing retirement age within the pension system by reducing pension amounts accordingly has rarely been exercised, as such a measure would exert a lifetime adverse effect on pension objectives. Early retirement is worthwhile to employers in the short range, but it is very damaging to the national economy and to individuals who stop working at age 55 or at times even earlier.

It thus emerges that the principal reasons for early retirement are personnel cutbacks and job dissatisfaction (see Table 4). It may be assumed that structured part-time employment within a workplace's personnel organization,

Table 4. The Most Important Cause for Early Retirement (Percentages)

Age group	Dismissal	Good severance payment	Health	Perfor-mance difficulties	Lack of satisfac-tion	Total
43-54	33.8	9.1	10.4	11.7	35.1	100
55-59	39.6	17.8	14.2	7.3	21.2	100
60-64	33.9	10.1	16.8	11.9	27.3	100
total	36.3	13.0	13.4	9.9	27.5	100

Source: King, 1994, p. 30.

combined with suitable training, will markedly reduce the effect of these two factors.

Some employees who opt for early retirement work in a secondary market to conceal their income because their pension plans (primarily those involving "budgeted" pensions) may deduct the difference between their incomes and early pensions. Other retirees continue working on the open market. In the United States, for example, 23% of retirees work at other jobs (Habib and Nusberg 1990, p. 34), primarily motivated by a need for additional income to maintain their standard of living and keep them in good health so they can continue working. Such people claim that were it not for the offset between additional income and social security benefits, they would work even more. In Israel, in contrast, only 16% of early retirees work (King, 1994, p. 38). At relatively younger ages (45-59), the percentage rises to 35%, but then declines steeply. The percentage of educated, white-collar workers is higher than that of blue-collar ones among early retirees, providing us with some indication of the feasibility of having part-time work replace early retirement.

In certain occupations and workplaces, introduction of the practice of part-time work reduced the incidence of early retirement, thereby saving the tremendous costs it entails, primarily for employers, while creating an additional product that benefits all factors involved. A detailed analysis of early retirement (King, 1994) shows that the phenomenon has numerous drawbacks for all relevant parties (high cost to employer despite work force rejuvenation, pressure and generally a decline in income for individual employees and major long-term damage to the national economy).

Several problems addressed by early retirement would be solved much more effectively by part-time work combined with partial pensions: Insofar as employees are concerned, there is no detachment from work, so that participation in the labor force does not decline; most psychological and organizational pressure imposed by early retirement is avoided and a path is

paved towards occupational renewal that enables continued work for many years to come. Such work improves physical and mental health, enabling older adults to continue working. For employers, there are major savings in financing; the work force can be altered without losing the human capital accumulated among old workers. The government and the national economy will benefit because fewer people will be out of the work force (because of disability, illness, unemployment and early retirement), thereby saving the costs of financing lack of productivity and subsidizing future pensions that will thus decline for each retiree.

At times, governments consent to allocate a share of their unemployment compensation funds as supplementary income for employees who agree to work part-time, thus putting our proposal into practice by instituting part-time work with supplementary income from a source external to direct work relations.

In Israel, formal retirement age for new applicants was set at 65 for both sexes in the 1995 pension reforms. In the construction industry, the problems of early retirement are partly solved by relaxing occupational disability restrictions, enabling fine-free retirement for men aged 60 and up who are certified by a committee as incapable of on-site construction work according to highly flexible criteria. In contrast, unlike other developed countries, Israel has few part-time work arrangements for older men (somewhat more part-time work is available for women), although there are extensive early retirement plans for defense system employees and all workers with "budgeted" pensions. In the private market as well, there are numerous arrangements for early pensions or government-supported work financed by state unemployment insurance funds.

As indicated earlier, an NII survey (Morgenstin, Nimrodi and Schmelzer, 1997) shows that employee benefit recipients earn respectable livelihoods by working during the five years between the permissible (with fine) and absolute ages of retirement. There is no doubt that reducing or eliminating the fine would increase this percentage considerably. Postponement of retirement age could thus prove effective under appropriate conditions: Suitable worker training, workplace adaptation and elimination of legislative hurdles.

The Personal Aspect of Retirement

We begin by defining the term "old worker" (Habib and Nusberg, 1990, pp. 123-143), that is neither chronological nor functional in nature, as it applies to a wide range of people in both these spheres. Functionally speaking, workers of advanced age cannot perform strenuous physical labor and also suffer from a decline in simple manual motor skills. However, as indicated, it emerges that

intellectually, there is no decline until a very late age: University studies and other research indicates that older adults have no difficulty absorbing new knowledge. Furthermore, industrial experience shows that old workers can perform considerable assembly work and certainly may continue in administrative and control jobs that are primarily cerebral in nature. Consequently, the term is not defined according to personal abilities or age, but rather by social criteria, reflecting a norm resulting from market conditions. During periods of unemployment, a worker dismissed at age 45 has difficulty finding a job and is considered old, but when working hands are scarce, either in general or in a specific occupation, even workers aged 65 are in demand. Therefore, retirement age is not an objective variable determined according to a person's situation at a given age, but is dependent on market conditions and social norms. This should be taken into account when preparing for institution of the proposed changes calling for part-time work among people of advanced age.

A retirement system imposed at a specific age suited the old labor market, in which most workers performed one job at one enterprise for most of their lives. The typical example is a major industrial plant with numerous employees, each of whom maintains his job and workstation for many years. The old worker eagerly awaits the moment he can retire, receive a proper pension and spend time with his family, resting from his many years of hard work. Some workers retire earlier thanks to disability (loss of ability to work) insurance, an option exercised extensively during periods of unemployment, when pressure to vacate positions increased and veteran and tired workers willingly agreed to become "disabled". In the Netherlands, for example, the phenomenon became particularly widespread, requiring special reforms over the past few years.

In many countries, including Israel, changes took place in the market and in personal aspects over the past 20 years, as reflected in the development of retirement campaigns by trade unions, in cooperation with employers, consisting of publicity work to help employees get used to the idea of retirement. Workers at an advanced age are healthier today than their predecessors were in previous generations. There is some decline in physical ability, but in most jobs, physical demands are limited or entirely absent. Older people feel that work gives satisfaction to their lives and keeps them on their feet. Consequently, they exert all efforts to hold onto their jobs and continue working as long as possible.

Some workers reach retirement age without having accrued the full pension rights they desire, especially women who entered the labor force late or stopped working for some time to tend to their children. Such workers are very interested in continuing working to become eligible for full pension rights and

thus guarantee for themselves suitable returns as they approach the "third age". There is considerable variation in total returns obtained and to the percentage thereof represented by the employment pension (Mivtahim Pension Fund, 1996). A similar situation prevails in other major Histadrut (Israel General Federation of Labor) pension funds as well (Central Pension Fund, Comprehensive Fund). According to Mivtahim data, men at conventional retirement ages receive pensions of close to 70% of the average wage, while women receive only 28%. Hence those interested in part-time work to enable accumulation of full pension rights are primarily women. The findings of a survey of the elderly (Zipkin, 1993, pp. 2-3) show that only half the men and a quarter of the women have pension coverage after retirement, amounting to only 35% of the average wage. Consequently, most retirees are very interested in continuing work, even part-time work, to increase their pension returns.

Table 5 displays the three principal motivating factors for work at an advanced age that vary quantitatively according to age and education. These factors encourage people to continue working, gradually shifting to part-time work and backed by appropriate training until a very advanced age. According to one study (Zipkin, 1993, p. 25), in the United States and Israel, about one third of all retirees at formal retirement age want to continue working but are deterred by fines imposed on their social security benefits. Some 78% of men aged 60-64 still work full-time. Above that age, 68% work part-time and receive full or partial benefits and pensions. The reasons for transition to part-time work are: Health problems (32%); employer's decision (28%) and a desire to improve pension rights (23%). Continuing to work at an advanced age

Table 5. Principal Factors Motivating Continuation of Work, by Age at Retirement and Educational Level

Characteristic	Wish for Framework and Occupation	Need for Income	Value Motive	Other	Total
Age					
Under 55	27.1	49.2	23.7	-	100.0
55-59	37.8	34.6	24.3	3.2	100.0
60-64	36.6	29.3	29.2	4.9	100.0
Education					
Elementary	33.5	47.2	14.9	4.4	100.0
High school	42.5	38.2	18.3	0.9	100.0
Post High school	29.6	34.0	33.0	3.4	100.0
Total	34.5	37.4	25.4	2.7	100.0

Source: King, 1994, p. 47

generally entails changing one's workplace, although in Israel, most such persons remain with the same employer.

Studies have found psychological and social motives for continuing work besides the desire for increased income: According daily life a fixed, orderly structure; having a purpose in life at an advanced age; maintaining opportunities for social ties; preventing loneliness (primarily among the widowed).

Studies have shown that most workers perceive announcement of retirement as a heavy psychological blow that retirement preparation campaigns are designed to alleviate. Data also reflect a wave of suicides during the initial period following retirement. People need activity appropriate to their physical abilities to maintain proper mental and physical balance, to which the best response is suitable work. Some people find an outlet in volunteer activity, particularly social services and helping the handicapped. Generally, such volunteers are already receiving their pensions, so that the pressure they feel is principally mental rather than physical. Obviously, sweeping changes in the labor market impel employers to dismiss older workers through early retirement or other government-subsidized plans. This situation engenders insecurity and fear of what the next day will bring among all workers, particularly the older ones, as well as constant trepidation that a brief notice of dismissal will arrive at their homes and induce severe trauma. Workers spend several years before official retirement age, sometimes ten years or more, under constant psychological stress induced by fear of dismissal, realizing that they have virtually no chance of finding any alternative in the labor market. Under such circumstances, they are willing to undertake part-time work in which, at the very least, they will perform activities to which they are accustomed and continue earning some kind of livelihood. In some cases, spouses work as well, solving the problem of sufficient income. Part-time work options are attractive to employers for the reasons noted above and foster an overall atmosphere that reduces employee distress.

The labor market is capable of including workers of advanced age who have adapted to technological and organizational changes through constant training efforts at ages 50-60, including completion of general education and direct vocational training. Some employers recognize the advantages of keeping on old workers: Stability and tenacity at the workplace and consequently fewer voluntary absences (partly offset by slightly more absences for health reasons); accumulated experience of both professional and organizational value; willingness to take on part-time and flex-time jobs according to workplace needs, thereby facilitating work organization and increasing efficiency greatly.

At one time a major U.S. food service company initiated special courses for older workers, preparing them for continued work following retirement from their regular jobs, departing from the usual practice of hiring young unskilled persons for such positions.

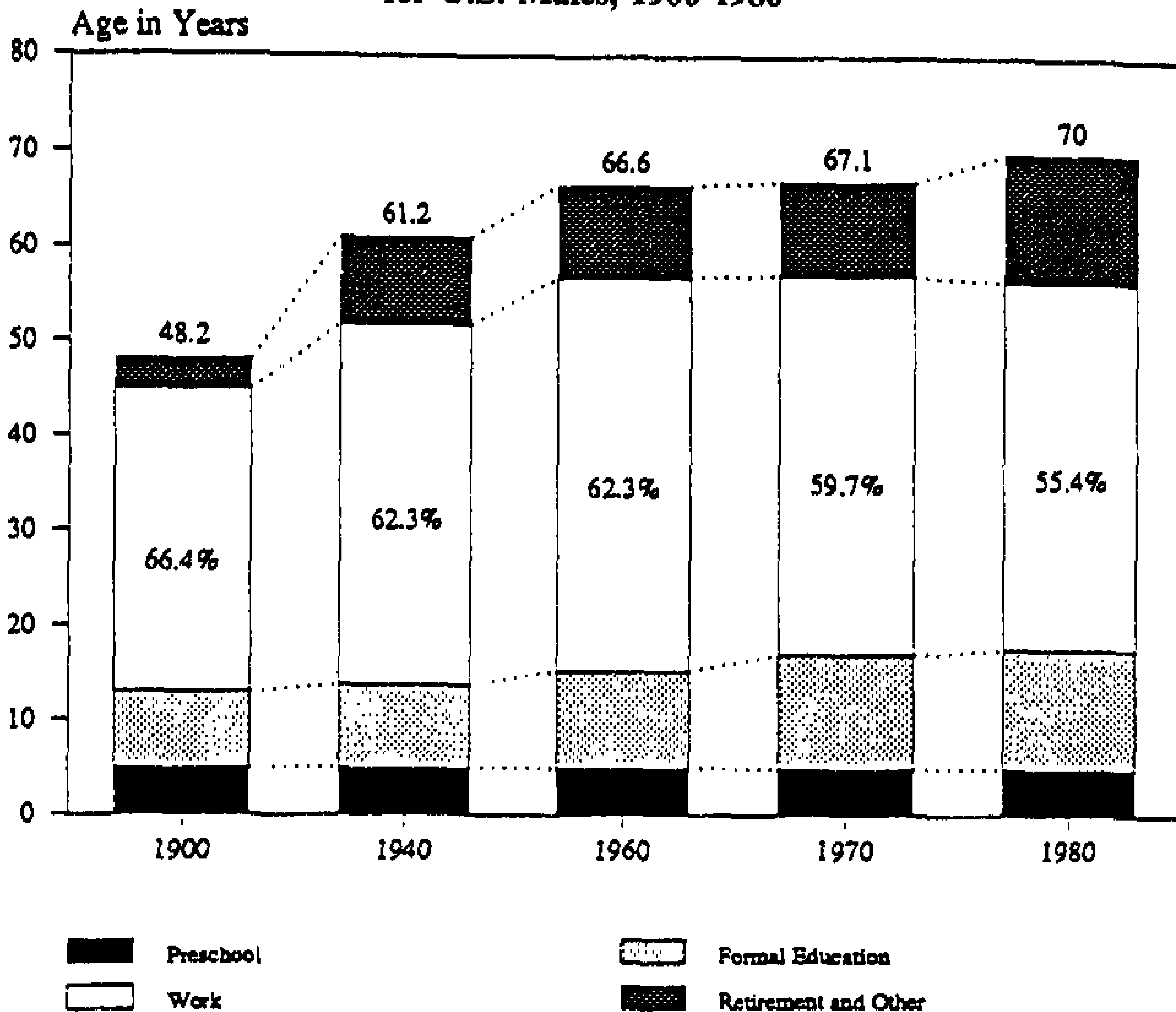
The problem is that many old workers balk at the idea of basic or vocational training, especially when it involves attending sessions together with younger persons. They are embarrassed to reveal gaps in their general knowledge and difficulties in absorbing information. Old workers often display lack of confidence when facing new technology and consequently refrain from applying it. This situation calls for an innovative "human resource management" measure - employing various means to ensure that even old workers receive basic and vocational training and adjust to modern technology. Once such preparation becomes a social norm, it will pave the way towards continuing work (including part-time) until a very advanced age.

At this point, we present a novel and futuristic approach, calling for sweeping changes in the working person's life cycle. The conventional cycle is linear, beginning with studies, followed by work and eventual retirement to a life of leisure. During the working years, a certain percentage of one's income is set aside for insurance premiums, pension fund payments, savings, severance pay funds, etc., most of which will only be realized after retirement. According to this pattern, asset management emerges as linear as well. The housing sphere may constitute an exception to this pattern: In countries in which homes are generally owner-occupied, such as Israel, they are acquired rather early in life, largely financed over a long period of time by mortgages and eventually transferred to the next generation rather than handled like other assets. Quantitatively speaking, for the middle class, the value of financial assets and pension rights is no less than that of real estate, implying maintenance of a linear approach.

Figure 3 displays the life cycle changes and rise in life expectancy over the years (since 1900): During the designated time span, the period of education became extended, that of work curtailed and the leisure years following retirement increased considerably. As such, the financing of long-term, costly education and lengthy years of retirement becomes increasingly problematic as the work period diminishes in duration.

The proposed innovation eliminates linearity and combines all components throughout life. Studies, for example, continue throughout one's lifetime, up to and including old age, including general education as a basis for specialized occupational knowhow, as well as studies offering personal satisfaction according to individual inclinations. Furthermore, general or plant-specific

Figure 3. Lifetime Distribution of Education, Work and Leisure for U.S. Males, 1900-1980



Source: Habib and Nusberg, 1990, p. 219.

vocational training, conducted periodically throughout working life as a result of the above changes, may be carried out by one's workplace or at its initiative, combined with full-time or part-time work and regular or partial salary payments. Some study programs may entail absence from work for periods of up to several years, implying that education need not be linear any longer (Habib and Nusberg, 1990, pp. 195, 210, 219, 255).

Part-time work may begin during acquisition of post-secondary education. Among women, childbirth may lead to total and then partial withdrawal from the work force. At present, the participation of both sexes in child care is becoming more and more acceptable. At middle age, work may be interrupted by studies or family needs, such as tending to children or elderly parents. An unstable labor market leads to frequent changes of workplace and even occupation, sometimes causing brief or more extended non-working periods.

These intervals demand extension of working life to a highly advanced age, 75 or more, to ensure that returns suffice for maintenance of an appropriate standard of living throughout life. This means that work linearity, too, is no longer mandatory. Some work periods will consist of part-time work that is convenient for employee (care of the family, studies) and employer alike.

Younger people exhibit a preference for various amusements, some of which even preclude working. Young Israelis often travel the world after being discharged from military service before they assume the yoke of earning a living and supporting a family. Furthermore, people may seek some rest and relaxation even in the middle of a highly stressful and demanding working life by taking vacations or other leaves of absence that may extend over several years. As workers reach more advanced ages, the vacation component becomes larger quantitatively. However, such workers may seek to combine vacations with work periods because of personal interest or a desire to enhance income. The result is elimination of linearity in the leisure sphere (excluding regular annual vacation).

It thus emerges that the three components examined - studies, work and leisure - are thoroughly intermingled in this new course of human life. Obviously, part-time work during various periods suits this pattern well.

How is this new life cycle financed? Even today, people may exercise credit before actually generating income. However, most financing originates in savings or accumulated severance pay and pension rights. In contrast to current practice, realization of such rights should be permitted at the individual's discretion, throughout his lifetime, rather than limited to a defined time period. Nevertheless, it would be best to limit realization of certain assets: For example, two thirds of one's cumulative pension rights should not be freely available for spending until the age of 70. The rationale for this restriction is as follows: The principles of social security and the welfare state declare that society is responsible for its elderly. Consequently, appropriate steps must be taken to address cases in which personal interests may conflict with those of society and the state. All in all, it appears that financing, like the other aspects of life, has largely lost its linearity.

The proposed model is innovative and convenient, but much time is needed before it can be applied to most working people. In the interim, we suggest implementation of several of its components: For a 20-year period, beginning at a rather advanced age but long before full formal retirement (e.g. 55), the elements of part-time work, studies and vacations (measured in hours, days, weeks or years) are to be combined. During this period, the individual will have

the right to realize his accumulated assets, including part of his pension rights, to finance this integrative measure.

The Kibbutz Model

In friendly conversations and even at official kibbutz assemblies, one may hear young members saying to old-timers: "Let's switch things around! In any case, you older people work all your life and miss out on much of your accumulated vacation. We'll start taking vacations when we're young and promise to work just as long as you do when we get old".

This model has been practiced at kibbutzim (Israeli communal villages) for many years, with the component concerning older members in force for decades. Working hours for older male kibbutz members (aged 50-55) are reduced gradually by subtracting one hour from the work day every five years until age 65, at which men work only 4-5 hours a day. From age 70, work is at the discretion of the individual, with every healthy elderly member working about four hours a day. Some kibbutz members continue working well into their eighties. Women, in turn, begin working fewer hours from the time they start tending to their children. Younger kibbutz members (up to age 28) customarily set aside time for vacation and studies. At age 28-30, they start to settle into regular work patterns. The kibbutz allocates training resources for all its members, some for functional courses (for work or management purposes) and some for general training at the discretion and inclination of the individual members. Kibbutz members may accumulate vacation days and take longer leaves if coordinated with kibbutz work needs. Financing is provided by the collective treasury and consequently entails no particular technical difficulties except the risk of individual exploitation of the system against collective interests. In some cases, individuals have taken more assets for studies or vacations than their kibbutzim could afford.

The kibbutz thus effectively implements the proposed innovative model to a great extent. Some of the measures suggested in this article have been in practice since the first kibbutz was founded over 80 years ago, namely part-time work up to a very advanced age, combined with realization of accumulated benefits generated in cooperation with and invested in the kibbutz. In general, at established kibbutzim with a balanced age distribution (up to 25% of adult members are over 65), older members cover all their routine expenses through part-time work and their NII benefits. They have homes and are not considered dependents, as all healthy members work. The kibbutz experience provides some evidence that the proposed model can be applied and that it greatly

reduces the economic burden of maintaining a population of advanced age whose proportion increases steadily as life expectancy rises.

The Proposed Model

We begin with a very brief description of a plan that we reject out of hand: Elimination of the Second Tier (pension relative to wages) and rendering the First Tier (social security) mandatory for all citizens, with individual determination of salary deduction rates (up to or even beyond the tax-deductible ceiling) and of the timing and extent to which accumulated rights are to be realized. We believe that such circumstances will yield low returns for many people in the four lowest deciles and even in higher ones. Such people will be effectively abandoned or supported by society after having expended their accumulated assets. This model will solve the long-range economic problem but will thwart achievement of pension objectives. Consequently, it must be ruled out (OECD, 1996, p. 10). Proposals to lower the income (wage) ceiling for pension deductions to 1-1.5 times the average wage, as suggested in the Brodet Commission Report, essentially amount to elimination of the Second Tier.

Although targeting minimizes pressure, it also adversely affects pension objectives and is consequently ruled out. According to these calculations, deferment of actual retirement is the preferred practice. Linking pensions to

Table 6. Pension Expenditure Scenarios, in GDP Percentages, 1994

		1995'	2000'	2010'	2020'	2030'	2040'
U.S.	Baseline	4.1	4.2	4.5	5.2	6.6	7.1
	Less pension	4.1	4.2	4.5	4.9	4.9	4.9
	Wage index	4.1	4.2	5.0	5.8	7.5	8.0
	Late retire	4.1	4.2	3.6	3.9	5.1	5.7
Japan	Baseline	6.6	7.5	9.6	12.4	13.4	14.9
	Less index	6.6	7.5	9.6	11.2	11.2	11.2
	Wage index	6.6	7.5	9.6	12.4	13.4	14.9
	Late retire	6.6	7.5	9.3	9.4	9.3	10.1
Germany	Baseline	11.1	11.5	11.8	12.3	16.5	18.4
	Less pension	11.1	11.5	11.8	12.0	12.0	12.0
	Wage index	11.1	11.5	11.8	12.3	16.5	18.4
	Late retire	11.1	11.5	10.7	9.0	12.6	12.0
U.K.	Baseline	4.5	4.5	5.2	5.1	5.5	5.0
	Less pension	4.5	4.5	5.2	5.3	5.3	5.3
	Wage index	4.5	4.5	5.9	6.2	7.8	8.5
	Late retire	4.5	4.5	4.3	3.7	3.4	3.3

Source: OECD, 1996.

average wages is the best solution for pensioners, but is very difficult for the economy to bear.

The dependency ratio between maintenance of the population above retirement age and the product generated by working persons can be lowered by increasing each worker's overall contribution of income-generating work and reducing the time period in which the accumulated pension is realized. This objective will be achieved by applying the proposed model: From age 55, every worker (with full equality between the sexes) may shift gradually to part-time work and begin receiving supplementary income from his pension rights. To encourage this measure, his income will be higher than that obtainable by early pension, unemployment or occupational disability. For relatively healthy persons in the appropriate occupations, such part-time work will continue until age 70-75. Full formal retirement age will be raised to 70. All changes will be implemented gradually over a period of about 15 years, leaving enough time for training and change of habits until the Baby Boom generation retires.

As long as work is available, accumulation of pension rights through wage (or income) deductions will continue, guaranteeing suitable returns for the period following full retirement, that will be curtailed to a very great extent (by at least five years). At present, retirement (including early retirement, disability and unemployment) takes place at an average age of 57-58.

Transition to part-time work demands appropriate training, at government initiative, of workers aged 50 and up, enabling a change in occupation, workplace or workstation at a given enterprise. Private employers will not provide such general training, as they cannot be certain that the trainees will remain at their present workplace. The market may provide supplementary final training for certain functions within specific plants. The government will use unemployment insurance funds for this purpose, as their original use will decline markedly in the spirit of the "active work policy" approach developed in Sweden 30 years ago and recently accepted by the EU as a significant component of the "European Model". Additional financing for early pensions as a supplement to part-time work will be available thanks to a decline in realization of the "disability" option now practiced among persons of advanced age and even a reduction in the use of sick pay insurance funds.

Enterprises will receive government encouragement to prepare appropriate jobs for older people. Programs will be initiated primarily at small and intermediate-sized plants that have difficulty organizing for appropriate technological changes and the attendant training. In France, for example, such programs have been operating successfully for several years. The model is

described in detail, including rationale, in a new book published by the OECD (OECD, 1996, pp. 18, 23, 47, 65).

Nearly all workers worked full-time before early retirement. When they returned to work after retirement, about half of them switched to part-time work, essentially realizing the terms of the proposed model, namely part-time work plus partial pension (as the early pension is smaller than the final one).

To encourage transition to part-time work instead of early retirement, unemployment or disability, the NII should eliminate the fine it imposes on old-age benefit recipients who work during the first five years after becoming eligible and earn more than a designated amount. This fine has already been eliminated in several European countries. In England, cancellation of the fine in 1989 was shown to encourage more people to remain at work part-time or even full-time. As we know, the fine amounts to a marginal 100% tax, leading people to refrain from work altogether or to adopt the widespread ploy of transition to a secondary market in which there are no taxes and no income reports. For many reasons, it is best to avoid such a situation.

If the model is accepted in principle, details and regulations will have to be based on Israeli conditions and quantitative estimates, including demographic and economic forecasts. The parameters for regulations will have to ensure that the partial pension is not so large as to generate initiative to reduce the amount of work, nor so small that it encourages various forms of early retirement. The total wages from part-time work plus partial pension should be less than those of full-time work. Anyone who works according to the model continues to accrue rights. Consequently, despite early partial pensions, such people are entitled to full pension rights once they retire. In Israel, the model should be instituted at age 58, with gradual transition to formal retirement at age 70. Flexibility should be introduced in regulations regarding 10%-15% of workers in physically challenging occupations who cannot continue working, even part-time, at an advanced age. All will be accomplished gradually over a period of about 15 years. To enable all parties to become accustomed to the changes, the terms of the transition period, that are sometimes more complicated than the model itself, should be formulated clearly.

Conclusion

Implementation of the model proposed above will form an additional component of guaranteed income for older employees and their families. Some call it the Fourth Tier, as it augments the three familiar tiers recommended, for example, by the World Bank in 1994, namely minimal social security for all citizens, mandatory income-based pensions for all working persons and savings

and commercial insurance at the individual's discretion. At this tier, part-time work is combined with a partial pension for 15-20 years. Several European countries have already applied certain elements of this model, that is increasingly mentioned in professional literature either directly or as part of a process aimed at changing the entire employee life cycle, as described above.

A recent EC report (European Commission, 1997) devotes an entire Section (2.2.4, p. 8) to flexible retirement methods accompanied by continuation of part-time work and inception of pension receipt. The reasons stipulated for this measure are the projected long-term personnel shortage due to dependency ratios created, as well as the physical and economic pressure that pensions exert on the economy (leading to a recommendation that the measure be subsidized and that the Council of Europe set up special funds accordingly). Employees and workplaces alike should be duly prepared for inception of these arrangements.

In Israel, the model may be applied in several ways under the current system of work regulations and arrangements: Postponing retirement age insofar as eligibility for NII benefits stipends is concerned (formally, this measure constitutes no more than a literal interpretation of the prevailing law without the present option for advancing said eligibility by up to five years under limited circumstances) and permitting full or part-time employment until the employee reaches the designated age. Such deferment increases the amount of benefits due following full retirement. During the first quarter of 1997 (National Insurance Institute of Israel, 1997, p. 48), 16% of benefit recipients (18% of men and 14% of women) exercised this option before their retirement and 40% increased their benefits to the maximum (an increment of 25%). The data show (Morgenstin, Nimrodi and Schmelzer, 1997) that 54% of men retiring according to NII regulations and only 34% of women have employment pensions, reflecting some increase since the 1978 survey but indicating that extended work at advanced ages would improve the situation.

A more basic change, conforming with the proposed model, will be achieved by introducing the option of partial old-age benefits during the last five years before absolute retirement age, combined with part-time work and relaxation of the limitations on income at this stage of life, obviously combined with a partial pension only. The revolution will be complete if formal NII retirement age for women is rendered the same as for men, as it was regarding pension reforms.

According to pension regulations in Israel, there is no connection between pension receipt and work at a workplace other than the one at which rights were accumulated before retirement. Consequently, we are unable to obtain

direct statistics on pensioners' part-time work, although some conclusions may be drawn from data on the relevant age groups' participation in the work force. Furthermore, people who receive disability benefits because they can no longer work in their designated occupations may continue working part-time at other jobs (no quantitative statistics available). Retirement, like NII benefits, may be deferred by up to five years, with returns increased accordingly. Early retirement, up to five years before formal retirement age, is also possible, entailing some reduction in pension rights. This flexible retirement pattern parallels the proposed model. In practice, few pension fund members exercise either of these two options.

Another form of early retirement is effected through extended unemployÙ ment at an advanced age before formal retirement age, According to the *Statistical Abstract* (Israel Central Bureau of Statistics, 1996, Table 12.20, p. 314), during the high unemployment years 1991 to 1993, about 6% of persons aged 55 and up were officially unemployed. In 1995, the percentage dropped to 3.7%. Many countries allow extension of eligibility for unemployment compensation at these ages for several years. Israel, in turn, tends to favor guaranteed income through NII disbursements.

Employer-initiated early retirement is very common in Israel. In the defense system, for example, partial pensions are available for employees aged 40-45 who continue to work (most of them full-time) until retirement; persons with budgeted pensions may retire after age 40 if they have worked at least ten years. The private market offers numerous early retirement plans, beginning seven years before formal retirement. Dismissal of older employees with severance pay is another way of having them cease work and receive some source of livelihood.

In certain industries, workers have long enjoyed the option of continuing to work beyond formal retirement age, generally at their own discretion, with the support of their trade unions and to a certain extent their employers as well (usually in the public sector). Senior instructors at institutes of higher education may work regularly until age 68 and even continue part-time work thereafter; physicians may do the same; any clerk at a public institution who is needed by his employer and who so desires will find it easy to defer retirement up to a year and a half after formal retirement age.

In some of the free professions and even in other occupations (construction, plumbing, commerce), middle-aged and older persons tend to become self-employed, enabling them to work as long as they desire. In unemployment-ridden European countries, governments encourage this shift to independence because it creates additional jobs, offering such incentives as capital at

convenient terms and organizational and professional guidance. A quantitative rise in the percentage of self-employed persons among the working public has been noted in Israel as well.

The labor market is apparently changing in the directions recommended by the proposed model: Flexible retirement terms over a broad age span (55-70) plus part-time work and various sources of income. Consequently, models based on demographic changes that base assumptions on present parameters and forecast economic catastrophe are not necessarily correct. Such models lead pension arrangement opponents to posit harsh proposals according to the model described and rejected at the beginning of this section.

If work productivity continues to rise, current consumption as a function of the total product declines (rising in absolute terms because of an increase in the overall product), the proposed model is implemented and the actual average age of retirement rises (calculating years of part-time work and partial pension into a weighted average of full-time work and full pension) to about 65 for both sexes, the demographic dependency ratio will be translated into a far more convenient economic one (namely the ratio between the financing required for post-retirement life and resources generated by work) that will provide a reasonable actuarial accounting for a very long period of time. As such, the national economy and society will achieve its full pension objectives by adding a Fourth Tier and creating reasonable conditions for continued economic growth.

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ISRAEL'S HEALTH SYSTEM SINCE THE NATIONAL HEALTH INSURANCE LAW

by Revital Gross,* Bruce Rosen* and Arye Shirom**

Introduction

The aim of this article is to examine Israel's National Health Insurance Law (NHI) in a wide context by looking at the health system in the NHI era. To begin with, we will present the background and goals of the NHI legislation process and spell out the law's primary articles. Following that, we will go over the changes made to the law since 1995 and examine the law's effect on sick fund income and expenditures, the level of sick fund service, the satisfaction of sick fund members, and trends in member transfers to other sick funds. In addition, we will discuss whether the law has attained the major goals envisioned by its planners.[1]

Legislative Background of the National Health Insurance Law

The National Health Insurance law was enacted in 1994 and implemented in January 1995, in light of the recommendations of the official State Commission of Inquiry established in 1988 to examine the functioning and efficiency of the Israeli health system (State Commission of Inquiry, 1990, Vol. 1 and Vol. 2). The Commission's recommendations, presented to the government in 1990, included national health insurance legislation. Dissension within the Commission over the essence and content of the proposed law (see Vol. 1, pp.78-83, and Vol. 2, pp.38-64) later found expression in the legislative initiatives of Minister of Health Olmert (1992) and Minister of Health Ramon (1994), the latter's initiatives becoming law.

The official Commission of Inquiry was appointed against the background of economic and labor crises in the country's health system. There were a number of explanations for these crises.

One explanation claimed that government budgetary policy on welfare

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1. Some of the information presented in this article was gathered in the framework of research conducted by Revital Gross as part of her doctoral studies under Prof. Michael Harrison, Department of Sociology and Anthropology, Bar Ilan University, Israel.

services had led to a substantial, ongoing reduction in its share of health system funding for the same period (Doron, 1994; State Commission of Inquiry, 1990, Vol. 2, pp. 118-140; Yishai, 1994). Israeli households were financing an increasing proportion of the national health expenditure through sick fund membership payments and direct payments to private health service providers. Along with the drop in the government's share of health system funding, there had been a rise in the private sector's role in supplying health services. In addition, there had been an increase in the national health expenditure portion of the GDP (Kop et al., 1996). In an effort to reduce the rate of increase in the national health expenditure, the government continued its policy of budgetary cutbacks for health services.

Another explanation blamed the diversion of sick fund membership payments, especially by Kupat Holim Clalit (KHC), to non-health oriented needs. In the case of KHC, the country's largest sick fund and a subsidiary of the Histadrut labor federation, the diversion of funds was associated with a unified tax that included both KHC and Histadrut membership fees (State Commission of Inquiry, 1990; Vol. 1), stemming from the fact that, generally speaking, KHC members were automatically made members of the Histadrut, and vice versa.

An additional explanation tied the crises to resource allocations among sick funds. Fee levels were determined by member income, which encouraged cream skimming. KHC had fewer resources than other sick funds - whose members had relatively high-incomes - and insured a higher percentage of chronically ill, elderly and low-income members. This means that, on the one hand, the health needs of KHC members were greater, while on the other, the sick fund's income was lower. In 1992, for example, the age-adjusted per person expenditure for the Maccabi sick fund was 30% higher than that of KHC (Rosen and Nevo, 1996).

NHI was designed to deal with the financial crises plaguing the health system and with other problems. Chief among them were: incomplete insurance coverage; a lack of clarity concerning service eligibility; the distribution of resources among sick funds in a way that was not proportionate to health needs; sick fund member dissatisfaction with service; limitations on freedom of choice and movement among sick funds; and inequality concerning services for various populations and geographical areas (Rosen et al., 1996). At the same time, the law's implementation was accompanied by fears that some of its goals would remain unattained; that it would result in undesirable by-products, such as a decline in service following financial difficulties in some sick funds; and

that it would lead to an increase in the national health expenditure and the public's health expenditure burden.

The law unequivocally defines sources for financing the basket of health services, and spells out the state's responsibility to supply each citizen or permanent resident with the comprehensive services included in the basket. It also ensures universal insurance coverage for each citizen or permanent resident; eligibility for the basket of services regardless of one's financial ability; cross-subsidization in the payment of health premiums; and an allotment of resources to sick funds that correlates with membership age, a proxy for health needs. The law also says that a sick fund must accept any citizen or permanent resident for membership without imposing limitations or conditions, thus ensuring freedom of choice. An additional principle of the law is to end the financial bond between KHC and the Histadrut, and between the Leumit sick fund and the National Workers Federation (State of Israel, 1994).

NHI brought about a fundamental change in the operating principles of the health system. In the past, the system was based on voluntary insurance offered by sick funds competing over premium fees and the basket of services, a mechanism that, ideally, should have led to efforts to improve service and curb expenditures. However, flexible premium fees and baskets of services are an inducement for cream skimming. Since the law's implementation, the health system has been based on supervised competition in which citizens pay a uniform premium to a sick fund via the National Insurance Institute (NII), while the sick funds are required to provide a uniform basket of services and are subject to government regulation. This system does away with competition over premium fees and the basket of services, reducing the possibility of cream skimming. The law embodies an attempt to achieve compromise concerning the objectives of better service and increased equality, on the one hand, and streamlining and reduced expenditures, on the other, the initial two being in conflict with the latter two. Resource allocation according to the capitation formula provides an inducement for competition concerning service, and for attracting weak population groups. The directives concerning freedom of movement among sick funds and the setting of the basket of services have the potential to further the goals of improved service and equality. Streamlining and reduced expenditures can be achieved through the directives of the law that, by setting the budgetary framework for the health system, ensure that the sum total of all the systems resources is limited and subject to government control.

NHI does not deal directly with hospital reform, which in Israel is being undertaken, not through legislation, but through government decree, primarily

by the Ministry of Health, but also by the Ministry of Finance (Shirom et al., 1997). The law also has little to do with dental health, which falls under the purview of the private sector. Unlike in most European countries, where the basket covers preventive dental services, maintenance and routine care, the basket of services in Israel covers only preventive dental checkups for children (Barnea and Amadu-Grundstein, 1992). According to Horev (1996), despite the high level of national spending on dental care in Israel,[2] the accessibility of care is low, the country being ranked among the lowest of Western nations for almost every index of dental health. As such, it appears that there is inefficient use of the national resources invested in this area.

Examination of the Changes in the Health System Since NHI

NHI has led to major changes in health system regulations concerning funding, the allocation of resources to sick funds, and the provision of services. The following is an assessment of the differences between the pre- and post-NHI periods.

1. The Financing of Services: Prior to NHI, health insurance was voluntary. With the law's implementation, a mandatory health payment was imposed on each citizen and permanent resident. There was also a change in taxation levels, the health tax becoming more progressive (Achdut, 1998). The tax burden on weaker population strata was reduced, while it was increased for the more prosperous strata, and for married women and members of certain organizations (who previously enjoyed discounts). Prior to NHI, the sick funds themselves (or the Histadrut, in the case of KHC) collected membership payments. With NHI, collection was placed in the hands of the National Insurance Institute. In addition, the sick funds were no longer authorized to set rates of payment or co-payment, or to grant discounts. The law also stipulated that health tax money could be earmarked solely for the provision of health services, and could not be used to finance other activities, as it had in the past; thus, the historic links between KHC and the Histadrut, and between the Leumit sick fund and the National Workers Federation, were severed.

An additional change concerning system finance is the stipulation that the state transfer budgetary funding to the sick funds in order to supplement the cost of services called for by NHI; the funding is calculated according to the

2. A high percentage of Israel's national health resources (approximately 12%, compared to 7% in European countries) is directed to dentistry. This is expressed in, among other things, the high number of dentists relative to the population and the high cost of dental care in Israel relative to other developed nations.

basket cost, which is itemized in the law and updated according to a number of indices, including the Health Price Index published by the Central Bureau of Statistics (CBS). NHI also stipulates that the Minister of Health and the Minister of Finance can, with authorization by the Knesset Labor and Social Affairs Committee, alter the composition of the Health Price Index and update the basket cost according to additional parameters, particularly changes in demographics.[3]

2. *The Allocation of Resources to Sick Funds:* As sick funds previously collected health payments themselves, their income levels depended on the economic status of their members. NHI changed the regulations concerning allocations, stipulating that the health tax collected by NII be distributed among the sick funds according to the number of members and their ages. In addition, sick funds would now be eligible to be reimbursed for treating Gaucher's disease (major or intermediate), thalassemia, hemophilia[4] and kidney dysfunction requiring dialysis. A planned change that has yet to be implemented concerns financial allocations for the provision of preventive, geriatric and psychiatric services, and rehabilitative instruments. So far, these services have been financed by the Ministry of Health and from a separate budgetary framework for special allocations. According to NHI, responsibility for the provision of these services was to have been transferred from the state to the sick funds following a three-year interim period. The law also stated that the funding for the provision of these services would be transferred to the sick funds within the general funding framework, and not as a special allotment. It was later stipulated that preventive medical services would remain within the purview of the state; the law was not activated for the purpose of transferring responsibility for the remaining services.

3. *Regulations Concerning the Provision of Services:* NHI set a uniform basket of services required of all sick funds. Prior to NHI, each sick fund set the composition of its own basket. The law stipulated that at the end of a three year interim period, the Minister of Health would be authorized to set regulations

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3. Demographic parameters linked to population growth and aging are mentioned in the law. A committee of experts recommended that the basket cost also be updated according to technological progress. The Ministry of Finance wants the efficiency levels required of sick funds taken into consideration, something done for all public bodies.
4. In 1998, AIDS was also recognized as a serious illness.

detailing the basket of services, as well as standards concerning their quality (e.g., waiting time for services, distance from the members home to where the service is to be provided, and arrangements for choosing suppliers).[5] Previously, the sick funds had been allowed to set their own standards. NHI allows sick funds to offer additional services that are not included in the basic basket, within the framework of supplemental insurance. However these programs are subject to Ministry of Health regulations concerning content and price.

Another change concerns transfers among sick funds. NHI requires sick funds to accept everyone seeking membership, including those on whom they previously had been able to impose eligibility limitations due to poor health or other reasons, and those they had been able to reject outright.

An additional change strengthens the Ministry of Health's standing relative to the sick funds. NHI stipulates that the Ministry regulate quality of care in the sick funds, and that the sick funds provide the Ministry any information it seeks. The law also requires that sick fund development budgets be approved by the Minister of Health.

Finally, NHI further exposes the health system to public scrutiny by: involving the Knesset Labor and Social Affairs Committee in decision-making concerning the Health Ministry; calling for the establishment of a National Health Council that will serve as a consulting body to the Minister of Health and consist of members representing the public and various system bodies; and stipulating that the National Health Council and sick funds appoint a public ombudsman.

Legislative Developments Since January 1995 and Their Significance

Fundamental changes were made to NHI in the form of legislative initiatives during the law's first four years. The initiatives were included in budget arrangements bill's accompanying each government budget enacted since 1997. Following are short synopses of these changes and discussions of their significance.

1. Budget Arrangements Bill, 1997: At the end of 1996, after the health system posted a deficit, amendments were drafted in order to slow the growth in the national health expenditure and ensure that monies from public funding sources are put to their intended use (Budget Arrangements Bill, 1997; Chap.

5. In 1998, a panel of experts in the Ministry of Health recommended that the basket of services not be detailed, and that quality parameters not be set.

5). Within the framework of the amendment, government oversight of sick fund activity, and sick fund dependence on the government, increased. The Minister of Health and the Minister of Finance were empowered to appoint an outside comptroller for a sick fund posting a deficit, and to limit the sick fund's development budget and absorption of new members. It was also stipulated that the parallel tax, paid by employers to NII and designed as an earmarked tax for financing the health system, be replaced by direct government support.

Within the framework of amendment directives, sick fund autonomy concerning matters of internal management was limited in order to increase streamlining and avoid deficits. The amendment limited sick fund control of corporations and empowered the Minister of Health to set standards concerning the channels of investment of non-health related sick fund assets. In addition, the amendment included directives limiting the scope of annual sick fund expenditures on development, marketing and sales. It also stipulated that the Tenders Law regarding contacts with suppliers be enforced for sick funds, and that the Minister of Health approve sick fund charters. Further, it was stipulated that in order to avoid superfluous expenditures due to overlapping services, the Minister of Health and the Minister of Finance limit the expansion of a sick funds infrastructure (e.g., the opening of clinics) and impose requirements for joint sick fund acquisitions..

The amendment stipulated that allocation rates to sick funds be updated quarterly, and not semi-annually as had been the practice in the past, so that the resources allocated respond more rapidly to changes in membership levels.

Due to hospital complaints of cash flow delays, and complaints by some sick funds concerning the financial burden of maternity hospitalization, the amendment stipulated that NII pay hospitals directly for such hospitalization, as had been done prior to NHI, and not by way of the sick funds. In addition, due to hospital complaints concerning the over-use of hospital services by sick funds, a change was made in the hospital capping arrangement. The original arrangement stipulated that payments to hospitals be limited to an increase of not more than 2% beyond the increase in the cost of a hospitalization day. Under the new arrangement, each sick fund was assigned a ceiling for payments to each hospital; once the ceiling is reached, the hospital can charge the sick fund only half the standard fee for additional services. As such, it was stipulated that hospitals receive payment, albeit reduced, for the provision of services beyond the ceiling, and no longer be asked to provide these services for free. The goal of this hybrid arrangement was, on the one hand, to encourage sick funds to curb their demand for hospital services, and, on the other, to encourage hospitals to curb the supply of their services.

2. Budget Arrangements Bill, 1998: At the end of 1997, a limit was placed on sick fund advertising and marketing efforts, which, in light of heightened competition against the backdrop of continuing budget deficits, were being expressed in pretentious and aggressive marketing campaigns, some of which were illegal. The 1998 amendment stipulated that one would have to go to a post office in order to sign up for sick fund membership, instead of going directly to the sick fund or signing up through the sick fund's sales representative, as had previously been the practice. In addition, strict limits were placed on the sick fund's advertising budgets in order to restrict the use of NHI funding for this purpose. To reduce expenditures stemming from overlapping services, limitations were placed on sick fund activity in small localities; no more than one could operate in a locality of up to 5,000 residents, and no more than two could offer services in a locality with 5,000-10,000 residents. In order to ensure quality of service, it was stipulated that the sick funds operating in small localities would be chosen by tender on the basis of price and service. Despite the limitations placed on competition, sick funds could become more competitive concerning the basket of services by being allowed to add further services, as per authorization by the Minister of Health.

The amendment also stipulated that sick funds could demand co-payment for physician visits in order to increase their income, as per authorization by the Minister of Health and the Knesset Finance Committee. The sick funds were now able to compete among themselves in setting co-payment rates, subject to approval by the Minister of Health. Nevertheless, the sick funds would have to adhere to amendment criteria in order to limit the extent to which the additional payments would adversely affect weak populations or be utilized as an instrument for cream skimming. The co-payment rate would have to be uniform and unlinked to income levels. In addition, the amendment stipulated that exemptions and discounts be awarded to the chronically ill and elderly, and to new immigrants, large families and those receiving income supplements.

Additional directives of the 1998 Budget Arrangements Bill concern the provision by sick funds of services covered by supplementary insurance (now called Supplementary Health Services, or SHS). The amendment allows sick funds to offer additional services that are not included in the basic basket in return for a separate premium covering service costs. It also sets standards for the operation of SHS: The service will be provided by the sick fund itself or by a subsidiary that it fully controls as a distinct entity with a balanced budget. SHS will be involved solely in the provision of services by the sick fund, and not in financial compensation. Nursing hospitalization services will not be included in the SHS framework. Among the programmatic criteria itemized in the

amendment: Every person seeking membership must be accepted, regardless of health or financial status; a sick fund is forbidden to favor specific participants over others; the fee will be uniform for all age groups. In addition, the Minister of Health will have the authority to regulate and control the programs and to set regulations for all aspects of proper operation. Finally, the amendment stipulates that the sick funds publicize information concerning the basket of services, basket of supplemental fees, and supplemental health services. Providing residents with complete information is a requisite for fair competition among sick funds.

3. Budget Arrangements Bill, 1999: At the end of 1998, additional directives that increased government involvement in the internal management of sick funds were included in the budget arrangements bill. The amendment authorizes the Director-General of the Ministry of Health to warn a sick fund's directorate of managerial deficiencies. In instances where a sick fund fails to correct a deficiency, the Director-General is authorized to appoint an examining committee that includes a representative of the Attorney-General. The Minister of Health is authorized to take steps against a sick fund that fails to correct deficiencies noted by the examining committee; the Minister can have the committee's findings published, order the sick fund to desist from disbursing funds for the purposes of advertising, marketing and sales for a specific period of time, and delay advance funding that is due the sick fund (up to 2.5% per month). Another directive allows the Minister of Health, through the Attorney-General, to sue a member of the directorate or other official of the sick fund for damages caused to the sick fund.

The Minister of Health, with the agreement of the Minister of Finance, has been authorized to transfer funds directly to Magen David Adom (Israel's Red Cross) for the operation of ambulances providing emergency intensive care. The money will be transferred from NHI funding sources and charged against payments to the sick funds. The sum provided to Magen David Adom will be determined by the Minister of Health and Minister of Finance.

Other amendment clauses help control expenditures by increasing competition in the pharmaceuticals market, which is expected to lead to a considerable decline in prices and substantial savings in the health system. The amendment allows the simultaneous import of pharmaceuticals, providing additional importers, including the sick funds themselves, with entry into the market. The amendment also provides for the supervision of pharmaceutical prices, with maximum rates being set according to the average price for a number of countries, a move that is also expected to bring prices down. Additionally,

pharmacists have been authorized to provide generic pharmaceuticals, even where a pharmaceutical has been prescribed according to a trade name, unless the prescribing physician has specifically stipulated otherwise. This change should reduce expenditures on pharmaceuticals in sick funds and encourage manufacturers and importers to produce or import generic pharmaceuticals that are less expensive.

Yet other clauses help reduce expenditures by limiting the rights to medical services of residents who have returned to Israel after two consecutive years abroad. The amendment stipulates a waiting period of two months for each year outside the country. This directive does not apply to new immigrants, army veterans who have returned to civilian life within the previous 24 months, minors, or those who paid the health tax to NII during their time abroad. The amendment also sets a redemption mechanism. In this respect, the amendment includes regulations determining residency and retroactive eligibility.

The amendment stipulates various concessions concerning co-payments. It states that a yeshiva student receiving income supplements from the Ministry of Religious Affairs is eligible for the same discounts provided to the recipients of NII income supplements. Similarly, it stipulates that the ceiling for co-payments for the chronically ill apply not only to pharmaceuticals, but also to disposable equipment. Finally, the amendment directs that in 1999-2000, hospital billing procedures will continue to be based on capping, with each sick fund paying at a rate of 50% for services provided beyond ceiling limits. It was also decided that the ceiling would be updated annually by 1.25% beyond the routine rate for hospitalization day fee updates (representing a reduction compared to previous years, when the annual ceiling update was 2%).

The changes made in NHI between 1996 and 1998 show a clear trend of increased government involvement in the law's implementation. This is in order to effect tighter supervision and increased governmental regulation of managerial and decision-making processes in the sick funds. The trend has been accompanied by control and regulatory mechanisms established within the framework of the Ministry of Health, including a system of financial control over sick fund expenditures. The system also includes control over the adoption of technological changes and the operation of supplementary insurance programs by the sick funds.

The policy of increased sick fund regulation is apparently aimed at restricting health system expenditures in light of the ongoing deficit. Since NHI's enactment, there has been concern in the Ministry of Finance that the policy of setting a global budget for the health system would prove inadequate for restricting expenditures and preventing deficits. Similarly, the law had failed to

specify the means for enforcing sick fund responsibility to remain within budget. Accordingly, the budget arrangements bills include additional directives aimed at achieving this objective. In addition to the directives imposing limits on sick funds, there are directives concerning system-wide savings (e.g., by canceling superfluous services and encouraging competition in pharmaceutical imports). At the same time, however, the budget arrangements bills include directives that adversely affect the sick funds ability to control payments to suppliers. Two examples are the directives allowing the Ministry of Health to set a ceiling on payments to Magen David Adom and to withhold funds from NHI sources due to delays in payment transfers.

The directives in the budget arrangements bills also include changes aimed at streamlining sick funds through the mechanism of competition. Examples include the directives allowing competition on the extent of the basket of services, the level of co-payments, and the extent and price of supplemental insurance coverage.

An examination of budget arrangements bill directives shows that budgetary restraint could adversely affect some of NHI's goals. Co-payments might adversely affect the principle of government responsibility for financing the basket of services.[6] The ability to compete over co-payments and ceilings could allow sick funds to use price to influence enrollment patterns. Similarly, a considerable increase in co-payments without concessions to populations lacking means could adversely affect the principle of equitability in health service accessibility (Saltman and Figueras, 1997). In Israel, it has been grounded in law that recipients of income supplements, recipients of benefits according to Chapter 9 of the National Insurance Law, and those eligible for NII alimony allowances would be exempt from co-payments. In addition, a ceiling for quarterly family payments[7] was set, in which families with an elderly member pay only up to half the maximum rate. There is still no empirical information concerning the extent to which these concessions solve the problem and those who are in poor health are prevented from seeking necessary treatment. The fee is assessed for visits to secondary physicians, out-patient clinics and institutes. The Maccabi sick fund has been given special permission

6. As it was stipulated that co-payments not be a component of the funding for the basket's cost, they will not be written off [?] from governmental supplements to this cost. Nevertheless, in the long term, the existence of this income source could affect the way the government sets the basket cost, and thus adversely affect its participation in the system's funding.
7. The ceiling is NIS 80 in Maccabi, NIS 120 in KHC, and NIS 140 in Meuhedet and Leumit.

to continue collecting a fee for visits to a primary physician. In all the sick funds, the fee is not progressive according to income, is no different for physician- or patient-initiated visits, and is even collected for physician visits concerning preventive medicine, meaning it can prevent more urgent visits.

The fee for physician visits is often viewed as a way to prevent unnecessary visits, and thus lower sick fund expenditures without adversely affecting quality of care. However, it must be remembered that during the past 20 years there has been evidence of a certain decline in physician visit rates compared to European countries (Israel Ministry of Health, 1998; pp. 135-142), though data that would allow a precise comparison of countries are lacking. Studies conducted in the United States among middle-class populations show that, in general, a physician visit fee reduced the number of visits without adversely affecting population health (Newhouse et al., 1982; Keeler et al., 1987; Manning et al., 1988).

Other budget arrangements bill directives might adversely affect the quality of sick fund services (e.g., in small localities where there is no competition). The limitation on development budgets can also adversely affect the level of service, primarily in the long term. Similarly, allowing the sale of supplemental insurance could reduce the incentive for sick funds to raise the level of services in the basic basket and divert competition to the area of supplemental health services.

Finally, as the Knesset decided to continue to maintain Ministry of Health responsibility for the provision of preventive medicine, and as responsibility for the provision of psychiatric and geriatric services has yet to be transferred to the sick funds (though the interim period ended in December, 1998), the objective of freeing the Ministry of Health from having to provide routine services has not been completely achieved. Since NHI's implementation, there has been continued public debate concerning the advantages and disadvantages of transferring responsibility for these services from the government to the sick funds. The primary advantage in transferring psychiatric and geriatric services to the sick funds lies in strengthening the continuity of care, improving coordination among various agencies and grounding the rights of citizens in law.

Since June 1995, efforts have been underway to implement the law in the area of mental health services, and there have been discussions aimed at reconciling differences concerning funding levels, rehabilitative services and the benefits package for the chronically ill. Similarly, arrangements concerning long-term hospitalization have yet to be addressed. Some claim that reorganizing the area of long-term hospitalization can lead to savings because,

among other things, it would allow substitution between institutionalization and care in the community (Michaeli, 1997). Others fear that grounding eligibility in law could lead to a considerable increase in demand, and thus drastically increase expenditures.

In Israel there presently are some 80,000 disabled patients who are unable to carry out a significant number of Activities of Daily Living. The vast majority (about 77%) are cared for in the community, and many are eligible for an NII supplement under the provisions of the Community Long-term Care Insurance Law, enacted in 1988. Twenty-three percent of Israel's long-term patients are cared for in long-term care institutions (Be'er, 1999). The patient and his family pay for hospitalization to the extent that they are financially able, the balance being paid by the Ministry of Health within the framework of the allocation budgeted annually for this purpose. The cost of hospitalization is a heavy burden on most families who are not recognized by the Ministry of Health as being entitled to subsidies according to a means test (Eckstein, 1998). At the end of 1998, some 1,900 elderly patients recognized by the Ministry of Health as nursing patients were on a waiting list, about 600 were waiting to be hospitalized and the rest were in the process of being recognized for eligibility (Geriatrics Division, Ministry of Health, 1998). During the waiting period, most were being cared for in the community, the Long-term Care Insurance Law covering some of the cost of care, the families covering the remaining costs. In other instances sick funds were bearing the burden of care costs even though they received no funding for these benefits under NHI. The situation in other countries shows that there are a number of alternative arrangements, which are reviewed in the article by Rachelle Kaye (1999).

So far we have examined the components of NHI and legislative developments concerning the law, and have discussed issues associated with NHI's implementation. At this point we will present findings concerning the influence NHI has had on three central issues: The financial situation of sick funds, the level of sick fund services, and freedom of movement among sick funds. Data for the period up to 1997 will be presented for most areas, and it should be noted that there may have been significant developments in the interim.

Sick Fund Income and Expenditures

NHI and other developments influenced the number of resources available to the health system and led to changes in the allocation of resources among sick funds. This chapter will present the primary findings of an analysis of sick fund financial report data (Rosen et al., 1998; Ivancovsky et al., forthcoming;

Vitcovsky and Nevo, 1998). The analysis is presented in real terms, based on the Consumer Price Index (CPI),[8] and deals with current income and expenditures related to the services in the NHI basket. It should be emphasized that the analysis does not include income and expenditures related to financing and development.

Before we survey the changes that have taken place in the financial situation of sick funds since NHI, we must note two very significant events that took place in 1994. First, physicians, nurses and other health workers were awarded substantial wage increases compared to those awarded in other economic sectors. Second, within the framework of the rehabilitation agreement between the government and the Clalit sick fund, KHC was awarded a large subsidy to cover its current deficit (in addition to government assistance in covering the accumulated debt). These events mean that during the base year (1994), income and expenditure levels were much higher than for previous years.[9]

1. Changes During the First Year of the Law (1995)

During the first year of NHI, total income for all sick funds rose by almost 8%.[10] This growth rate was only slightly higher than that of the standardized number of persons insured by the sick funds, meaning that there was almost no change in total standardized per person income. Alongside this stability, there was a dramatic change in the income's composition (see Table 1). "Income as per Law", meaning funding that the government transferred to sick funds for basket cost[11] under the provisions of NHI, was much higher than what the sick

8. The analysis was conducted on an accrual basis, which is to say that income and expenditures related to activity in a given year related to the same year, even if the funding was transferred during a different year.
9. Opinions differ as to the extent to which these two events were related to government efforts to create successful conditions for NHI legislation. In other words, it is unclear whether and to what extent the 1994 wage increases, and the subsidy awarded the same year to KHC, should be included when tabulating the effects of NHI.
10. It should be noted that this figure also includes income from January 1995 - the missing month - which reached sick funds only at the beginning of 1997. We include this income in our calculation for 1995 because it was provided vis-a-vis activities that took place that year, and because our examination was done on an accrual basis. Without income from the missing month, total sick fund income for 1995 rose by only 5% (i.e., at a rate 2.5% below the growth in the number of standardized persons).
11. According to the law, basket cost is determined annually by the Minister of Health and the Minister of Finance; during the law's first year (1995), agreement by the Knesset Labor and Social Affairs Committee was also required. Basket cost is the allocation to sick funds for the provision of the services in the basic health basket covered by NHI. In 1995, the decision on the basket's cost was based to a great degree on efforts by the staff, which analyzed sick fund expenditures per standardized person in 1993 and constructed estima-

Table 1. Standardized per Person Income in the Overall Sick Fund Economy, 1994-1997, in 12/96 Prices (in NIS)

	1994	1995	1996	1997
Income as per Law	2,179	2,364	2,319	2,280
Co-payments	121	129	135	153
Other Income	90	100	96	75
Total, without Subsidies	2,389	2,594	2,550	2,508
Subsidies	277	91	39	3
Total	2,665	2,685	2,589	2,511

funds received from member payments and the parallel tax on the eve of NHI. This increase, however, was offset almost completely by the substantial decrease in the extent to which the government and Histadrut, both at their discretion and according to rehabilitation agreements, subsidized sick funds.

As expected, the patterns of change were different among sick funds, especially for specific categories of income. It is especially important to emphasize the changes that took place in "Income as per Law", this being the single largest component of sick fund income. Due to the increase in sources for this category, as well as the move to the capitation method, there was an increase of almost 15% in "Income as per Law" per person in KHC, while in Maccabi there was a decline of almost 10%. In KHC, the increase in income from Income as per Law was offset by a dramatic decline in the scope of subsidies. On the other hand, the dramatic decline in "Income as per Law" in a number of the small sick funds was partially offset by government subsidies that were provided for 1995 activities in order to ease the transition. Due to these offsetting changes, the rates of change in total standardized per person

Footnote 11 continued:
tes from expected increases in the price of key inputs, a widened circle of members and additional changes. NHI stipulates that the basket cost be updated annually according to the Health Price Index, and that the Minister of Finance and the Minister of Health be authorized to update the basket cost according to additional parameters, such as population growth and aging.

income in various sick funds were much more similar than the rates of change in "Income as per Law": an increase of about 2% in Leumit, an increase of about 1% in KHC, a decline of about 1% in Meuhedet and a decline of about 2% in Maccabi.

The year 1995 was also characterized by cash flow problems in the sick fund economy (that are not expressed in the aforementioned figures, which were calculated on an accrual basis). The Ministry of Finance transferred money to finance the activities of January 1995 (the so-called missing month), only at the beginning of 1997, influencing the 1995 cash flow in all sick funds. In addition, the 1995 cash flow of some of the small sick funds was affected by delays in the transfer of government assistance for the transition period.

The sick funds reacted to developments concerning the scope of income and cash flow by undertaking various efforts aimed at curbing expenditures, the result being that 1995 standardized per person expenditures declined by almost 3%, the drop being much steeper in some of the smaller sick funds. The decline is especially impressive in light of the fact that in 1995 the cost of a hospitalization day rose 10% beyond the rise in the CPI. Among the steps that contributed to the reduction in expenditures (especially in the small sick funds) were salary reductions in some of the sick funds, pressure on medical suppliers to reduce prices, and an increase in efforts to monitor hospitalization and save on hospital services. Ceilings imposed on hospital income from sick funds also assisted the sick funds to reduce their expenditure levels.

Due to the decline in standardized per person expenditures and the stability in standardized per person income in the overall sick fund economy, 1995 was characterized by a balance between current income and current expenditures, with no significant deficit (Bin Nun, 1999).

2. Changes During 1995-1997

Unlike 1995, 1996 witnessed the advent of a significant deficit for the entire sick fund economy, the scope of which increased in 1997 (Bin Nun, 1999). The question is, were these deficits caused by the increase in standardized per person expenditures, or by the decline in total standardized per person income? Apparently, they stemmed from both, though the contribution of the decline in total standardized per person income was larger, at about 6%, than the rise in total standardized per person expenditures, which was almost 2%. In the following paragraphs we will first discuss changes in income, and then changes in expenditures.

As Table 1 shows, the primary source for the decline in total standardized per person income between 1995 and 1997 was the decline in the scope of

subsidies,[12] the standardized per person decline in subsidies having a major influence on the small sick funds. In addition, there was a considerable decline in standardized per person "Income as per Law", which had an effect on all sick funds. In setting the basket cost each year, the government and the Knesset decide how to monetarily express increases in population, as well as aging, advances in technology, better efficiency and other changes.

In this context, it is important to note the ongoing argument surrounding the Health Price Index, the special indicator called for by NHI to automatically express changes in health services input prices.[13] The Health Price Index takes health sector wages into account, as well as wages for the entire public sector, the price of pharmaceuticals and the price of construction input. It does not directly or automatically express increases in the price of a hospitalization day, and only partially[14] expresses increases in the wages of health workers.[15] Accordingly, it has been claimed that the index does not give proper and full expression to changes in sick fund input prices, in so doing adversely affecting the purchasing power beyond the extent reflected in Table 1, which presents data in terms of the CPI.

The decline in standardized per person income was apparently influenced by, among other things, economic developments that influenced policy. First, the recession that characterized the Israeli economy in 1996 and 1997 probably influenced the scope of overall government revenue, which limited the state's ability to invest in health to the degree it did in other areas of activity. Second, the Ministry of Finance policy has been to try to reduce the government's share

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12. A considerable part of the subsidies awarded to sick funds in 1995 was predefined as temporary and designated for assisting in the transition to the new rules of the game. The Ministry of Finance claims that their decline in scope in 1996 was to a great extent expected and planned; the Ministry of Health claims that these subsidies were supposed to continue during the entire three year transition period.
13. In 1996, the Health Price Index rose by 10.9%, compared to an 11.3% rise in the CPI, a 12.4% rise in the price of a hospitalization day, a 12.9% rise in the wages of salaried workers throughout the economy, and a 10.4% rise in the wages of salaried health, social and welfare services workers. In 1997, the Health Price Index rose by 8.7%, compared to a 9.0% rise in the CPI, a 9.0% rise in the price of a hospitalization day, a 11.8% rise in the wages of salaried workers throughout the economy, and a 8.8% rise in the wages of salaried health, social and welfare services workers.
14. The Knesset set the formula for the Health Price Index according to the recommendations of a panel of health economists. Panel members were convinced that if sick funds receive full compensation for each wage increase in the health sector and each increase in the price of a hospitalization day, the sick funds would not join efforts to curb wages and the price of a hospitalization day.
15. The sick funds attempted, without success, to change the formula for the Health Cost Index. Here, too, one can speak of the effect of policy, and not only of technical constraints.

of the GNP in order to direct resources to the business sector and thus encourage growth. Third, the Ministry of Finance claimed that by streamlining, it would be possible for sick funds to reduce standardized per person income without adversely affecting the level of service, especially in light of the rise in the number of members and the opportunities for exploiting the advantages of size. Fourth, health system income was probably affected by changes in governmental priorities, expressed in the transfer of resources from health to education, social services and transfer payments (Center for Social Policy Studies in Israel, 1998), and possibly to other areas of activity as well. We do not have the necessary information for estimating the contribution of each factor to the decline in standardized per person income in the health system.

It is important to note that there were considerable differences among sick funds in the decline in overall standardized per person income for 1995-1997. For KHC there was a decline of about 4%, and for the rest of the sick funds there was a decline of about 10% (following the cancellation of subsidies).

As already noted, standardized per person expenditures in the entire sick fund economy rose by about 2% during 1995-1997. It should also be noted that the increase took place primarily in KHC, which is in line with one of the goals of NHI - to shift the allocation of resources among sick funds and increase that of KHC, whose population has greater health needs. As already noted, the standardized per person expenditure in the Macabbi sick fund in 1992 was some 30% higher than that of KHC; by 1996, the gap had almost disappeared.

If we take into account the entire period between 1994 and 1997, we find that total standardized per person expenditures for the overall sick fund economy declined by about 1%: In KHC it rose by about 3%, while in the other sick funds there were declines ranging from 4% to 13%.

3. Initial Information Concerning 1998

There is initial evidence that in 1998 the decline in standardized per person current income was halted and that, compared to 1997, there may even have been an increase. There is also evidence of a considerable decline in the standardized per person expenditure, though the official data required to quantify all changes in income and expenditures in 1998 were unavailable at the time we went to press. At this juncture it can be seen that in 1998, the government channeled considerable sums to the system for a safety net and for technological developments (Vitcovsky and Nevo, 1999). At the end of 1998, following enactment of the budget arrangements bill clause concerning new user charges, there apparently was a rise in co-payment income. The year 1998 was also characterized by serious efforts to curb expenditures in sick funds, and

by a real decline (of about 1%) in the price of a hospitalization day. The scope of the deficit in 1998 was much lower than in 1997.

4. The Increase in Sick Fund Assets and Number of Members

The analysis presented above related solely to current income and expenditures, and not to trends in capital expenditures, a matter that is especially complex and should be examined in depth in those studies. At this stage we will note only that the report recently prepared by the Ministry of Health (Israel Ministry of Health, 1998) shows that during 1994-1997, the rate of growth in the capital stock in the three small sick funds was much lower than the rate of growth in the number of members, while at KHC, the rate of growth in the capital stock was higher than the rate of growth in the number of members.

Level of Service and Member Satisfaction in the Sick Funds

The National Health Insurance Law had the potential to influence the level of service provided in the sick funds and the satisfaction of members, though there was no certainty concerning the influence's direction. An analysis of NHI's incentives shows, on the one hand, that as the allocation of resources to sick funds would now be based on the number of members and their ages, the level of service should have risen due to sick fund motivation to registered members. Furthermore, as NHI set a uniform basket of services and premiums, competition was likely to focus on the quality and availability of these services, meaning that one could look forward to improved service and satisfaction. NHI also stipulated that there be freedom of movement among sick funds, which also should have increased competition.

However, the NHI basket of services, which is identical to the basket provided by KHC on the eve of the law's enactment, is in a number of areas more limited than the pre-NHI baskets provided by the other sick funds (Gross and Brammli, 1996); this means that the law could adversely affect the extent of service in these areas. The scope of standardized per person income from NHI sources for these sick funds is smaller than in the past (Rosen et al., 1998), and the shortage of resources could also adversely affect the level of service. Similarly, due to the limits placed on competition regarding the composition and price of the basic basket, there is concern that sick funds have focused service development and competition efforts on the supplemental health basket, and only after this on the basic basket.

Findings from surveys of sick fund members conducted by the JDC-Brookdale Institute in 1995 and 1997 show the actual effects that NHI has had on the level of sick fund services and member satisfaction (Gross et al., 1998).

The findings show that in the fall of 1995, some 18% of the members reported an improvement in service compared to the previous year; 4% reported a decline, and the rest felt there had been no change (Berg et al., 1998). The proportion reporting an improvement was much larger in KHC (23%) than in the other sick funds, where the vast majority of respondents felt there had been no change, 7% to 11% felt there had been an improvement, and 4% to 13% felt there had been a decline.

The findings from 1997 show that, in comparison with 1995, a higher proportion of members in all sick funds felt there had been an improvement. Approximately 40% of the respondents felt there had been an improvement in sick fund services compared to the previous year, and only 9% reported that the situation had worsened. Between 1995 and 1997 there was also a statistically significant[16] increase in the proportion of respondents reporting a high or very high level of satisfaction with their sick fund (from 83% to 91%). The increase was especially substantial in KHC, though even in 1997, satisfaction in this sick fund was still lower than in the other sick funds. Increased satisfaction was also found in specific areas of service: the professionalism of family physicians, the professionalism of specialists, nurses' attitudes, the variety of pharmaceuticals, laboratory services, and facility cleanliness and maintenance.

The study findings also show that in the wake of NHI, there has been a statistically significant improvement in additional indices of service quality. There was a rise in the proportion of respondents reporting that they had a regular family physician, that they spent less than 15 minutes in the family physician's waiting room, and that they waited less than one week for an appointment with a specialist. There also was a rise in the provision of preventive medicine (blood pressure measurements and mammograms for women aged 50+). In addition, there was an increase in the proportion assessing their health as very good or good.

One of NHI's goals was to increase equality for different population groups and geographical areas. It was expected that with the adoption of the capitation formula, more funds would be transferred to KHC, with its higher concentration of weaker populations, enabling it to improve the services it provides to these and other populations. Similarly, it was expected that the capitation formula would be an incentive for all sick funds to compete for the weaker populations. The formula provides an incentive for attracting the

16. Only statistically significant changes will be noted from here on.

elderly, for whom funding is almost four times higher than it is for the young. It also provides an incentive for insuring Arabs and the poor, whose families are often large, as sick fund income for the basic basket is no longer related to member income, but rather to the number of members enrolled and their age mix. Therefore, an improvement was expected in the level of service and satisfaction for these population groups. However, it is still possible that sick funds will prefer young populations that require fewer services, as well as populations that are financially better off, as the sick fund's financial sources also include income from supplemental health insurance premiums and co-payments, while expected income from low-income earners is lower.

In order to learn about changes in the levels of service and satisfaction among the weak populations, a special analysis was conducted of the findings from JDC-Brookdale Institute surveys (1995 and 1997). The findings on the elderly population show an increase in satisfaction with their sick fund, and that their level of satisfaction is greater than that of the young. There also was improvement in the indices of service accessibility, service availability, and the provision of preventive medical services. Nevertheless, there remains a gap between the elderly and young populations for time spent in the family physician's waiting room and time spent waiting for an appointment with a specialist, and for the provision of mammograms (Bentur et al., 1999).

Findings from a study of the Israeli Arab population (Farfel and Yuval, 1998) show that from 1995 to 1997, some gaps between this population and the Jewish population were reduced. There was a reduction in the gap concerning self-perceived health status, time spent in the family physician's waiting room, time spent waiting for an appointment with a specialist, and convenience of specialist reception hours. In 1997, a very high proportion of the Arab population (70%, as opposed to 34% among the Jewish population) reported an improvement in the level of services since the previous year. However, the rise in the level of satisfaction among the Arab population between 1995 and 1997 was smaller than among the Jewish population. The findings also show that gaps for other areas of service still exist. There were lower utilization rates among the Arabs for urgent medical care in the community, mental health services and specialists. The utilization rate of preventive medicine is still lower among Israeli Arabs than among the country's Jews, as is the rate of supplemental insurance. A higher rate of Arabs reported forgoing medical service due to the distance involved. The study found additional indications that services do not meet the needs of the Arab population to the same extent that they do the needs of the Jewish population, with higher rates of Arabs re-

porting that the time it takes to travel to physicians' offices and that the time spent waiting for appointments with specialists were unacceptable.

Another study of the Arab population (Adler and Lotan, 1998) resulted in similar findings. On the one hand, improvements were found in sick fund facilities, the supply of physician manpower and diagnostic equipment, attitudes of the medical staff and the waiting time to see specialists. On the other hand, the findings indicated that there were unmet needs expressed in a low level of satisfaction with services and a high level of utilization of private medical services, indicating a lack of sufficient services in the public framework. There was also a low level of utilization of preventive medicine (blood pressure examinations, mammograms, hearing tests, etc.) and, in the researchers' opinion, little awareness of the existence of clinics. An additional study indicates a problem among Bedouin in southern Israel, many of whom appear to be unaware of their rights under NHI (Shvartz et al., 1998).

Findings from a study that analyzed JDC-Brookdale Institute surveys while focusing on low-income persons (Berg et al., 1998) show that members from the lowest economic quintile reported improvements between 1995 and 1997 in certain quality of service indices: regular physician, time spent in primary physician waiting rooms, time spent waiting for appointments with specialists, and convenience of sick fund office and laboratory reception hours. In addition, there was improvement in the satisfaction of low-income earners, and the rate of low-income earners reporting improved services was higher (49%) than among higher income earners (35%). Nevertheless, the study findings show that for certain areas (travel time to primary physician, satisfaction with sick fund services and accessibility to supplemental health insurance), considerable gaps remained between low-income earners and others.

Although study findings show that, in general, there has been a rise in the level of sick fund service since NHI, it is impossible to establish a clear, causal relationship with the law's implementation because there is no way of knowing which trends would have emerged in its absence. There is evidence that improvement efforts began in the sick funds starting in the early 1990s, prior to NHI, and that they were related to the increased inter-sick fund competition taking place at the time. This trend would probably have persisted without NHI. However, there is a stronger basis for linking NHI with the improvement observed among the weak populations in light of the changes that have taken place in sick fund financing and in the system of incentives.

The aforementioned findings from sick fund member surveys show that, contrary to concerns and despite sick fund budget difficulties, as of 1997 there had been no decline in the level of service, while there was a clear trend of

improvement in member satisfaction. There are a number of NHI-related characteristics that could explain these trends. First, the limitation on competition over basket content and premiums apparently shifted the focus of competition to the level of services: accessibility and availability, staff attitudes and facility care. Freedom of movement among sick funds was also likely to have increased competition in these areas. Second, it is possible that sick fund advertising and marketing efforts aimed at attracting new members (Shvarts et al., 1998) also influenced existing members and increased their level of satisfaction. Finally, the NHI provision covering freedom of movement allows dissatisfied members to leave their sick fund, while those who remain may reassess their level of satisfaction based on their decision to stay.

It must be remembered that despite the improvement seen in the level of service, it is important to track the quality of sick fund clinical care - a subject that has not yet been examined. Similarly, in addition to tracking satisfaction within the general population, there is room for an in-depth examination of the level of service provided to members suffering from a serious illness, especially those whose illness requires expensive care. NHI's incentives do not encourage sick funds to supply services to these members as, aside from certain diseases, the sick funds are not reimbursed for the treatment of serious illness. As such, there may be no equitable solution to the needs of these members. A study conducted by Rubin et al. (1998) shows that, according to self-reports, the seriously ill have greater problems with accessibility than do healthy members. It also will be important to continue to track the level of service to the general population as, due to the health system's continuing financial difficulties and the user fee directives of the budget arrangements bill, there might be a reduction in the level of services to residents or a decline in accessibility.

Trends in Transfer among Sick Funds and in the Composition of Sick Fund Members

Two of NHI's primary goals were to ensure freedom of choice in choosing a sick fund and to reduce the incentives to sick funds to engage in cream skimming. Prior to NHI, some of the sick funds made it difficult for the elderly and chronically ill to join, and their marketing efforts were geared to young, healthy, above-average income earners. Because of these trends, the elderly, the ill, and low-income earners were concentrated primarily in KHC, and also in the Leumit sick fund. In addition, a considerable number of KHC's members had joined due to pressure from their employers, who were linked with the Histadrut, or because they resided in geographical areas served only by KHC (Rosen et al., 1995; Rosen and Steiner, 1996).

The period prior to NHI (1991-1994) was characterized by a considerable decline in KHCs market share. Between December 1991 and December 1994, the proportion of members enrolled with KHC dropped from 73% to 63% (Rosen and Steiner, 1996). Furthermore, among those who left KHC there were considerable proportions of young people and high-income earners. It also was found that the tendency to join KHC and remain there was much lower among new immigrants than among non-immigrants. It is also important to point out that during both 1993 and 1994, about 4% of all sick fund members moved to a different sick fund.

It was expected that allocating resources to sick funds according to the capitation formula would increase the attractiveness of the poor and elderly as potential members. A priori, it was unclear whether the change in incentives would be sufficient to effect change in sick fund membership recruitment policy. A priori, it was also unclear whether the reform would affect KHC's market share. Certain researchers felt the clause in NHI allowing membership transfers would diminish KHC's market share, believing that many of its elderly, ill or Histadrut-affiliated members would move to a different sick fund. Others claimed that the change in the allocation of resources and the increase in KHC's share would allow it to improve its services and strengthen its position.

The trends that actually took place can be seen in an analysis of NII data (Bendelek, 1998; Cohen, 1993-1998[?]). From 1995 through 1997 - prior to enactment of the 1998 budget arrangements bill that limited sick fund marketing activity - each sick fund competed vigorously for new members (Shvarts et al., 1998). Nevertheless, at the end of 1997, the annual rate of transfers among sick funds was 4%, just as it had been prior to NHI.[17] KHC's market share continued to drop, from about 62% at the end of 1995 to 58.6% at the end of 1997 (Bendelek, 1998). However, the rate of decline was lower than in the pre-NHI period. In 1994-1997, KHC's market share dropped by five percentage points compared to a drop of 10 percentage points in 1991-1994.

The findings of population surveys conducted by the JDC-Brookdale Institute show a considerable drop in the proportion of KHC members who feel they would receive better services in another sick fund (from 37% in 1993 to 15% in 1997). Nevertheless, even in 1997, this proportion was higher than in other sick funds. The survey findings also show a considerable rise in the proportion of residents who report that more than one sick fund is operating in

17. The transfer rate dropped dramatically in 1998, apparently due primarily to the changes in the registration and transfer processes, and the limits on sick fund advertising imposed by the 1998 budget reconciliation bill.

the area where they live, meaning that there exists the possibility of choice (Rosen et al., 1996; Rosen and Shamai, 1998).

Israel's Arab population became a sick fund marketing objective because of the change in sick fund financing (which is no longer related to family income, but rather to the number of persons and their age), and because this population uses fewer services than does the Jewish population. The rates of sick fund membership transfer among the Arabic-speaking population were considerably higher than among the Hebrew speaking population (12% and 5%, respectively).[18]

There is less of a tendency among the elderly population to switch sick funds. For example, in 1997, about 8% of members aged 15-25 switched sick funds, compared to just 1% of members aged 65-74 (Bendelek, 1998). No data are available for examining whether the elderly have been switching sick funds at a higher rate since NHI. NII data (Cohen, 1993-1998) show that since NHI, the growth rates in elderly membership at the Maccabi and Meuhedet sick funds have been higher than for non-elderly membership growth. For example, in 1994-1997, the number of elderly members at the Maccabi sick fund grew by 47%, while overall membership grew by 30%. This trend is the opposite of what took place at Maccabi prior to NHI: In 1991-1994, the number of elderly members grew by 31%, while overall membership grew by 58%. There was a similar about-face at the Meuhedet sick fund.[19] A possible explanation is that NHI made the elderly population more attractive to sick funds. Nevertheless, an analysis of sick fund marketing efforts and interviews with sick fund directors indicates that all sick funds still prefer the young.

The transition to funding by capitation did not make the chronically ill more attractive compared to healthy people of the same age. Furthermore, interviews conducted in sick funds show that due to the complete freedom of movement stipulated by the law, there is now a tendency to refrain from developing improved services for the ill so as not to attract them to the sick fund. As it is now impossible to prevent people who are ill from joining, as had been the case in the past, some sick fund directors claimed that there has since been a

18. This may have been due, in part, to the after-effects of the random assignment of the pre-NHI uninsured to various sick funds. It may be that many of these people found themselves assigned to a sick fund that did not provide services in their area, and switched soon thereafter. There was a high concentration of Arabs among the pre-NHI uninsured.

19. On the other hand, the number of elderly members at KHC in 1991-1994 rose by 10%, while overall membership remained unchanged; in 1994-1997, the number of elderly members rose by 9%, while overall membership grew by 6%.

reduction in the development of these services (Gross, forthcoming). As such, it is of interest that initial data from a 1997 CBS survey of the utilization of health services show a more even distribution of the chronically ill among sick funds than do the findings from a similar survey conducted in 1993; this is also true after neutralizing the effect of the reduction in gaps in the age structure (Rosen, 1998) in a number of areas. It is possible that grounding freedom of inter-sick fund movement in law paved the way for the transfer of substantial numbers of chronically ill members of KHC to other sick funds, even though there is no true financial incentive for the sick funds to try to attract this population.

Summary and Discussion

What is the health system like since NHI? Have the laws goals been realized? Were the concerns over NHI justified? In general, data on the functioning of the health system since NHI show that the law achieved a considerable number of its goals: to provide insurance coverage for the entire population, to ensure freedom of movement among sick funds, to change the way resources are allocated to sick funds, and to equalize per person sick fund income. The incentives embodied in the law have encouraged the sick funds to improve the level of service provided to the average member, and to develop services in the periphery and for some of the weak populations. Overall, it can be seen that the law advanced the equality of populations and regions, though gaps remain. There may have to be additional policy instruments in order to close the gaps.

From the financial perspective, concerns that NHI would lead to a rise in the national health expenditure were not realized. Since NHI was implemented, the national health expenditure's share of the GDP dropped from 8.8% in 1994 to 8.4% in both 1996 and 1997 (Israel Ministry of Health, 1998). In the wake of NHI, there was a decline in the current standardized per person expenditure in the Maccabi, Meuhedet and Leumit sick funds, with no reports by members, at least through 1997, on a decline in satisfaction or level of service. This trend could indicate streamlining. In KHC, the picture is different; indeed, one of the goals of NHI was to increase KHC's per person income to the point where it equals those of other sick funds. Accordingly, and in parallel with member reports of an increase in satisfaction and service levels, there has been a slight increase in per person expenditure.

Nevertheless, the findings indicate that, despite NHI, the system has yet to attain financial stability and is operating with an ongoing deficit. In addition, there is disagreement concerning the system's level of finance, and the updating processes leave much to government discretion, as in the past. The directives of budget arrangements bills legislated since 1996 strengthen the government's

status, as well as sick fund dependence on government decisions, especially concerning the extent of resources.

Another NHI goal was to release the Ministry of Health from having to *supply services and to strengthen its ministerial functioning.* It appears that this goal has yet to be completely fulfilled. The Ministry is still responsible for providing preventive, psychiatric and geriatric services due to second thoughts concerning the transfer of these services to sick funds. The government also remains involved in the management of government hospitals.. This continues to affect the Ministry's ability to focus on policymaking, priority setting, supervision and regulation.[20]

The Ministry of Health fulfills these functions and serves as a Ministry; the latter is crucial to the effective implementation of reform in the health system, as noted by the official Commission of Inquiry (1990, Vol. 1 and Vol. 2). In recent years there have been qualitative changes in Ministry functioning, including restructuring and the professional training of its workers. In this framework, for example, units were established for the supervision of sick funds, and for quality control, technological assessment, planning, and information gathering on the populations health. Nevertheless, the Ministry of Health has yet to unshackle itself from roles relating to the supply of services, particularly hospitalization services. Overlapping roles prevent the Ministry from properly focusing on its ministerial functions, and raise questions concerning a conflict of interest in operational decision-making for the health system.

There are a number of areas urgently requiring Ministry of Health policy and regulation, including the effective regulation of sick funds and the enforcement of established regulations. Another area concerns regulations designed to prevent unwarranted surgery and the over-development of wards in the hospital sector. In addition, it is important to establish principles for the operation of specialty services in order to prevent waste stemming from redundancy between community clinics and outpatient clinics, on the one hand, and various service providers in the same area, on the other. Finally, Ministry intervention is urgently required for the distribution of information that allows citizens to make educated decisions. For example, citizens lack information on the quality of care in sick funds and hospitals.

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20. It is important to remember that there is a difference in the extent to which the supply of various services by the Ministry of Health interferes with its ability to function as a Ministry. For example, involvement in hospital management adversely affects more than just its responsibility for mother and child services.

The reform recommended by the official Commission of Inquiry, part of which was implemented with the legislation of NHI, was the first step toward solving the problems of Israel's health system. Yet even today, four years after NHI went into effect, policymakers must cope with serious policy issues having far-reaching implications for both finance and care. The articles appearing in this issue deal with some of these issues: system funding; the mechanism for setting and updating the basket of services; the arrangement of care for nursing patients; the level of service and quality of care for the elderly, who are the primary service users; manpower planning; the organizational structure of the hospital system; and the organization of primary health services.

As is already known from experience in other countries, health system reform is a long and dynamic process of far-reaching change. One of the most important components of the process is up-to-date information that can assist policymakers to track the process of the reform's implementation and its results. The information can identify problems in implementation, as well as unwanted byproducts. On the basis of this information, the reform program can be improved and problematic components adjusted. A unique aspect of the Israeli reform is the directive whereby 0.1% of the health budget is designated for study of the law's effect, being allocated through the National Institute for Health Policy and Health Services Research. Study findings can contribute to efforts to improve the health system. As such, it is important to continue the research community's effort to focus on the latest policy issues. It is also important to strengthen its ties with policymakers so that maximum use is made of study findings in the decision-making process.

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THE FUTURE OF LONG TERM CARE IN ISRAEL

by Rachelle Kaye*

Preface

The purpose of this article is to examine the alternatives in Israel for a reasonable solution to the existing problems in the provision of adequate long-term care services for the dependent elderly population. The basis for this examination will be the cumulative experience of several European countries that have successfully implemented relatively comprehensive programs in this area such as Holland, Denmark and Germany. The article will address primarily long-term care services for the dependent elderly that are not included in the basket of services provided by the Israeli sick funds within the framework of Israel's National Health Insurance Law, i.e.:

- *Home Care* - provision of personal caregiver (non-professional) assistance with the activities of daily living in the home, such as eating, dressing, walking, etc.

- *Institutional Care* - where the emphasis is on care for dependency (i.e. functional disability) as distinguished from skilled or complex nursing care, rehabilitation, psycho-geriatric care and care for the mentally frail.

The problems in these areas are just beginning and will become increasingly severe in the coming years with the expected increase in the elderly population requiring these services.

"People in industrialized nations are living longer than ever before. In this century alone, average life expectancy from birth has increased by more than 25 years, and nearly five of those 25 years have been added to average life expectancy from base age 65. Indeed, the most rapidly growing age group comprises those aged 80 and above, and in some countries people over the age of 100 are leading the way in the rate of population growth by age. Western societies with declining birth rates are approaching the point where older

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This article is dedicated to the memory of Rafi Roter who, within the framework of his activities as Director General of the National Insurance Institute, and later on, Director General of the Maccabi Health Care Fund, contributed greatly to promoting the rights of the elderly in Israel and the development of supportive, social and health care services to meet their specific needs.

people will soon outnumber children. This unprecedented trend in population aging has profound effects on society and its institutions, such as the state of the economy, delivery and use of health services, pension systems, family life, medical research agendas, end-of-life decision making, private and public resource allocation, and living arrangements. One especially critical concern is the perceived role of population in driving up "unsustainable" health costs. (Butler, 1997, p. 1082).

According to all projections, the elderly population will comprise 20% of the world's population by the end of the first quarter of the present century. As a result, health care systems will have to cope with increasing demands for healthcare services addressing long-term chronic illnesses and the problems of aging. It will become imperative to develop new frameworks to meet the specific needs of this population. In Europe, where the population above age 65 has already reached 15% of the population, on average, policy-makers have already given these issues priority status and have begun implementing the necessary changes in their health and social service systems to cope with them.

The population in Israel, as in the rest of the world, is aging rapidly and the above age 65 population will reach 12% of the total population within the next 25 years.[1] This population utilizes a disproportionate amount of medical and health care resources, far beyond its relative size in the population. It is therefore anticipated that there will be an increasing need for specific services to address health care problems associated with aging, including institutional long-term nursing care and supportive services in the community.

Today, the Israeli Ministry of Health budgets approximately NIS 600 million for nursing home care alone (Ministry of Health, 1998), which covers partial participation in the funding of 7,500 nursing home beds from among the 12,000 nursing home beds operating in Israel (Ministry of Health, 1997).[2] Nursing home patients and their families spend another approximately NIS 600 million per year out-of-pocket (including patients who receive no Ministry of Health

1. According to figures from the Israeli Central Bureau of Statistics, in 1996 the above 65 population numbered 550,000 of which approximately 40% were above age 75. According to Ministry of Labor and Social Affairs estimates (Bar-Giora and Kerem, 1996) the above 65 population will increase to 650,000 by 2005, of which approximately 47% will be above age 75.
2. According to the State Comptroller's Report for 1998, there are approximately 11,000 nursing home beds (not including beds for the mentally frail) and in 1997, 7,145 patients were hospitalized with some level of financial participation from the Ministry of Health. Likewise, 1,772 elderly people who met the eligibility criteria of the Ministry of Health were wait-listed due to lack of funds.

funds and bear the entire financial burden by themselves). The National Insurance Institute (NII) is the major source of funding for personal homemaker services and in 1996, the NII spent NIS 760 million for 32 million hours of personal caregiver services to 66,000 dependent patients (National Insurance Institute, 1996).[3] There are no official estimates of the out-of-pocket expenditures of families for home personal caregiver services: nor for hours of care supplementary to those funded by the NII for eligible cases or care for people who do not meet NII eligibility criteria.

According to the above figures, the estimated current national expenditure in Israel for long-term care services - institutional and home care - is approximately NIS 3 billion (about 12% of the total national health care expenditure).[4]

The structure of the services in Israel for the dependent population (most of whom are elderly) is very complex. The responsibility for service provision is divided among at least four separate public or quasi-public authorities, but the major burden of responsibility still falls upon the family of the patient.

- The sick funds are responsible for medical care and rehabilitation including institutional skilled nursing care, hospitalization, and medical and rehabilitative home health care services.

- The Ministry of Health is responsible for financial assistance to low-income families for nursing-home care, including geriatric hospitalization, psychogeriatric hospitalization and institutional care for the mentally frail.

- The Ministry of Labor and Social Affairs is responsible for financial assistance to Low-income families for intermediate nursing home care (the dividing line between skilled and intermediate care is not altogether clear), home assistance for the dependent (including the employment of foreign workers, which requires, in addition, approval of the Ministry of the Interior) and other community services such as day care centers.

- The National Insurance Institute is responsible for administering the system set up by the Long-term Care Insurance Law which provides eligibility for

3. According to the State Comptroller's data, more than 70,000 elderly people receive services in their home by virtue of the Long-term Care Insurance Law (State Comptroller's Office, 1998). According to reports of those responsible for administering these funds in the NII, the expenditures for 1997 within the framework of the Long-term Care Insurance Law exceeded a billion new shekels.

4. This estimate of an expenditure of 3 billion new shekels includes a rough "guesstimate" of the private expenditure for home personal caregiver services, including foreign workers. Because there are no official data on these expenditures, it may very well be that the overall expenditure is underestimated.

personal assistance with activities of daily living in the home (albeit limited - a maximum allowance of 15 hours of personal caregiver services per week).

For those requiring care, and even for those legally eligible for such care, it is very difficult to know to which authority to turn and how to actualize their eligibility in order to obtain services. The State Comptroller, in her 1998 Report observes: "At the point of need for service or institutional assistance, the elderly and their families are faced with a perplexing multitude of different agencies: the Ministry of Health, the Ministry of Labor and Social Affairs, the National Insurance Institute, sick funds, local authorities, private and public institutions. The elderly person and his family often have no idea to whom to turn and, as a result, there are those who run back and forth among the various offices and organizations in search of the appropriate address" (State Comptroller's Office, 1998, p. 183). In addition, the eligibility criteria for the various services differ from service to service and all together provide only a partial solution for a relatively small proportion of those in need.[5]

It is possible, therefore, to conclude that the public coverage for these services leaves a great deal to be desired. The various public services provide a partial solution predominantly for the indigent or those in financial distress. The wealthy population can afford to pay for these services privately out-of-pocket. It is therefore the broad middle class that is left with virtually no solution in this area. In response primarily to the needs of this population, the sick funds have developed, in recent years, long-term care insurance programs within the framework of the complementary health insurance schemes offered to their membership. These insurance schemes offer relatively broad coverage (between 40-80% of actual expenditures for up to 5 years) in exchange for very low premiums, primarily due to the ability of the sick funds to spread the risk among a broad population base. Commercial health insurers (most of whom only started to market complementary health insurance after the implementation of the National Health Insurance Law in 1995) also offer long-term care insurance, but for the most part with more limited coverage, strict under-

5. A more complete picture of the complexity of the system of geriatric services in Israel can be found in the report of the State Commission of Inquiry on the Functioning and Efficiency of the Israeli Health Care System, 1990 (the "Netanyahu Commission"), Vol. 1, Part B, "The Geriatric System", pp. 405-430. It should be noted that since the publication of that report, matters have only gotten worse as a result of the implementation of National Health Insurance Law. If, in 1990, the sick funds provided partial funding for long-term care services (albeit ex gratia), today, as a result of financial deficits and the fact that these services are not in the basket of services they are required to provide by law, even this partial funding no longer exists.

writing, and substantially higher premiums than those of the sick funds. According to a Brookdale Institute Survey published in 1997, approximately 40% of the Israeli population is insured by the complementary health schemes of the sick funds, including long-term care insurance, whereas only about 4% of the population have purchased long-term care insurance from commercial carriers (Gross and Bramli, to be published).

With the passage of the Budget Arrangement Bill in 1998 (which contained various amendments to the National Health Insurance Law), the sick funds were prohibited from offering long-term care insurance. This has, in effect, returned the middle class to "square one" with no reasonable options in this area. It is logical to assume that with the withdrawal of the sick funds from the competition in the field of long-term care insurance, commercial insurance premiums will rise even higher and we will witness a dramatic increase in the population not insured for these risks.

This change in the Health Insurance Law was motivated in part by a fear on the part of government that the sick funds, which have been in financial deficit since the implementation of the National Health Insurance Law, will be unable to sustain sufficient actuarial reserves to maintain the financial viability of their long-term care insurance and as a result, their deficits in this area will require additional financing from the National Budget. However, in view of the fact that only 4% of the population is insured by commercial carriers, giving commercial insurance companies a monopoly in this field is more likely to create a situation where ever increasing portions of the population are not insured for this risk. This will create pressure on the public bodies responsible for these services today - the Ministry of Health and the National Insurance Institute - and there will be no alternative but to increase their budgets. If this scenario is correct, the entire financing of long-term care will fall squarely on the National Budget - in toto!

In the meantime, the expenditures of the sick funds for acute care hospitalization are likely to skyrocket as, without any ability to fund long-term care services, they will have no ability to maneuver and to move patients to a lower level of care. As a result, the length of stay of the frail elderly population in acute care hospitals is likely to increase far beyond what it is today. The occupancy rate in these hospitals will therefore increase, intensifying the overcrowding that already exists on internal medicine wards.

As a result of the projected growth of the elderly population, and particularly the dependent elderly, whose numbers have increased more than two-fold in the last two decades (Joint-Brookdale Institute, 1998), it is clear that the care for dependence will become an increasingly central issue in the

coming years, both in terms of its relative importance within the total system of health and social services as well as the relative portion of the total national expenditures which it will consume. In light of these projections, it is important to examine the options and to prepare solutions for the problems we are already facing today, so as to prevent them from becoming tomorrow's crisis!

Long-Term Care Experience in Other Selected Countries

In examining the health and welfare systems of Europe, we find a variety of different solutions to the problems of long-term care. As one might expect, each country has tailored its solution to the unique structure of its existing health and welfare system. As a rule, countries with centralized national health care systems provide long-term care services on a centralized basis, be it via the health care system or the social services system, and these services are financed by general taxation. In countries with decentralized health care systems, the care of the elderly is also decentralized and falls within the responsibility of the local authorities. Countries with social insurance systems tend to solve the problems of care for the elderly by expanding social insurance coverage in one fashion or another.

In the Netherlands, care in nursing homes is financed under a national insurance scheme and care in homes for the elderly is financed out of the national budget. In Ireland the same budget pays for health care and for old age homes but provision is poorly coordinated with the hospitals. Germany has recently implemented an additional but separate social insurance scheme for long-term care and in Denmark, the responsibility for institutional and community long-term care is devolved on the municipalities.

Home nursing is poorly developed in Belgium, Germany, France and Luxembourg where there are plans to develop it; it is virtually non-existent in Greece and low but growing in Spain, Portugal and Italy. The most extensive and dynamic service appears to be provided in Denmark (Abel-Smith et al., 1995, p. 45). Meeting the social service and health care needs of the elderly is one of the cornerstones of the Swedish welfare state and an area that continues to be given priority. The municipalities have the responsibility for social services and health care of the elderly and disabled persons, including housing, institutional nursing care, day care for the elderly as well as services within the community including home help services (Haakansson and Nordling, 1997, pp. 204-205).

There is more or less general consensus that all countries need more geriatric research, more community physicians specialized in geriatrics as well as special hospitals for geriatric patients and social security reforms which provide for a

coverage of the risk of long-term care (Schulte 1996, p. 152). There are six recurring topics that are of special concern to the policy-makers in all EU member states:

(1) The lack of integration between health and social services: In most countries the financing and operation of health and social services are separated, with different levels of government or different national ministries being in charge of the two kinds of services. There is a lack of coordination between them in addressing the needs of the client and as a rule, the criteria for eligibility are different and unsynchronized.

(2) The lack of special geriatric hospitals or of special facilities for long-term care: In many European countries there is a shortage of residential facilities for the elderly, nursing homes and geriatric hospitals. The existing institutions are expensive and there are often problems with recruiting personnel, so that many of the existing institutions suffer from manpower shortages.

(3) The inadequacy of coverage of long-term care under social security: Most of the public social security systems in Europe do not provide comprehensive cover for long-term care, be it in the community or in institutional frameworks. As a result, most of the financial burden for these services falls on the shoulders of the family.

(4) Deficits in coordination of community care services: The separation between health care and social services and the division of responsibility for the different services between local and national authorities results in a lack of coordination among the various community services such as home health care, personal caregiver services, housing assistance, and the like. Each of these is provided by a different source and according to differing criteria.

(5) The need for decentralized services that would integrate public and other forms of help. Because some of the benefits for the dependent population are provided by centralized national authorities while others are the responsibility of local authorities and yet other services are provided by private community bodies, there is no integration among the various services. No one manages the care of the patient to assure the optimum combination of central, local, public and private services.

(6) Problems of coordination between hospital and community services: Since the status of the dependent elderly tends to change rapidly and vacillates between periods of deterioration and periods of improvement, these patients tend to move frequently between their home and the acute care hospital or geriatric institutions. There is little, if any, coordination among all these. The staff that cares for the patient in the hospital is not the same as that which cares for him in the nursing home, and community care is provided by other people

altogether. As a rule there is little or no communication among the various caregivers resulting in a lack of continuity and coordination in the care of the patient.

In this article, we will survey three European systems with relatively comprehensive solutions to the problems of care for the dependent population. We will begin with the systems that function today in the Netherlands and Denmark, the former within the framework of a social insurance system and the latter within the framework of a decentralized national health care and social services system. We will conclude the survey with an examination of the thinking and decision making process which took place just recently in Germany in this area, as there is a great deal of similarity between the German and the Israeli systems and because of the not inconsiderable documentation of both the process and the rationale behind the German solution. The purpose of this survey will be to extract those elements that may be relevant for us in Israel as we examine the solutions for the above-mentioned problems implemented in the various countries.

1. The Netherlands

In the Netherlands there is a special system for long-term care insurance. The Dutch system is comprised of two levels of social insurance:

- *Level One* is a mutual social health insurance system provided through sick funds for the population (under a specified income level) obligated to insure itself in statutory insurance. This system is financed by a health care premium based on the income of the insured. A central body collects these premiums, and the funds are divided among the sick funds, partially by a risk adjusted capitation formula and partially according to actual expenditures. The population not obligated for statutory insurance voluntarily insures itself in a private health insurance company (the majority of which are non-profit organizations) for the same basket of services provided by the sick funds. This insurance, be it mandatory or voluntary, covers "regular" risks such as: physician visits, diagnostic and therapeutic services, acute care hospitalization, medications, limited coverage of dental care and medical accessories.
- *Level Two* is a national social insurance system for exceptional medical expenses and it is obligatory for the entire population regardless of income level. This system is also financed by an earmarked premium or tax based on income with an upper limit. It is administered by the same sick funds and approved health insurance companies which provide first level health insurance, however, the government finances their total expenditure and they are not at financial risk for the coverage of services. They are, in effect, strictly

implementing bodies according to rules established by the government. This insurance system covers the following long-term care services system (Hermesse, 1996, pp. 116-122):

- nursing homes
- centers for physically disabled people and housing for disabled people
- day care centers for the frail and handicapped
- day care in nursing homes
- services of home healthcare organizations
- psychiatric hospitals
- psycho-social outpatient care
- regional accommodation organizations
- non-residential psychiatric care
- psychiatric consultation and part-time psychiatric treatment
- care for blind and visually impaired people
- care for deaf people in audiology centers
- care for the mentally handicapped in residential institutions/day centers
- treatment and care in hospitals beyond the first 365 days.

It is important to emphasize that in this level two insurance (as distinguished from level one), the funds collected from the insured are not divided among the insurer by risk adjusted capitation - the insurers receive full reimbursement for their expenditures.

There are two major reasons for this:
(1) to prevent any incentive to the insurer to do "quality skimping" in order to encourage high risk patients to go elsewhere - or to take advantage of people (including and especially those requiring long-term care) who do not have the (mental) ability to make a trade-off between price and quality.
(2) the necessary data about catastrophic risks (including long-term care) for the contraction of an adequate risk adjustment formula are virtually nonexistent (Van de Vent and Schut, 1994, pp. 1469-1471).

Nursing homes play a key role in the delivery of care to the elderly for whom no acute treatment in the hospital is necessary or possible. Today, the total number of beds in nursing homes in the Netherlands approaches the total number of acute care hospital beds. Due to the growth of the psycho-geriatric part of the nursing home sector, it is to be expected that, in the future, the total bed capacity of nursing homes will exceed that of acute care hospitals. These same nursing homes provide day treatment to patients who live at home but visit the nursing home to receive care. The number of day care units is rising as they fit perfectly into the overall policy of the government to have the elderly living in their home setting as long as possible. The Exceptional Medical

Expenses Act covers the major part of the total expenses for nursing home care. Patients pay the remainder by means of income-dependent user charges for hotel costs.

The Dutch long-term care system is by no means perfect. Although the total capacity of nursing homes has significantly grown over the last two decades, there are still shortages resulting in long waiting lists. A local assessment committee measures the capabilities of the applicant for a place in a nursing home. Only the severest cases are admitted (Maarse, 1997, pp. 146-147). At the same time, priority has been placed on the accelerated development of community services, including different types of residential arrangements, home care and the like. The complementary health insurance schemes in the Netherlands provide supplementary coverage for home care but do not cover nursing home care.

2. Denmark

In Denmark, nursing home care is part of the social services system as opposed to the health care system. As a rule, nursing home care and home health services for the elderly are the responsibility of the municipalities and the local communities (which are also responsible for the delivery of health care services). The health care and social service systems in Denmark are financed predominantly by local and regional taxes.

In the 1960s and the 1970s many nursing homes were built and local governments invested heavily in manpower development to service these institutions. As a result, over 50,000 people are employed in nursing homes, equivalent to 63 staff members per 1000 people aged 65 and over (Schulte, 1996, p. 152). During the 1980s the policy changed from institutional care toward more care given in the home. In 1987 it was decided not to build any more nursing homes, and state subsidies were given to the construction of special housing for the elderly, often containing substantial assistance facilities. Likewise, funds were concentrated on increasing the number of nurses caring for patients in their own homes and the number of home-helpers. As a result the number of home health care nurses increased from 2,000 in 1975 to 7,000 in 1992. In the same period, the number of home-helpers increased from 14,000 to 32,000. In Denmark, with a total population of 5.2 million people, 15.4% are above the age of 65. It therefore follows that the ratio of home health care nurses is 1:115 people above age 65 and the ratio of home-helpers to this same population is 1:25.

The majority of communities have established 24-hour domiciliary care where the handicapped and the infirm that live in their own homes can call for

help at any time. Practically all communities also provide meals on wheels. Day centers with varying services such as hobbies or rehabilitation programs are available in most communities. Parents who care for their seriously ill children and relatives who care for dying patients are entitled to reimbursement by the local community for lost earnings.

Institutions for the physically handicapped are available as part of the social security system, which is also responsible for institutions for the elderly, day care centers, general social services and so forth. These are organized and run by the social and health authorities of the municipalities, and governed by municipal political social committees. Geriatric departments for rehabilitation of elderly hospital patients have now been established in several counties as part of the public hospital system (Krasnick and Vallgarda, 1997, pp. 39-40).

3. Germany

There is particular relevance for Israel to the processes and recent changes in the German system for providing long-term care services because of the strong similarity between the German and Israeli health care systems. The German health care system, like the Israeli system, is a social insurance system that operates within the framework of a national health insurance law. The health care premium/tax is calculated as a percentage of income and the sick funds are responsible for the provision of health care services. There are, however, significant differences between the two systems. For example, in Germany the sick funds continue to collect the health care premium directly from their members, even within the framework of the national health insurance law. The employers continue to pay their portion of the premium, unlike the situation in Israel. With the cancellation of the parallel tax that constituted the employers' participation in the health care premium, the employer in Israel has been absolved of any responsibility for the financing of health insurance for his employees. In addition, the German population above a specified income level is not obligated to purchase statutory insurance, although the majority joins a sick fund voluntarily.

Until recently, the policy regarding long-term care in Germany was similar to that which exists today in Israel. The care for dependence was considered a private risk. If the need for long-term care led to financial hardship, income-tested welfare benefits were provided by social assistance. These benefits were means-tested and granted to cover the costs arising in long-term care including financial assistance in the cost for home help, home visits by professional nurses, and, if the person in need of long-term care reached a certain level of disability, nursing home care. There were tax exemptions for long-term care

and care periods provided by private caregivers could be credited in the framework of the invalidity and old-age pension insurance to a certain extent (Schulte, 1996, p. 161).

Despite the above-mentioned provision, there was no comprehensive social protection against the risk of need for long-term care in Germany until 1995. For a period of about 10 years there was a public debate in Germany with regard to long-term care policy. As in other European countries, basically three alternative models were discussed:

(1) The "*market solution*" which would make all citizens beyond a certain age liable to insure themselves and their dependents privately against the new risk (following, for instance, the model of private but compulsory insurance against car accidents).

(2) The "*transfer model*" would introduce a tax-financed long-term care allowance following the general model of housing of child benefit schemes.

(3) The "*social insurance model*" is based on the idea of a contributory benefit scheme which would either be organized by a special scheme or affiliated with an already existing sickness, invalidity or old age insurance scheme (Schulte, 1996, p. 153).

The conclusion of the discussions and debates in Germany over the course of a decade was as follows: "As the transition from an acute care illness to dependence is frequently a gradual process which requires a flexible integration of medical assistance, nursing rehabilitation measures and social services - only an integrated coverage of both risks under the common roof of health insurance or a coordination of health insurance and care insurance guarantees that frail persons in need of care receive continuous services without becoming the victims of lack of coordination and controversies between various financing Agencies." (Schulte, 1996, p. 153).

Each of the alternative models was examined against the backdrop of this conclusion:

(1) The *market solution* was found to be inappropriate for the following reasons:

(a) Private insurance premiums are actuarial premiums and, as a rule, are too expensive. Because of this it is unlikely that the entire population would be able to afford it.

(b) As the transition from acute illness to dependence is gradual, most of the dependent population requires medical services and supportive care simultaneously. There seemed to be no logic in creating a system that deliberately creates a structural dichotomy between the two services.

(c) There would be no overall responsibility for the insured person who would

be likely to "fall between the cracks" between the sick funds and the insurance companies, enabling each of them to shirk its obligations by claiming that the other is responsible.

(2) The *transfer model* was also discarded in light of the fact that the welfare system is not equipped to provide services in kind but rather a cash benefit. Those in need of the system would receive money and would have to seek out the appropriate services by themselves without the necessary know-how to make the appropriate choices. In addition, they would need to coordinate among all of the various services and caregivers by themselves.

(3) The *social insurance model* appeared to best meet the requirements of a system which would be capable of providing services to an increasing proportion of the population suffering from multiple illnesses as well as dependence upon care, because of its very nature. Contributory benefit schemes or social insurance is comprised of two essential elements: On the one hand there is risk spreading which is typical of insurance, and on the other hand there is a social component. It is this second element which distinguishes social insurance from private insurance, social insurance being characterized by the fact that, within this system, there is a spreading of risk and a social equalization, independent of individual needs, among the insured. In contrast to private insurance premiums, social contributions are not set according to the typified (average) risk of the insured individual, but are rather calculated according to social criteria by means of a redistribution mechanism, i.e. they are set according to the income of the insured.

The primary task of social insurance is to protect the insured against situations of individual need, e.g. against the consequences of illness, invalidity or old age. It has an additional function which is to protect the state against any liability to grant social benefits simply because the individual has failed to make any appropriate provision against the risk concerned. This protection function is intimately connected with the principle of equality, because those citizens who make adequate provision by themselves are subjected to a double burden if they have to pay both insurance contributions to support themselves and taxes to support others. The distinguishing feature of social insurance is therefore that it is, in most cases *compulsory* in order to keep the number of persons who have to rely on social assistance financed from general taxation as small as possible; and in order to take into consideration the ability to pay of the insured person with the consequence that the better off pay higher contributions than do those who earn less. Compulsory social insurance can thus be used to make sure that a risk sharing and some sort of redistribution for social purposes takes place (Schulte, 1996, pp. 155-157).

Therefore, Germany decided that from January 1, 1995, the risk of long-term care will be safeguarded within the framework of a statutory social long-term care insurance scheme administered and in the control of the same sick funds responsible for coverage of illness within the framework of the statutory health insurance system. All persons who live in Germany are legally obliged to enter the statutory long-term care insurance scheme, regardless of income level. Persons who are not subject to statutory health insurance may be released from this obligation provided they prove that they are covered by a private long-term care insurance which offers benefits of a nature and extent which are essentially comparable to those of the statutory long-term care insurance scheme.

The provision of benefits in this scheme are governed by two main principles:
(1) prevention and rehabilitation come before nursing;
(2) home care comes before institutional care.

Persons entitled to claim benefits are those who require help in performing the regular day-to-day activities. The need for long-term-care is divided into three categories, the degree and frequency of care required being the primordial criterion for the assignment of a person in need of care to one of these categories.

The new law is centered on the improvement of the conditions for home care and includes a nursing cash benefit for home care, graded in accordance with the severity of need for long-term-care. If the nursing benefit is inadequate to ensure an appropriate degree of home care, basic nursing and domestic care are provided by the sick funds as benefits in kind.

If home care cannot be adequately guaranteed, there is a possibility of part-time institutional care by day or night, or of admittance to a short-term nursing institution. If institutional care is necessary, the long-term care insurance scheme pays up to DM 2800, in exceptional cases 3300, per month towards the nursing-related costs. The costs for accommodation and meals are borne by the insured, as would be the case with home-care.

The long-term care insurance scheme is financed through the contributions of the insured persons and their employers. The contribution rate is 1.7% of the income of the insured. The new scheme is intended to be a suitable solution for the majority of the population. The very poor who are unable to afford even the co-payments (at home or in the nursing home) will be eligible for additional social assistance within the framework of the welfare system (Schulte, 1996, pp. 161-163).

The German long-term care insurance system was implemented in two phases: the home care benefit was implemented in 1995 and the institutional benefit was implemented in 1996.

Table 1. Comparison between the Systems in the Netherlands, Denmark and Germany According to Selected Parameters

Parameters	The Netherlands	Denmark	Germany
Integration between the care for illness and the care for dependence	Sick funds or insurers who provide basic medical insurance also provide care for exceptional medical expenses including long-term care to their beneficiaries.	The municipalities are responsible for the provision of medical as well as social services including long-term care.	The same sick funds responsible for statutory health insurance are responsible for statutory social insurance for long-term care.
Equity in access for the entire population according to functional status without regard to financial ability	The entire population is covered by insurance for Exceptional Medical Expenses and eligible for covered services. Only co-payment for nursing-home care is determined according to family's ability to pay.	The entire population is covered for long-term care services - both institutional and in the community.	The entire population is covered by statutory long-term care insurance and is eligible for benefits according to functional status according to ability to perform activities of daily living.
Priority for care in community	The explicit declared and implemented policy is to strengthen and expand home care and day care services for the elderly.	Explicit policy in favor of home care expressed practically by the ratio between the number of home nurses and home helpers to the elderly population and other support services in the community.	Explicit policy-provision of home care is always given first priority. Sick funds also provided supplementary services in the home in order to prevent institutionalization.
Incentives for keeping the dependent in the community	Yes, there is a financial incentive. The same body is responsible for financing both institutional and community services.	Yes, the same authority is responsible for financing long-term care services in the community and in institutions.	Yes, the sick funds finance all of the services, both in institutions and in the community.
Defined and earmarked funding for long-term care	Yes, within the framework of the Exceptional Medical Expenses Act. Citizens pay an earmarked premium according to income.	Yes, within the framework of local taxes the municipalities are authorized to collect from all of their residents.	Yes, within the framework of statutory long-term care insurance. The premium is 1.7% of income of all residents.
Single address for coordination and financing of all long-term care services	Yes, sick funds and private insurers who provide basic medical insurance.	Yes, the municipalities.	Yes, the sick funds.

As can be seen from the comparison in Table 1, the three countries reviewed here have all implemented systems which integrate the care for illness with the care for dependence, institutional care and home care under one roof with defined and earmarked financing for both. In this way, these countries have succeeded in overcoming the fragmentation in the care of the dependent as well as to strengthen the services provided for an ever-increasing elderly population.

Analysis of the Options for Israel

On the basis of the experience of the countries we have reviewed, what are the alternatives available to us in Israel and what is the optimal and most appropriate approach for our specific system? From the review of the experience in other countries, it is clear that there is not one single ideal solution, as the solution in every country has to be tailored to its specific circumstances and in particular to its existing systems. For example, the Danish solution is appropriate for a decentralized national system; however, it would not be appropriate for Germany or the Netherlands, with their systems of statutory social insurance provided through sick funds. What can be learned from Denmark is how to implement the policy decision to give priority to community services over institutionalization. On the other hand, the solutions in the Netherlands and Germany are very similar: in each of them there is an additional, separate and specific statutory social insurance for long-term care operated and controlled by the sick funds.

As previously mentioned, today in Israel services for the dependent elderly population are fragmented and provided mainly by 4 different agencies: Health care services (including medical services in the community, acute care hospitalization, skilled nursing home care, rehabilitation and medically-oriented home health care) are provided by the sick funds; personal caregiver services in the home (home helpers or foreign workers) are partially funded by the National Insurance Institute or the Ministry of Labor and Social Affairs or both; nursing home care is partially financed by the Ministry of Health; social services and other community services are the responsibility of the Ministry of Labor and Social Affairs.

Which model is most appropriate for Israel - the market solution, the transfer model or the social insurance model? And which of the agencies already involved in the provision of services to the elderly is the most appropriate body to coordinate long-term care services?

According to the review of the experience in other countries and taking into account the current division of functions in the care for the elderly among the

various authorities in Israel, it would seem that there are seven possible alternatives, as follows:

Alternatives A and B - the market solution: In these alternatives, the population would purchase long-term care insurance - either on a mandatory basis or voluntarily, in order to cover the risk of dependence. At this time, it is possible to purchase long-term care insurance voluntarily from two major sources: commercial insurers (*Alternative A*) or the sick funds (*Alternative B*) who offer this insurance either via an affiliated organization or by collective agreement with an insurance company. The results of the Brookdale Institute survey show that the long-term care insurance offered by the sick funds is more popular. Almost 50% of the Israeli population are insured in the schemes of the sick funds whereas commercial carriers insure only 4%. The reasons for this are explained by the research done by Gross and Bramli (1997).

The sick funds are non-profit organizations, experienced in the delivery of health care, directly or via contracts with health care providers and they have easy and direct access to their members. Their actual expenditures are significantly lower and therefore they have been able to offer insurance with broad benefits, low premiums, minimal marketing costs and minimal underwriting (i.e. rejection of bad risks or restrictions due to age or health status). This is true both for sick funds who have collective arrangements with insurance companies as well as for those who offer long-term care insurance through an affiliated organization.

The advantage of programs offered through organizations other than insurance companies is that the insurance is lifelong insurance and not limited in time like an insurance contract. Commercial insurance companies are for-profit organizations which apply strict underwriting criteria (such as age, health status, etc. to protect themselves from potentially "bad risks"), and the insurance policy is an insurance contract for relatively limited time periods, at the end of which the insurer may change the term of the contract. This insurance, be it offered by insurance companies or sick funds, is currently voluntary and is purchased according to the wishes and means of the insured. If it were to be decided to make it mandatory for the entire population to insure itself, it is difficult to visualize how this could be enforced via commercial insurance companies.

On the other hand, mandatory long-term care insurance in a health fund would be relatively simple to enforce. The major advantage of long-term care insurance via a commercial health insurance company is that it is portable, whereas there is a problem with continuity of health fund insurance should the insured decide to transfer sick funds. In addition, insurance companies are

required to show significant actuarial reserves, although in fact, they almost uniformly purchase reinsurance to cover their risks.

It would certainly be possible, by the same token, to require that the sick funds purchase reinsurance if this is felt to be necessary to assure the financial stability of their long-term care insurance.

For all of the above reasons, the more appropriate function of commercial insurers in long-term care would be voluntary complementary insurance whose purpose is to supplement a public basket of services - "luxury insurance" for the well-to-do. To the extent that long-term care insurance is perceived as a public obligation, it is more appropriate to relegate the task to a communal body.

Alternative C: The Transfer Model: In this model there would be a "long-term care allowance" similar to like allowances that exist today, such as child allowances, old-age pensions and so on. It would be possible to finance such an allowance from general taxes and to relegate the granting of the allowance to any government body. In accordance with what is customary in Israel, the natural way to do this would be to place the responsibility upon the National Insurance Institute that handles other allowances of this sort today. This would undoubtedly require an increase in social security taxes paid by the self-employed, the employed and their employers. It would be possible to provide this allowance to all people above a certain age, or only to those who need long-term care services according to an assessment of functional level. It would also be possible to limit the allowance to people below a given income level or to provide the allowance to the entire dependent population regardless of financial status. The dependent person would be free to choose his long-term care provider whether it be in the community or an institution. The disadvantages of this model are as follows:

(1) The dependent person or his family will receive a monthly cash allowance. There is no way to guarantee that it will be spent on long-term care services for the benefit of the dependent person.

(2) If indeed the money is used to purchase long-term care services, it will be the responsibility of the family to choose the service providers by themselves without the requisite knowledge and abilities to evaluate the level and quality of the services.

(3) The long-term care services will be totally unrelated and uncoordinated with the entire spectrum of medical and social services required by the dependent person.

Alternatives D, E, G: Social Insurance through one of the following: the Ministry

of Health, the National Insurance Institute, the Ministry of Labor and Social Affairs, or the sick funds.

The essence of social insurance has been explained at length in this article. This is the system chosen by the State of Israel in the area of health care with the National Health Insurance Law. Likewise, all of the benefits of the National Insurance Institute are provided within a social insurance framework, including the benefit for personal caregiver services in the home. The advantage to the provision of long-term care insurance as statutory social insurance is obvious. Long-term care insurance, like health insurance, will become a legislated right that the State guarantees for all of its citizens, with a defined source of financing and defined benefits. Theoretically, such insurance could be administered by any public agency with some relevance to the subject - that is the Ministry of Health or of Labor and Social Affairs, the National Insurance Institute or the sick funds.

There appears to be broad public consensus (both in Israel and abroad) that the function of government ministries is to set policy, to plan, supervise, regulate and accredit and that it is therefore desirable - even if only to prevent conflicts of interests - that they not be direct providers of services or even directly responsible for the provision of services though contracts with other providers. It follows, then that the administration of social insurance by either the Ministry of Health or the Ministry of Labor and Social Affairs is not the preferable solution. Therefore, a more feasible option would be social insurance within the framework of the National Insurance Institute, which is already responsible for personal caregiver service in the home (albeit according to a financial means test). It would be possible, for example, to expand the existing Long-term Care Insurance Law to include nursing home care, to eliminate the financial means test and to provide benefits for the entire population according to functional status.

Likewise, it would be at least equally feasible to empower the sick funds to administer statutory long-term care insurance. Institutional geriatric care, including nursing homes, already appears in the third appendix to the National Health Insurance Law, and the intention of the legislators was clearly to transfer this responsibility from the Ministry of Health to the sick funds. It would be fairly simple to add to these personal caregiver services in the home and to transfer the funds from the National Insurance Institute for this benefit to the sick funds. It is obvious that if the entire population is to be eligible for long-term care based on functional status alone (eliminating any financial means test), *additional sources of funding will be required* above and beyond those currently available to the Ministry of Health for geriatric hospitalization

and to the National Insurance Institute for personal caregiver services in the home.

All of the above alternatives can be differentiated according to social philosophy in regards to long-term care insurance as well as the varying incentives for the development of long-term care services for the dependent population. The alternatives can be systematically examined in terms of their advantages and disadvantages according to criteria derived from the review of the different systems operating in other countries in the first part of this article as well as additional criteria important to policy makers in Israel.

(1) Integration and unification of the entire spectrum of services required to meet the needs of the dependent population: As previously mentioned, the transition from an acute illness to dependence is frequently a gradual process and this population generally requires, simultaneously, both medical services and supportive services. Coordination and continuity among the various services make it much easier for the dependent person as well as assuring provision of the appropriate services according to his changing needs over time. As the sick funds in Israel are responsible for the provision of medical services for the treatment of illness, they have a distinct advantage according to this criterion.

(2) Giving top priority to care in the community: This principle is practically axiomatic in all Western countries. In all of the European countries surveyed as well as the United States and Canada, there is broad consensus that care for the dependent elderly in their natural environment within the community is preferable to institionalization - both in terms of quality of life as well as from an economic point of view. Commercial insurance companies have neither interest nor capability to determine the framework within which services are to be rendered. A commercial insurance policy provides reimbursement for services or a cash benefit, in accordance with the terms of the insurance contract. Likewise, the *transfer model* that would provide a long-term care allowance has no means for encouraging the provision of care in a given framework. On the face of it, government ministries or the National Insurance Institute, within the framework of statutory social insurance, could establish criteria for the provision of institutional long-term care which would require exhausting all of the possibilities for care in the community first. The sick funds, which actively manage the care provided to their members, are capable of directly giving priority to care in the community and already do so today.

(3) Incentives to assure sufficient numbers of long-term care service providers: All of the alternatives are likely to encourage the supply of long-term services as a result of the injunction of additional funds into the system for this purpose. We have only to recall the mushrooming of competing personal caregiver

agencies immediately following the implementation of the Long-term Care Insurance Law in the 1980s.

(4) One address for the coordination and funding of long-term care services so that those in need of services do not become victims of lack of coordination and controversies between various funding agencies. This issue is closely related to the first criterion, "integration of the entire spectrum of services". In Israel today, as previously noted, there is no single address. Consequently, the dependent elderly often remain hospitalized in acute care hospitals for extended periods of time, at the expense of the sick funds, waiting for approval for a nursing home bed from the Ministry of Health or while their eligibility for personal caregiver services at home is being processed by the National Insurance Institute. Transferring the responsibility for institutional long-term care from the Ministry of Health to the National Insurance Institute would provide for greater integration of the services for dependence; however, there is still a great danger that the dependent and chronically ill elderly will fall "between the cracks" between the sick funds and the NII as a result of their need - simultaneously - for acute medical care and dependence care. Therefore, so long as the sick funds are responsible by Law for the provision of health and medical care services, the only way to assure a "single address" for the coordination and funding of medical and dependence care is to place the responsibility in the hands of the sick funds.

(5) Equity of access to long-term care insurance: In the market solution, long-term care insurance through commercial insurance companies will be available according to insurance principles alone. According to these principles, the health status and the potential risk of need for services of each individual, plus a profit margin for the insurance company determine the level of the premium. Thus, there will be inequitable access for different population groups in accordance with their economical ability to purchase such insurance, as the premiums are likely to be relatively high. Long-term care offered by the sick funds (within the framework of their supplementary health insurance schemes) is considerably less expensive, for reasons cited earlier, making the sick funds a more preferable alternative, so long as the purchase of insurance remains voluntary. Mandatory long-term care insurance provided by the sick funds could assure equity of access to such insurance. The *transfer model*, in which there would be a long-term care allowance, will be equitable only if eligibility for the allowance is not conditional on a financial means test, but on functional status alone. We can assume that all of the alternatives within the *social insurance model* will be equitable.

(6) Equity in the standard of care provided: In every health care system in which

it is possible to purchase private insurance, people with higher income are able to receive a higher standard of care in the private sector. Therefore provision of long-term care insurance by commercial insurance companies will provide access to high standard long-term care only to that portion of the population which can afford to purchase the insurance. It should be noted, however, that all health insurance policies stipulate, unequivocally, that the insurance company has *no responsibility for the quality of care*, even if rendered by health care providers under contract with the insurance company. Provision of "private" long-term care insurance by the sick funds will broaden its affordability (regardless of whether the sick fund provides such insurance by itself, through an affiliated organization or via a collective agreement with an insurance company), while continuing to assure broad benefits in exchange for lower premiums. The *transfer model* is not likely to have any influence on the standard of care. All of the statutory social insurance options should assure, to some extent, equity in service level by providing equal benefits for long-term care services based exclusively on objective functional assessment. Even today, the National Insurance Institute has established standards for accrediting home care agencies that are permitted to provide services within the framework of the Long-term Care Insurance Law. Likewise, providers of services who wish to contract with sick funds are obliged to meet criteria for acceptable professional standards of care, efficiency, timeliness and accessibility.

(7) Actual cost: The real or actual cost of the insurance in toto will be influenced by the ability of the responsible body to manage the care of the patient and to coordinate the entire spectrum of services he requires, so that he receives the level of care most appropriate to his needs. For example, a person requiring nursing home care will not continue to be hospitalized for an extended period unjustifiably in an acute care hospital if it is possible to transfer him efficiently to a nursing home. Likewise, a person who can be discharged to the community will not have to remain in the hospital or the nursing home if supportive services in his home can be efficiently organized. The cost of a unit of care, whether it be an institutional or community service of any kind, will be a function of the ability of the responsible organization to utilize his power as a large purchaser to negotiate the most reasonable price for the most comprehensive service. In this area, the sick funds, within the framework of social insurance, have an advantage over the other alternatives, and particularly if they will be required to provide the services in kind.

(8) Portability between sick funds: In the second alternative within the *Market solution*, wherein the sick funds are permitted to offer long-term care insurance on a voluntary basis within the framework of their supplementary insurance

programs, there is a problem with the continuity of the insurance should the insured choose to transfer to another sick fund. This problem does not exist in the option of long-term care insurance offered by insurance companies or in any other of the alternative.

(9) Integration between local initiatives and centrally-administered, nationwide programs: Today there are many supportive services in the community which are the responsibility of local authorities and it is to be hoped that these will increase in number and in scope as the elderly dependent population grows. One of the important functions of the body responsible for provision of long-term care services nationwide will be to coordinate and integrate their services with these local community services. The extent to which the responsible organization is decentralized in structure, with local branches dispersed throughout the country, will be a factor in its ability to coordinate and integrate services at the local level. Although there are regional offices throughout the country of the Ministries of Health and Labor and Social Affairs, as well as the National Insurance Institute, these do not compare in number or geographical distribution to the local branches and clinics of the sick funds. Therefore the sick funds have an advantage over the others in this area as well.

(10) Public Supervision: All of the alternatives we have been discussing operate under some sort of public supervision, although the public supervision of health insurance companies is pretty well limited to the fairness of the policy and their financial capacity to provide the insurance. In all of the other options, the bodies in question are all public bodies per se and function, by definition, under public supervision.

The analysis of the seven alternatives according to the criteria presented above reveals that all of the options have pros and cons. The relative pros and cons of each of the alternatives are summarized in Table 2.

Conclusion

One can conclude, according to what has been presented here, that the optimal solution is statutory social insurance through the sick funds:

- The sick funds already bear the responsibility for providing health care services to the entire population (including the population in need of long-term care) within the framework of the National Health Insurance Law.
- Within the framework of the sick funds, the dependent population will have one address - both for their medical and health care needs as well as their need for long-term care, be it at home or in an institution.
- The sick funds have the most extensive experience in managing contract with

Table 2: Pros and Cons of the Seven Alternatives According to Criteria Presented in the Article

Criteria	Market Solution		Transfer Model	Social Insurance			
	Insurance company	Sick funds		Ministry of Health	National Insurance Institute	Ministry of Labor and Social affairs	Sick funds
1. Integration of full spectrum of services	-	+-	-	-	-	-	+-
2. Prioritization of community care	-	+	-	-	+-	+-	+
3. Incentives for suppliers of services	+	+	+	+	+	+	+
4. One address for funding of all services	-	+	-	-	-	-	+
5. Equity in access to insurance	-	+-	+	+	+	+	+
6. Equity in standard and level of care	-	+	-	+-	+-	+-	+
7. Real Cost	-	+	+	+-	+-	+-	+
8. Portability between sick funds	+	-	+	+	+	+	+
9. Integration between local and national services	-	+	-	+	+	+	+
10. Public supervision	+-	+	+	+	+	+	+

- Negative influence on criteria.
+ Positive influence on criteria.

service providers and they will be able to provide the services through preferred providers that meet their criteria for quality and efficiency.

- Since the sick funds will have to assure provision of these services to their entire membership, they will have the advantage of being a large purchaser in their negotiations on prices for long-term care services, which will assure the provision of high quality services at lower cost.

- The sick funds will have the ability to maneuver between acute care hospitalization, institutional long-term care and home care which will enable them to develop the most suitable solution for each patient and to prevent inappropriate acute care hospitalization.

- All of the sick funds have a decentralized structure, with numerous local branches and clinics throughout the country. They will therefore be in a position to bring about integration between their services and local initiatives and services.

Today, in the absence of a formal statutory social insurance for long-term care, the sick funds are compelled in any case to provide many long-term care services, despite the fact that they are not included in the basket of services they are obligated to provide by law. They simply cannot ignore their overall responsibility toward their members. They cannot cast an elderly patient, who is medically ready for hospital discharge, onto the street simply because his authorization for nursing home care from the Ministry of Health has not yet come through or because his eligibility for a home helper has not yet been processed by the National Insurance Institute. The expenditures for these services contribute today to the increasing financial deficits of the sick funds. According to the projected growth of the dependent elderly population, these problems will simply be exacerbated as time goes on. The Long-term Care Insurance Law administered by the NII is in deficit; there is a waiting list for Ministry of Health funding for nursing home beds every year, all of which bear witness to serious budgetary distress in these areas. To add insult to injury, the granting of a monopoly for long-term care insurance to the commercial insurance companies (as was done in the Budget Arrangement Act of 1998) has limited access to this insurance to the wealthy. It is imperative that Israel address these issues now in order to develop a reasonable solution for the entire population, so that the elderly citizens of Israel may live out their last years in dignity and with the highest possible quality of life.

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INTEGRATION OF SERVICES FOR THE ELDERLY: A PROPOSED MODEL

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Introduction

For the older person in the community, health, cognitive status, functional independence, social support and economic resources interlock closely and determine the ability to maintain a satisfactory life style. The medical factors in this balance play a decisive role and require specialized care. Older people often suffer from several concomitant diseases that exacerbate each other, magnify each other's impact and complicate therapy. The competing influence of multiple illnesses also masks the presentation of each, leading to atypical symptoms and confusion in diagnosis and prognosis. Although a geriatric disease is often chronic, only the timely provision of acute care can prevent the development of chronic disability. Sub-acute care is critical to shepherd the older patient back to independence and full activity. Diseases prevalent among the aged, particularly dementing illnesses and those limiting mobility or sensory acuity, constitute a direct assault on self-sufficiency. Only an approach that recognizes the social consequences of each medical decision can prevent the progression from infirmity to functional deterioration to dependence and, ultimately, to institutional care.

Conversely, several distinctive risk factors characterize the social climate of the aged and in turn affect health. As children establish their own families and homes, the nuclear family disperses, in this era sometimes over more than one continent. Cessation of employment can also lead to social isolation for the elderly, eroding self-confidence and breaking links of mutual encouragement and assistance. In extreme instances, isolation is closely associated with depression, increasing morbidity and need for medical care (Stessman et al., 1996a). Besides diminishing social contact, retirement often leads to increased financial exigency. In 1997 16% of Israeli families lived below the poverty line

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but among those older than 65 the proportion was 23% (National Insurance Institute of Israel, 1998). Economic hardship reinforces the negative health factors already detailed while poverty may even compromise nutritional status and the ability to secure adequate care.

These reciprocal influences of health and social forces are recognized in the multiplicity and variety of services available to the elderly to maintain health and independent living at home. Despite wide differences in the nature of these services, the site of their performance and the different providers and specialties involved, they share a common purpose, the continued success of the recipient to lead a satisfying life at home. These programs serve not only to fulfill the nation's obligation to its most veteran citizens but ultimately, through the prevention of hospitalization and residence in institutions, they intend to reduce the overall cost of support.

The utility of these medical, nursing and domiciliary services, provided at all stages of illness and distress, must by measured equally by the dual standards of succor and cost efficiency. Uniform techniques to evaluate these services can be used to judge how they can best complement each other and how limited resources can best be distributed among them. The recent development of sophisticated assessment tools (Hawes, 1997) provides the basis needed for informed decisions about these programs and the technical feasibility of significantly integrating them.

A brief overview of the variety of assistance programs available to the elderly in Israel affords a valuable insight into the advantages and difficulties in raising the level of cooperation between these efforts.

Acute Medical Care and Hospitalization

Older persons require relatively greater utilization of medical facilities. In Israel although those over age 65 constitute only 10% of the population, they represent 35% of hospital patients and 40% of inpatient hospital days (Brookdale Institute-Joint Distribution Committee, 1998), including 64% of hospital days in internal medicine departments, 50% in intensive care units and 39% in surgical departments. Among the older old the disparity is even greater; citizens over 75 constitute only 4% of the population but 17.5% of inpatients (ibid.). Hospitalizations for older patients are longer but even so one third of all people admitted to the hospital are over 65, more than three times their representation in the population (ibid.). Older persons tend to concentrate in urban areas and so do their acute medical needs. In the country's central regions the elderly are responsible for 40-50% of hospital admissions.

Despite being clearly indispensable and productive, hospitalization always

bring risks, which are greatly magnified with the increasing age of the patient (Gorbien et al., 1992). Commonly heretofore stable, chronic conditions acutely deteriorate in the hospital environment. A frequent example of this phenomenon is the delirium or acute confusion that sometimes follows surgery or accompanies an acute infection or the exacerbation of heart disease. Similarly, patients hospitalized for strokes commonly suffer secondary infections of the urinary and respiratory tracts. For these reasons, efforts to prevent or shorten the stay of an older patient in the hospital are particularly beneficial.

Geriatric Emergency Room

Older patients, more fearful that illness may be life threatening and possessed of less physiological reserves if care is delayed for even a few hours, are particularly likely to turn to the emergency room for acute care. Despite this increased utilization, or perhaps because of it, the elderly do not find an especially receptive environment in the general emergency ward. Often their care is delayed by the arrival of younger, more overtly urgent cases such as trauma victims. Furthermore, the presenting symptoms of geriatric disease, such as diminished responsiveness or debility, are not widely recognized as reflecting acute disease. For these reasons, some emergency rooms have created special geriatric divisions (Maaravi et al., 1999) to triage older patients more quickly, assess the unique manifestations of their illnesses and expedite treatment tailored to their needs, whether in the general hospital, special geriatric departments, institutions or home.

Sub-acute Geriatric Care

Special departments devoted to functional as well as medical recuperation and emphasizing excellent nursing care and mobilization can treat older hospital patients in the latter stages of their hospitalization more effectively and at lower cost than general hospitals. In order to benefit from sub-acute care, patients must have passed the initial phases of diagnosis and stabilization but often the medical care in these departments is still very demanding and very active. Sub-acute care is generally based on good bedside care for patients who do not need highly technical procedures but still require close follow up. Under meticulous supervision and cautious pacing, patients are encouraged to return to their pre-morbid life style. Because of the lower level of technical support, sub-acute departments provide care at 40% of the cost of general hospitals. The joint emphasis on physiology and activities of daily living helps older patients not only get home but also manage well there. Recently sub-acute care has gained

recognition throughout the world as an efficient and humane advance in care, but in Jerusalem this model has been active for fifteen years.

Geriatric Rehabilitation

Just as geriatric acute and sub-acute medicine provide care in an atmosphere that recognizes the needs of older patients, geriatric rehabilitation stresses those issues most germane to this population and fashions therapy to meet its special challenges. Geriatric rehabilitation also acknowledges the distinct pace of care among the elderly. When necessary, the need to extend hospitalization is recognized. Conversely, when the rate of improvement is exceedingly slow, more rapid discharge to care in the appropriately prepared home, in a sub-acute care setting or, if no alternative is available, to institutional living, is arranged.

The experience of rehabilitation in the home has been particularly rewarding for the elderly. When adequate temporary personal care can be established, rehabilitation at home has the dual advantages of encouraging the patient in a familiar environment and of solving directly the problems that arise from the patient's needs at home. Home rehabilitation can take place in the home itself or in a day rehabilitation unit with a transportation service.

Home Hospitalization

Just as the home becomes an element in the treatment plan when rehabilitation is provided there, it can also serve the particular demands of the older patient and his family in the treatment of other medical problems. At a stage of therapy similar to that at which sub-acute departments are advantageous, many patients can complete their medical care at home if reliable and frequent medical and nursing attention is available in the form of home visits and telephone consultations. This is the underlying principle of the Jerusalem Home Hospitalization Program, which has flourished since 1991 (Stessman et al., 1996b) and now numbers over 400 patients at any given time. By enabling patients to leave the hospital sooner, the program has more than offset the cost of intensive care at home. Such care depends on family members who must provide considerable care for the patient. Alternatively, it eliminates the burden of traveling to the hospital and staying at the patient's bedside and provides the invaluable comfort of an immediately accessible doctor or nurse personally familiar with and to the patients. Patients and families have expressed near unanimous satisfaction with home hospital care.

Institutional Residence

The need for a patient to leave the community and receive institutional care signals the failure of geriatric therapy and rehabilitation to preserve function from the onslaught of disease. Patients requiring care in these areas suffer from the effects of illness but their need is defined as custodial rather than medical because of the determination that medical treatment can no longer reverse their disability. The recognition of the patient's need for full time assistance, whether in the more sophisticated, instrumental activities of daily living, or in more personal and basic functions is critical, even life saving. However, the decision to institutionalize is often irreversible. As such, it requires comprehensive medical evaluation and careful analysis. The systematic assessment of the need for an older patient to enter an institution has not always commanded medicine's full armamentarium and a clear commitment to this challenge is required now.

Frail Elderly

For individuals who can no longer manage their own homes, whether due to physical or milder cognitive limitations, but who are generally competent in the sphere of personal care, the Ministry of Labor and Social Affairs provides residences with a minimum of direct, personal care. Such people generally require assistance in instrumental activities of daily living, such as meal preparation, cleaning and administration of medications, but only minimal help in personal care. When family or friends are unable to provide the required support, they turn to such residences for the frail elderly. The Ministry of Labor and Social Affairs and the local municipal authority share in funding such care.

The Ministry has been in the forefront of developing, funding and overseeing such institutions. In 1965 it established the legislative basis for governmental support through the Law for the Supervision of Institutional Residences, 1965, which formulates the standard of care as well as the mechanisms to assure that adequate care is provided in these homes. The central weakness in this concept has been the understanding of frailty as a social phenomenon without exploring its possible medical, cognitive and psychological causes. Without a deeper understanding of the factors that lead to frailty, no attempt can be made to reverse them or even to anticipate their progression. The recognition of the special needs of the frail and the efforts to meet these needs is an outstanding accomplishment, but further development requires more precise delineation of this condition within the continuum from self-reliance to total dependence.

Skilled Nursing Care

Skilled nursing care provides the most basic personal care: hygiene, continence, eating, transfers, locomotion, and protection from potentially dangerous behavior. In Israel the Joint Distribution Committee undertook the initial development of these services through a network of institutions called "Malben". Subsequently, supervision and regulation of all skilled nursing facilities has become the purview of the Ministry of Health through its Division of Chronic Diseases and Geriatrics. Exactly as its title implies, this division, responsible for control of chronic diseases such as tuberculosis, as well as for the geriatric population, has regarded its mandate as the oversight of the care of patients suffering chronic morbidity. Initially, nurses were primarily responsible for this division and they followed established guidelines which were not always scientifically up to date. Only in the last two decades has this Ministry of Health administration of this division been attended by a critical awareness of the dynamics of geriatric care. This period has witnessed a proliferation of facilities (both public and private, profit and not for profit) devoted to skilled nursing care as well as governmental and nonprofit geriatric hospitals. Much progress has been made in establishing an orderly structure for this wide variety of institutions and in setting a tone of quality control and even in formulating explicit guidelines for skilled nursing care (Ministry of Health, 1994), but much remains to be done to guarantee a uniform, high standard of care.

Complex Skilled Nursing

Faced with the burgeoning cost of geriatric nursing care, the Ministry of Health has attempted to share this burden with other funding sources in health care. The natural partners in this field are the four sick funds, which provide prepaid health care to all citizens and which, since the introduction of National Health Insurance in January 1995, are funded by health insurance premiums as well as government funds. Initially the largest of the sick funds, Clalit, insuring over two thirds of the population over age 65, established its own geriatric hospitals with departments for the long term care of aged patients with particularly complicated medical conditions. Eventually a compromise was made regarding chronic care: the sick funds were not responsible for "maintenance" care of chronic patients unless their condition was active or "complex". Conversely, the Ministry of Health agreed to provide financial assistance to the elderly requiring care although primary responsibility remained with the family. Government assistance was available according to a means test of the patient and family. This agreement, named "Habot-Porat" after those who negotiated

it, established, in principle, the first recognition of chronic nursing care as an element of guaranteed health care. Consistent budget shortfalls, however, have prevented implementation of this right. In the 1995 National Health Insurance Law, complex nursing care achieved formal recognition as part of the health care package though this recognition has not yet been fully implemented.

The Habot-Porat agreement (Habot, 1991) created a new patient category, the complex nursing patient, defined by any one of five criteria: (1) axial or sufficiently voluminous decubitus ulcer, (2) feeding by nasogastric tube, as opposed to gastrostomy or jejunostomy tubes which do not confer complex nursing status, (3) requirement of constant oxygen therapy, (4) oncologic disease that is responsible for the dependence on nursing care, (5) requirement of constant physician availability. Only the last of these criteria has been shown to be associated with increased cost or intensity of skilled nursing care and the others remain contestable. Indeed, nursing patients with active medical problems such as recurrent infections, congestive heart failure or metabolic instability are generally more complex and demanding than those currently defined as such. The composition and administration of complex nursing departments are still in flux and require methodical, evidence-based refinement.

The Law for Community Long-term Care Insurance (CLTCI)

This farsighted law, implemented in 1988, had, from its inception, the innovative goal of providing personal care in the home and so preventing or delaying institutional care.

Within a year this law funded a tremendous increase in home-based services to the elderly, and today serves 86,000 older, disabled patients. This aid is generally provided not in the form of a direct cash payment but rather as hours of help in the home from a caregiver sent through a professional agency. Alternatively, for a small minority of recipients, the law offsets the cost of day care centers, emergency call devices, absorbent garments for the incontinent or other necessities. In 1999 the National Insurance Institute (NII) is expected to spend NIS 1.4 billion funding this entitlement, covering 11% of the elderly (men over age 65 and women over 60). The law also determines that 30% of annual collections under this insurance program be allocated to the Ministry of Labor and Social Affairs and the Ministry of Health toward beds for the institutional care of the elderly. The Institute is currently reassessing this law, its implementation and goals, in order to utilize funds in the most effective manner.

Cost and Financing of Services

In reviewing the development of health services to the elderly, it is critical to

appreciate the magnitude and sources of their budget. Table 1 displays estimated public expenditures on care to the elderly derived from the Ministry of Labor and Social affairs, the Ministry of Health, the National Insurance Institute, the four sick funds and out of pocket expenditures by older patients and their families. The contribution made by patients and families is generally commensurate with their means. The table includes over one billion shekels annually paid privately for live-in, usually foreign, aides and institutional residence. It does not include payments by privately purchased nursing care or complementary health insurance, offered by the sick funds and private insurers to supplement the basic services provided by the National Health Insurance. To these expenses must also be added the not insignificant cost accrued in rehabilitation and other general hospital departments while older patients await transfer to chronic care beds. The total annual cost of maintenance care for the disabled elderly reaches NIS 4.3 billion. Adding the cost of acute hospital care for patients over age 65, 40% of overall hospital expenses or NIS 5.5 billion, yields the total outlay for health care for the elderly in Israel 1999, NIS 9.8 billion.

Assessment of the national health budget in Israel frequently fails to include the considerable outlays for equipment and services critical to home-based nursing and custodial care. Thus these figures consistently underestimate the true cost of health care and its fraction of the Gross National Product. This inaccuracy is especially important when drawing comparisons to other countries, such as the United States, where home care costs are included in health cost statistics.

As staggering as medical costs are, it is important to appreciate the unique role of Community Long-term Care Insurance (CLTCI) in the chronic care

Table 1. Annual National Expenditures for Long Term Services - 1999 Estimates
(NIS Millions)

	Cost to the public sector	Private sources	Total expense
Community Long-term Care Insurance (NII)	1,600	-	1,600
Frail Elderly	130	130	260
Skilled Nursing Department	785	215	1,000
Complex Nursing	450	50	500
Live-in Caregivers	-	470	470
Private Nursing Care	-	500	500
Total	2,965	1,365	4,330

Note: Does not include private complementary health or care insurance.

component. The health care budget is regulated by law, which mandates the payments made to the four sick funds according to enrollment. Hospital expenditures are also fixed through a capping formula. As a social insurance program, benefits paid to the elderly under the CLTCI, on the other hand, are not predetermined by law, not constrained by a fixed budget and permit a more flexible response to the needs of dependent, older recipients living at home.

Coordination or Unification of Services to the Elderly

The way in which health services to the elderly have developed in Israel has fragmented responsibility and financing among several social and medical bodies. As a consequence, patients often must simultaneously seek assistance from the local welfare bureau, the social security offices, the district nursing division of the Ministry of Health and their sick funds. Only a small minority of physicians or nurses is familiar with the maze of responsibilities, regulations and requirements governing these separate bodies. Even the staffs of the various offices do not comprehend the benefits and criteria of their counterparts. This tangle of overlapping bureaucracies quickly frustrates families and patients, wastes their time in repetitive applications and delays the timely provision of crucial services. Although the voluntary and charitable institutions devoted to the elderly, such as Yad Sarah and Yad le Kashish among dozens of others, provide invaluable and generous aid, their contributions are not often aligned with government assistance and sometimes remain sadly untapped because of ignorance or confusion.

Recently a number of proposals to synchronize or merge these diverse agencies have been raised. Knesset (Israeli parliament) Member, David Tal, currently chairman of the Parliamentary Committee on Labor and Social Affairs, has suggested establishing a national agency to manage issues relating to older citizens and coordinate relevant services. Despite its potential advantages, however, such an office would be an additional bureaucratic layer draining scarce resources, isolating recipients from decision-makers and further lengthening the route to practical change. A central authority with direct responsibility for all services provided to the elderly (Kaye, 1999), on the other hand, could institute change and coordinate efforts nationwide. This solution, precisely because of its far-reaching impact and despite its clear utility, would face formidable political and administrative opposition. Logistically it would be prohibitively difficult to create a single budget from sources in the Ministries of Health and of Labor and Social Affairs, the National Insurance Institute and the sick funds without new legislation. Perhaps such a law is feasible but more immediate steps are required.

A Proposal to Integrate Services

In our experience, the many professionals called to the aid of the elderly - physicians, nurses, social workers, physiotherapists, occupational therapists and speech therapists - although referred from different sources and representing a variety of professional approaches, have no difficulty finding common language and methodology. The Law for Community Long-term Care Insurance itself is the best example of the potential for cooperation, being implemented by local committees comprised of a municipal social worker, nurses from the sick funds and a representative of the NII.

We propose to expand this level of cooperation from the field to management and from the local to the national level. The first consequence of this cooperation will be geographic. No longer will anxious children or frail spouses have to navigate frantically among the many offices that regulate services to the elderly. Instead, the local Ministry of Health office, municipal welfare bureau, NII committees, sick fund administration and continuing care units will share a common site, a single entry point.

A refinement of this improvement will be the adoption of a unitary form to apply for services and a uniform assessment instrument. This will spare families the onus of repeatedly transmitting the same information and ensure that all bodies base their decisions on complete and uniform data.

As agencies gain experience working together, sharing assessments and becoming aware of the full spectrum of available assistance, a unified evaluation tool or scale of need can develop. Through such a scale, recommendations can be given for residence in the home or an institution, with full cognizance of the resources in each setting, including hours of personal care from the NII, day care in the municipal respite center or home hospitalization from the sick fund. Referrals to institutional living will draw from the knowledge of all sectors in determining the appropriate type of long-term care arrangement.

In parallel to this integrated assessment of the consumer of services, a single process used by all agencies to assess family and personal resources for private funding will avoid duplication and produce a fairer judgment as to the requisite level of public support. Finally, joint staff meetings and improved communication between the different services can be used to further improve care and its effectiveness.

Critical to the acceptability of this proposed juxtaposition of authorities and the integration of the database is the preservation of the full authority of each participating body. Sharing the fruits of each of the office's efforts among all the participating agencies will yield operational savings but far greater are the

potential savings from increased home care and diminished reliance on institutional care. Of course, older beneficiaries will agree to remain at home only so long as the provision of home-care is prompt, thorough, appropriate to needs and comprehensive, including contributions from all the professionals involved in this enterprise. The Jerusalem Home Hospitalization program has demonstrated the ability to care for older patients at home, even during crises or in the presence of complex problems. Home care requires that patients and families know that, when needed, there will be timely referral for more intensive care, whether in nursing facilities, geriatric hospitals or emergency wards (Stessman et al., 1997). Again, the cooperation between the various funding and service authorities in this realm is an integral part of that commitment.

Current Programs of Comprehensive Home Care

A program integrating all phases of care is certainly ambitious and the anticipation that augmented home services will prevent hospitalizations and forestall institutionalization may seem optimistic. There are, however, limited programs extant which support these expectations. Locally the Jerusalem Home Hospitalization program has demonstrated that acute medical care in the home can safely reduce hospital utilization and satisfy patients and families. Similar, smaller programs have reported success in Italy (Cella et al., 1999), and the United States, (Leff et al., 1999).

Operating at selected sites in the United States since 1986, the Program for All-Inclusive Care for the Elderly (PACE) funds comprehensive support in the home, including personal care, to prevent entrance to a nursing home (Bodenheimer, 1999). Currently PACE maintains twenty-four sites across the country serving 6,000 frail, indigent elderly. PACE receives funds from Medicare and, because its participants have exhausted their own financial resources and therefore qualify for welfare, Medicaid. Services are specifically tailored to each participant by a multi-disciplinary team and can be far-reaching, even including 24 hour live in care. Cost comparisons to similar patients receiving standard American medical care estimated savings of 38% in the first six months after enlistment in PACE and 16% in the subsequent six months. Medicaid payments were 85-95% of those generally made to such a population. These results, admittedly in a select and tiny sample, suggest the potential financial gains of strengthening the home network. The personal and social gains are, of course, immeasurably greater.

Evaluating Change: The Resident Assessment Instrument

Critical to any initiative is the ability to judge its impact. In 1987, as part of

sweeping and controversial efforts to reduce its geriatric medical spending, the United States government mandated a system of data collection that would monitor the results of these measures. Initially conceived as an exhaustive profile of nursing home residents, this Minimum Data Set (MDS) grew into a family of survey instruments, each applicable to a different phase of geriatric care. (Hawes, 1997). The settings for which MDS instruments are available now include acute care, post-acute care, home care, assisted-living and mental health. These interlocking systems of resident assessment instruments (RAI) have now been translated into several languages and have been validated under the most stringent criteria. The RAI reliably tabulates a myriad of variables, under diverse circumstances and in numerous countries. RAI collects data on social support, economic resources, health, functional independence, cognitive integrity, emotional status and required support. Follow-up use of the RAI indicates the outcome of intervention.

The MDS 2.0 for nursing home residents and MDS-HC for evaluating recipients of home care have been translated into Hebrew. These tools now provide the means to identify trends in the well-being of Israel's aging population, compare its status to similar groups around the world, separately follow subgroups stratified by several criteria and judge the impact of specific policies and initiatives.

Investigative Trial of Integrated Long-term Services

Since the attempt to coordinate services provided by several professional and government regulated bodies is nearly unprecedented, we propose beginning a model program in two communities while maintaining the current system in the remainder of the country. In trial sites, the MDS instruments will measure the adequacy, efficiency, and social impact of as well as public satisfaction with integrated services and the use of ancillary services, such as hospitalization rates, physician visits and prescription costs. The estimated duration for such a trial is two years. The project steering committee should include representatives of all participating organizations as well as researchers from the Brookdale Institute and other centers of geriatric and social research. If this trial proves the efficacy and economy of integrating services, nationwide implementation would follow shortly. Ideally, the resulting improvements in care, convenience and cost effectiveness will stimulate the transfer of authority for all long term care, including institutions, to a single entity, such as the sick funds.

Good care in the community pays its own way by reducing hospital and institutional costs. Social services complement medical care to prevent morbidity and enhance quality of life. This common purpose unites all service

professions and is the basis for focusing their efforts, integrating their resources and, in the end, magnifying their accomplishments.

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PERSONAL SOCIAL SERVICES IN ISRAEL: MAIN ISSUES AND DILEMMAS

By Joseph Katan*

Introduction

Personal social services are one of the main levels of social service that a welfare state provides, along with education, health, income maintenance, employment, and housing.

The personal services meet the needs and treat the problems of individuals, families, groups, and communities that find it impossible or difficult to cope with various hardships that severely limit their functioning and life quality and impede their social integration.

The population groups whose needs and problems are treated by these services include children at risk, teenagers in distress, battered women, families in crisis, the disabled, the mentally retarded, recent immigrants who have difficulties in adjustment, released prisoners, the elderly, disabled and retarded persons in states of disability and distress, and substance abusers.

The various service organizations that deliver personal welfare services provide these population groups with a wide variety of types of aid: counseling; treatment; information; mediation; instruction at the personal, family, and group levels; and material assistance. They also develop and raise resources for a range of community and institutional services such as institutions, clubs, and day centers for the elderly; centers and community housing for the retarded and the disabled; shelters for girls in distress and battered women; day and afternoon settings for children; rehabilitation centers for the disabled; family counseling centers; and alcohol and drug detoxification facilities.

This article explores several problems and dilemmas that face the personal social services and that affect their structure and patterns of activity.

The article is divided into two main parts. The first part describes several main characteristics of these services and indicates how these characteristics may affect their performance. The second part examines several main issues in the structure and functioning of these services that must be resolved if the

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services are to meet their goals and consolidate their profile. In the summary, the article presents several ideas and proposals concerning the directions in which the personal social services ought to head.

Main Characteristics of the Personal Social Services

The personal social services have several main characteristics that strongly affect their structure and patterns of activity.

1. Involvement in a Wide Range of Needs and Problems

As stated, the personal social services engage in a wide range of needs and problems of individuals and population groups. Many of these needs and problems are not constant; they change continually as a consequence of various economic, social, and demographic changes, e.g., unemployment levels; the pace, composition, and origins of immigration; and population aging. Occasionally the services encounter new needs to which they had been oblivious or inattentive.

The range, intensity, and mutability of the needs and problems present the personal social services with continual challenges and pressures that they must address. This makes it difficult to draw up a list of types of problems and needs that fall within the ambit of these services and that fall outside this ambit; it is also difficult to position the problems and needs on a scale of priorities that would dictate defined and clear patterns of resource allocation and development of various programs and activities. It is especially important to establish a clear scale of priorities at a time when the personal social services are called upon to devise and formulate transparent patterns of activity.

2. Concern for Weak and Vulnerable Population Groups

Unlike other social services - such as income-maintenance benefits for various population groups to which most citizens of Israel belong, education services that serve all children and youth, and health services that most of the population uses - the personal social services are meant for special population groups such as the disabled and the retarded, children at risk, the disabled elderly, teenagers in personal and social distress, battered women, and families in crisis. Many (but not all) of these population groups are marginal in terms of social, economic, and political status; some of them also suffer from stigma and its social and personal repercussions.

Thus, the targets of the personal social services are the weakest and most vulnerable links in Israeli society. The principal challenge facing these services is to establish a meaningful relationship with the population groups in need, to

serve them in a manner that corresponds to their needs, and to extricate them from their hardships. This preoccupation with weak population groups may diminish the status of the personal social services and make the government less willing to keep them adequately funded. Indeed, various indicators show that the personal social services are in dire financial distress.

3. Limited Consumer Involvement

One of the characteristic developments in Israeli society in recent years is an upturn in the involvement of consumers in determining the policies and the modus operandi of social-service providers. This trend is reflected in various fields, such as growing parental involvement in schools, establishment of a national organization of health-service consumers, organizational action by residents of urban neighborhoods, and various actions taken by families in housing distress (Churchman, 1988; Deri, 1994; Evrani and Shapira, 1997). These developments correspond to the trend of consumer empowerment that allows social-service users to influence the services' patterns of activity not only as individuals who thus express their personal needs, but also as groups and organizations that represent the interests of population groups that have shared needs (Sadan, 1997).

This development has not been strongly manifested in the personal social services; consumers of these services have not organized vigorously to affect the services' activity. What is more, these population groups have not benefited greatly from the activity of political lobbies that have operated on their behalf. Therefore, most of the personal social services have not yet had to face the challenge of heightened consumer involvement.

4. Varied Involvement of National- and Local-Level Organizations

Central government plays a very dominant role in funding the personal social services, and the financial resources it earmarks for these services do much to dictate their scope and patterns of activity. In contrast, central government's role in direct delivery of these services to population groups in need is partial (Eisenstadt, 1996; Katan, 1996). Several additional players operate very intensively in this arena: municipal welfare departments, nonprofit organizations (NPOs), private businesses, employers, and informal support systems composed mainly of self-help groups and family networks. These organizations and systems are active mainly in delivering personal social services and partly in helping to fund them. The process of partial privatization, reflected in transfer of responsibility for delivering various social services to nongovernmental

organizations (NGOs), has also been spreading in recent years (Doron, 1994; Gal, 1994; Katan, 1997).

Thus, the arena in which the personal social services operate reflects the processes that have been transforming the complexion and activity patterns of the welfare state in recent years - a slow decline in the extent of central-government involvement, a slight increase in the power of local government, and privatization processes that have been giving NPOs, private businesses, and informal support systems, national and local, a larger role to play. Thus, the personal social services are marked by a trend toward considerable organizaÙ tional diversification and the creation of a mixed economy, in which many national and local players take part.

This situation has created much ambiguity and raises a series of questions about the trajectory that the personal social services are following: Are they heading for accelerated privatization, or will government organizations continue to play a central role? What division of labor will the various national and local organizations work out among each other? Will the proliferation and the different types of organizations confuse consumers? What effect will this situation have on the scope and quality of service that consumers receive?

5. Incomplete Legal Infrastructure

The personal social services rest on an infrastructure made up of a very broad set of statutes. Various laws dictate the services that must be offered to different population groups and determine the form of service to be rendered. The roster of statutes includes the Welfare Services Law, 1958; the Youth (Care and Supervision) Law, 1960; the Legal Fitness and Custody Law, 1962; the Protection of Wards Law, 1966; the Welfare (Care of the Mentally Retarded) Law, 1969; the Prevention of Abuse of Minors and Helpless Persons Law, 1989; the Prevention of Family Violence Law, 1991, and the Long-term Care Insurance Law, 1996, to name only a few. The list includes laws (such as the Long-term Care Insurance Law), that require the relevant authorities to provide consumers with a basket of special services, and laws that order these authorities to protect various population groups at risk (Shnit, 1988; 1996).

Although social legislation has been developing and the issues and needs covered by the laws have been expanding, the infrastructure still fails to respond to several major needs. The question to explore in this context is whether it would be better to expand the scope of social legislation to cover all or most of the personal social services or to leave some of these matters unanchored in binding legislation.

6. Difficulties in Reporting, Measuring, and Evaluating Outcomes
The wide variety of intervention methods used in the personal social services makes it difficult and complicated to measure and evaluate the results. The proliferation of intervention methods stems from various factors, such as the variety of population groups and their needs; workers' knowledge and experience; the quality of the vocational training given; the working patterns of the organizations at issue, and the legal requirements that staff must meet. It is true that, in recent years, professionals in the personal services have become increasingly aware of the need to direct their intervention toward the attainment of clear and defined goals and to evaluate the extent to which these goals have been attained. However, many of the difficulties in reporting, measurement, and evaluation remain unsurmounted. This situation hinders the service providers in evaluating and reporting the results of their work, noting achievements, and proving that the inputs they have been given (financial resources, human resources, facilities, etc.) are paying off. In the current era of accountability, the difficulty in pointing clearly to the outputs and results of the personal social services may weaken the services, render them less able to endure public criticism, and make it harder for them to deflect allegations frequently expressed in the environment of personal social-service organizations, such as the accusation of failure to provide appropriate responses to various needs and of having encouraged the formation or perpetuation of various problems. The critics infer from these charges that an effort to downscale the vast resource allocations for the social services should be made. Therefore, the personal social services still seem challenged to demonstrate the results of their activity and their effect on the life quality of their targeted population groups.

7. Activity in a Change-Intensive Environment
The personal social services, like other social services, operate in a stormy and uncertain environment typified by economic, ideological, political, and technological changes that are affecting their structure and patterns of activity (Schmid and Hasenfeld, 1993). These changes are manifested, among other things, in zero growth or reductions in central-government allocations, privatization processes, and the introduction of market economy elements in the social-service arena. To operate in such an environment, the service providers have to adjust in various ways. An unsuccessful adjustment may be severely detrimental to their functioning and, at times, to their survivability.

Therefore, the system of personal social services has several main characteristics that affect its modus operandi in the present and the possibilities

of its development in the future: involvement with various kinds of weak and vulnerable population groups, the presence of numerous organizations under different types of ownership at the national and local levels, reference to a very wide variety of human and social needs, inadequate consumer involvement, a proliferation of intervention methods, difficulty in measuring and evaluating the results, and activity in an environment of turbulence and frequent change.

These characteristics bring up several major issues and dilemmas in respect to these services' policies, organizational structure, and activity patterns. The typical traits of the personal social-service arena - wide organizational diversity and intensive involvement of national and local organizations - have focused attention on issues such as the nature of relations between central and local government and the extent of privatization in this field. The small scale of consumer involvement raises questions about the quality of the services rendered. The chief preoccupation of the personal social services with weak population groups makes one ask whether these services should be universal or selective. The incomplete nature of the services' legislative anchor prompts debates over the desired extent of legislation in this field. The next part of this article discusses some of these issues.

Main Issues and Dilemmas in the Activities of the Personal Social Services

Three of the aforementioned issues - matters of concern to policymakers, service providers, professionals, and others involved in shaping the image of the personal social-service system in Israel - discussed below:

(1) How much centralization or decentralization should there be in the personal social services? Should central government retain far-reaching powers, or might it be best to give local communities more responsibility and autonomy?

(2) Should the scope of the social legislation that forms the binding, normative infrastructure of the personal social services be expanded, or should the intention to expand it be resisted and reversed?

(3) Should the privatization processes in the services be expedited or inhibited?

The following discussion of these issues is based on a review of the relevant literature and examination of various discussions of the relevant topics.

1. Centralization or Decentralization in the Personal Social Services

This issue pertains mainly to the division of labor between central and local government, as well as additional community players, in the allocation of personal social services.

Today, local authorities, by means of the welfare departments that each authority operates, are the main providers of personal social services for

various groups in need. NPOs and private businesses are also involved in the direct provision of services. Most funding comes from the central government, by means of earmarked participation from the Ministry of Labor and Social Affairs in local welfare budgets. Most authorities also receive grants from the Ministry of the Interior to fund various operations, including social services (Deri, 1994).

The central government's earmarked participation is supposed to cover 75 percent of local authorities' social-service budgets; the authorities are expected to fund the remainder from their own resources and from the Ministry of the Interior's grant. This grant is not uniform; it is allocated more generously to localities in development areas. The government claims that its allocations to local authorities are determined on the basis of uniform, constant criteria that pertain to each locality's economic, social, and demographic traits. The local social-service budget is not global; it comes with a detailed distribution by main items and sub-items.

Local authorities are not allowed to deviate from the budget lines and may not transfer money from one line to another. Authorities that overspend their budgets in respect to any line must make up the shortfall from their own sources. Several years ago, an attempt was made to introduce flexible budgets in some local authorities; the participating welfare departments were given a lump sum that they could use in accordance with priorities that they chose for themselves. The attempt failed in most of the participating authorities (Deri, 1994).

Central-government participation in the local budget is tendered in monthly installments. Local authorities' financial activities are monitored by inspectors at the district offices of the Ministry of Labor and Social Affairs and at the ministry's head office.

This method of budgeting and monitoring gives the central government a great degree of control over the social-service activities of local authorities, especially in fields that are budgeted by the state. However, local authorities may allocate additional financial resources to social services by drawing on their own funds and making use of other sources. Indeed, the rate of local participation in social-service budgets exceeds the stipulated 25 percent and has been growing in the past few years from roughly 38 percent in 1980 to some 44 percent in the early 1990s. Notably, however, the local participation rate in social-service budgets varies among localities and in different years (Katan, Yanai and Sherer, 1996).

Central government derives its vast influence on the activities of local welfare departments not only from its principal role as funding agent but also from its

function in implementing and applying the social laws that determine the activity patterns that the relevant authorities must invoke in specific fields, such as protection of children at risk and prevention of family violence. While local authorities usually discharge the duties stipulated in these laws, it is the central government that appoints the officials who wield the authority to implement the laws (welfare officers) and that inspects their operations (Shnit, 1996).

One of the laws that directs the activities of local welfare departments is the Welfare Services Law, 1958, which instructs every local authority to establish a welfare bureau to assist those in need. This law is noncommittal about clients' entitlements, the specific services they should receive, and how the costs of the services should be covered. These lacunae are partly filled by instructions from the Director-General of the Ministry of Labor and Social Affairs to local welfare departments. These instructions give specific, detailed expression of the ministry's policies, guidelines, and requirements with respect to the structure and function of local departments and their staff, and with respect to the services that they are to provide. Many professional and administrative decisions made and implemented at the local level are actually based on these regulations.

Therefore, the division of labor between central and local government is such that local authorities provide a broad spectrum of services for population groups in need but lack full control over the contours of these services and most of the resources needed for delivery. In contrast, the central government is responsible for most resource allocations and determines most of the local welfare departments' professional and administrative operating methods - without being responsible for the provision of service.

The implications of this complex division of labor for the extent and quality of services rendered have not been examined systematically thus far. However, a review of various data and talks with senior social-service officials, at the national and local levels, point to several initial conclusions:

1. There is a serious lack of clarity in relations between central and local government. On the one hand, the central government occasionally states its intention to give local authorities greater autonomy and power but rarely follows up with concrete measures. On the other hand, local authorities and other community players that attempt to express their autonomy by developing particularistic community programs often face difficulties when they wish to marshal the central-government support that the programs require.

2. Government officials claim that their support of local welfare budgets is based on uniform criteria that aim to create equitable resource allocation and prevent the emergence of unjustified disparities among localities. It seems,

however, that additional factors take part in determining the level of this support, such as political and professional relations among local and central-government players, local initiatives that attract central-government support, local pressure on the central government, and allocation patterns that have jelled over the years (Weiss, Rosewitz and Schnitzer, 1993; Deri, 1994; Katan, Yanai and Sherer, 1996). These factors have had the effect of creating disparities, very large in some cases, in the level of central-government funding for social-service budgets of different localities and, consequently, in the level and quality of service that different localities offer their populations. Thus, the centralization trends that have typified the personal social services have not prevented the formation of large inequalities in central-government allocations for different localities' social-service budgets and in the level of services the localities offer.

(3) The disparities among local social-service budgets are actually widening because local authorities provide different levels of participation in funding these budgets. The disparities in local participation may be traced to various factors, such as local leaders' social-service policies, the authorities' economic potential and fund raising ability, and the status, influence, and entrepreneurial abilities of local social-service departments and other local players (Katan, Yanai and Sherer, 1996; Katan, 1997).

Thus, the current arrangements in the division of labor between central and local government in regard to personal social services, as described above, are burdened with problems that affect the performance of the local welfare departments and therefore require attention.

One of the main questions arising from the foregoing discussion is whether this division of labor should be modified in some way. Should greater centralization be preferred - allowing central government to be the main player not only in funding and supervision but also in the delivery of services - or might it be best to reinforce decentralization and localism trends and give local authorities more autonomy and responsibility in directing the personal social services that they provide to their residents?

Those who have an interest in substantively bolstering the decentralization trend by giving local authorities (including their welfare departments) greater independence, cite several main arguments to justify their stance (Deri, 1994; Doron, 1994; Kaspi, 1994; Ben-Ilya and Knaani, 1996; Katan, Yanai and Sherer, 1996):

(1) Local autonomy reflects the communitarian idea, which regards the local community as the most appropriate setting for an adequate response to its residents' needs.

(2) Local autonomy gives appropriate and practical expression to the fact that many local authorities are already shouldering much of the burden of their social-service expenditure.
(3) The local welfare department, due to its location, experience, and proximity to the population, should be well acquainted with the population's needs and particular and diverse conditions. Accordingly, it can create a local social-service policy, establish organizational structures, develop services, and determine the priorities and the modus operandi that will meet these needs in the most appropriate way.
(4) Over the years, many local social-service departments and other local organizations have developed a talented professional leadership of stature as well as skilled staffs that are both capable of and interested in assuming responsibility for the development of local services on an appropriate level and quality. Such officials and staffs do not need the tutelage, control, and custodianship of central-government officials who are sometimes out of touch with local realities and unaware of each locality's unique problems.
(5) The autonomization of local professionals and administrators may allow them to display flexibility, enterprise, and creativity in developing programs and intervention methods that correspond to changing local needs, and may let them modify activities and programs in accordance with changes in the locality and its population's needs. Large, centralized organizations such as central government typically lack this capacity for flexibility and change.
(6) The encouragement of local enterprise that local autonomy animates may permit a higher level and scope of social services than the central government requires.
(7) Reducing local authorities' dependency on central government in social-service affairs may encourage these authorities to take greater responsibility and make more efficient use of the resources available to them.
(8) Autonomy may allow local departments to develop more easily strong cooperative relations with other community entities (volunteer organizations, businesses, informal support systems, etc.) and to induce them to pledge their financial and human resources to the development of social-service programs. In this sense, autonomy may help reinforce and encourage the components that make up civic society at the local level.
(9) Greater empowerment of local departments may inspire clients to become more involved in devising local social services and, thereby, may help attain the goal of consumer involvement and empowerment.

Thus, the decentralization trend rests on two foundations: value-centric considerations of reinforcing the local community and making it more

responsive to its members' needs, and pragmatic organizational considerations associated with the desired nature of the activity of local social-service agents. This trend is also consistent with political and ideological processes in Israel that are diminishing the strength of central government and reinforcing the local orientation as manifested in the direct election of mayors, local primaries for Knesset candidates, and various privatization processes. Similar processes are occurring in other Western countries.

Those who favor the continuation of intensive and extensive involvement of central government also cite several arguments to justify the centralization approach (Doron, 1994; Ben-Ilya, 1996; Ben-Ilya and Knaani, 1996; Katan, Yanai and Sherer, 1996):

(1) Central-government involvement makes it possible to make national policy and apply national standards in social services; it also assures a large degree of equality and territorial uniformity in the allocation of essential social services for population groups that require these services and live in different localities. If local authorities are free to determine the nature and extent of the social services they provide, regional disparities in the level of services that different population groups receive may take shape, and in some cases the allocation of services to powerless groups that cannot express their needs and exert their influence on the performance of social-service agents may be endangered. The assumption underlying this argument is that the willingness of influential local players to pledge sufficient resources to the social services cannot be assured. In several localities, for example, there is evidence of opposition among influential local players to the development of services for special population groups or ethnocultural groups such as immigrants from Ethiopia. Thus, decentralization of social services may rule out an allocation of services that corresponds to national standards of level and of services (e.g., in care for children at risk and in services for the elderly). It may also result in different levels of services for individuals with similar vital needs due to their place of residence.

(2) Extensive involvement of central government assures the continuation of state responsibility for the funding of personal social services and prevents the tasking of these services to local authorities that, in many cases, are economically weak and perforce dependent on extensive central-government support. Thus, a local orientation that vitiates state responsibility for personal social services may become an impediment to weak localities whose populations have multiple needs.

(3) A strong central influence may facilitate the development of regional-level services run jointly by several localities. In contrast, an emphasis on autonomy will prompt localities to develop their own services even when the small

population of consumers makes this cost-ineffective. In many cases, too, small localities have established their own services and handed the funding responsibility to the central government.

(4) Large-scale involvement of central government may reinforce local social-service departments vis-a-vis local agents that wish to reduce social expenditure in favor of expenditure for other purposes.

The arguments of the local autonomy advocates assume that large-scale decentralization may encourage community responsibility, allow local capabilities to find adequate expression, enhance sensitivity to the local population's diverse needs, and promote local enterprise. Those who reject this approach cite the possible price of attaining these goals: erosion of the state's commitment to its citizens and the vitiation of its ability to make and implement an inclusive social policy and enforce national standards in respect to personal social services; the creation of inequalities in services available to inhabitants of different localities; and underallocation of services for special population groups. Furthermore, to maximize the benefits of decentralization, the local personal social services must be run and directed by local politicians and professionals who are strongly committed to the provision of adequate services for population groups in need. Reality shows, that the fulfillment of this condition is not assured in many localities.

Thus, the controversy over the division of labor and functions between social and local government is very complex; it touches upon issues of substance and principle that rest at the focal point of current debates over the image of the Israeli welfare state and the role of local social services. To make the necessary changes in the structure and activities of the personal social services, it is vastly important to resolve this controversy by redividing powers and functions between central and local government in respect to these services and their interrelations.

2. Anchoring of Personal Social Services in Legislation

The number of social laws that guide the patterns of activity of the personal social services and their professional staff has been growing over the years. These laws span a wide range of fields, such as home-care services for disabled elderly who cannot perform various activities of daily living without assistance, care for children at risk, aid for battered women, care of the mentally retarded and the disabled, protection of residents of hostels, and care for teenagers at risk.

Notwithstanding the breadth of needs and problems that these laws address, many aspects of personal social services still lack a legal infrastructure. They

include home care for seniors who have been found ineligible for service under the Long-term Care Insurance Law, arrangements for the mentally retarded in institutions, various additional kinds of assistance for persons in need (transport for medical care, basic furnishings, housing renovations, and so on), care for drug addicts and alcoholics, and community work in disadvantaged neighborhoods, to name only a few.

Many of the needs not covered by legislation are probably no less crucial and urgent than those to which the laws presumably respond. Notably, too, the laws that guide the activities of the personal social services (apart from the Long-term Care Insurance Law) are protective statutes that stipulate assistance for those in need (children at risk, battered women, etc.), but do not spell out the specific services to which these population groups are entitled (Shnit, 1996).

The question of expanding the legislation to include additional types of needs, and to demarcate the compulsory basket of services to which citizens in need are entitled, is a major issue that preoccupies various government officials and professionals. These agents are divided among those who favor the expansion of social legislation to create a generous rubric of personal social services that would assure a response to a wide variety of needs, and those who express concern about this expansion and believe in avoiding the passage and implementation of new laws - insofar as this is possible - and in making an attempt to downscale the scope and incidence of existing statutes.

The support of broader legislation and the development of a basket of personal services anchored in law rests on three major arguments (Doron and Yanai, 1994; Korazim, 1995; Gal, 1996):

First, social legislation in the personal services, as in other fields, is the most obvious way to assure the provision of crucial services for individuals in need on a uniform and equal basis, irrespective of place of residence and sociocultural affiliation. In the absence of an adequate legislative infrastructure, the provision of these services depends on various national and local conditions that may not be present, e.g., availability of resources, political support, administrative and professional decisions, and consumer pressure. Anyone who wishes to allocate services to needy population groups in a regular, stable, and equitable manner over time, without arbitrary bureaucratic behavior, and who wishes to avoid disparities among localities, must favor a legal infrastructure in which the services will be anchored.

Second, legislation is the way in which the state emphasizes its acknowledgment of the need to deal with the special needs of various population groups and expresses its commitment to meet them adequately and permanently.

Third, legislation helps individuals in distress, and their families, to recognize

and reveal their needs. It legitimizes these needs and encourages individuals to apply to service providers for assistance that may improve their situation. Social legislation also reinforces the awareness that social services are not acts of charity but basic social entitlements that individuals receive because they are citizens. Accordingly, social legislation helps mitigate the possibility of stigma, which sometimes deters people from applying for assistance even if it is very badly needed.

For this reason, extensive legislation may help the personal social services tackle one of their main problems: how to create a binding and meaningful relationship with population groups in distress. Various data indicate that several national and local programs in the personal social services that have made a demonstrable contribution to improving the life quality of families in distress - such as Yahdav, Dror, and the establishment of neighborhood aid centers - are operating on a limited scale and for this reason reach only part of the population in need. Furthermore, the Ministry of Labor and Social Affairs reports that local welfare departments serve only a small proportion of children in distress countrywide (Israel Ministry of Finance, 1997). The State Comptroller's Report for 1995 notes that the service agencies tasked with aiding teenagers in distress have made only partial inroads with this population group (State Comptroller, 1996).

Legislative enshrinement of personal social services for these population groups may help change this state of affairs in two ways: by forcing social-service organizations to expand their services considerably and by enhancing the relevant population groups' consciousness of the services and the possibility of making use of them.

Opponents of the expansion of legislation have justified their approach in various debates by bruiting several arguments:

First, anchoring the activities of local social-service organizations in statutory rules, which entail a large degree of uniformity and equality, may transform social workers into guardians of binding rules expressed in laws and procedures that are often typified by a great deal of rigidity. This situation may circumscribe their autonomy and vitiate their ability to make decisions on the basis of professional judgment in regard to individuals' different needs and the particular responses that they require. This differential attitude is especially important in Israeli society, which is noted for broad cultural and social diversity.

Second, the experience amassed in Israel and elsewhere indicates that quite a few difficulties arise before social laws on behalf of various population groups are enacted (resistance from the Ministry of Finance, objections from various

interested parties, etc.). Once the laws are approved, however, they are very hard to repeal or to amend in substantive ways. Accordingly, legislation may introduce considerable rigidity in an arena that requires, because of the many changes it undergoes, a large measure of flexibility and adaptability to changing conditions.

Third, broad legislation that requires the state to serve citizens in various ways expresses, with the greatest possible emphasis, the adoption of the principle of responsibility for providing the population with the assistance it needs. The adoption of this principle may unnecessarily aggravate disadvantaged individuals' dependency on the state and may absolve them, or other players such as family members and organizational support networks in their communities, of responsibility.

Fourth, legislation that requires the state to provide services countrywide and on an equal and uniform basis - and to allocate sizable financial resources for this purpose - may create a low threshold in the level of services and, thereby, diminish the willingness of local social-service departments and volunteer organizations to develop services of superior level and quality. What is more, the uniformity in service allocation that flows from social laws meshes poorly with the wide diversity of needs occasioned by the social and cultural pluralism that typifies various societies, including Israel's.

Fifth, broad and inclusive legislation may result in a large upturn in the use of services and, in turn, in public expenditure for the personal social services. Consequently, the state Treasury will be given an additional burden that it will find difficult to bear.

Sixth, the present situation, in which only a small portion of the relevant individuals' needs are covered by law, may inspire the personal social services to focus increasingly on meeting those needs and to give less attention to other needs that are not rooted in law. This tendency may be manifested, among other things, in the diversion of resources (human, financial, and other) from fields not enshrined in law to activities with which, according to the law, the social services and their personnel must deal. This diversion is especially likely to occur in times of resource shortfall, when service organizations such as local welfare departments find it difficult to cover all bases simultaneously. This diversion may be important chiefly because several types of service have been given legislative underpinnings, to the exclusion of others, not only because they are essential but also due to the influence of political interests, actions of pressure groups, and the like. For this reason, those who rule out legislation maintain that unless it can be applied to all personal social services, or to as many as possible, it would be better not to apply it narrowly. The proponents

of broader legislation invoke the same argument to justify their demand to maximize the types of services anchored in law.

The various rationales in respect to broad legislation - pro and con - reflect contrasting ideological perceptions and different pragmatic considerations. The proponents of extensive legislation represent those who view social entitlements as an integral part of personal rights, support the principles of social solidarity and responsibility, and recognize the need for state involvement in the social services in order to assure the availability of assistance for population groups in need. The opponents of broad legislation advocate a cutback in state involvement, avoidance of the imposition of uniformity on societies that are typified by much diversity, and reduction in public social-service expenditure.

Data on the implementation of the Long-term Care Insurance Law may support some of the pro-legislation and anti-legislation arguments described above (Katan and Lowenstein, 1999).

Those who consider legislation a blessing can undoubtedly rest their case on figures that point to the large number of disabled elderly who, by virtue of the law, receive essential home-care services on an insurance basis at no charge to them. Before the law went into effect in March 1988, the state participated in the expenses of home-care services for approximately 7,000 seniors; in the middle of 1999, more than 85,000 seniors - a large majority of the population group for which this service is intended - received home care at no charge.

Thus, legislation has allowed the social services to create a comprehensive and meaningful relationship with a large population group - seniors in need of assistance - as they have not done with other population groups. Notably, the social services interrelate not only with the elderly but also with their families. In addition to direct service for the elderly, the Long-term Care Insurance Law has accelerated the development of an infrastructure of community and institutional services for seniors (establishment of day care centers, expansion of old age homes, etc.).

Those who object to the expansion of legislation may take note of data that show the results of the Long-term Care Insurance Law in a different light. For example, the large number of eligibles - far in excess of the forecasts - led to an unprecedented, unforeseen, and unprogrammed increase in outlays on account of the law. In 1999, approximately NIS 1.4 billion was spent on implementing the Long-term Care Insurance Law, 40 percent of the total expenditure for personal social services for the entire population, including children, the disabled, the mentally retarded, and families in distress (Kop, 1999).

The opponents of broader legislation claim, that this hefty expenditure has placed a heavy burden on the state budget, diverted a large share of resources

to the needs of one population group, and made it difficult to raise and deliver adequate resources for other groups in need.

Shnit (1996), in his discussion of other implications of legislation for the personal social services, notes (among other things) the existence of rather large disparities in the inputs available for legislated services in four cities in central Israel. This finding indicates that one of the main goals of the legislation - uniform allocation of services - has not been attained.

The dispute between proponents of broader legislation in the personal social services - as in other fields - and those who advocate restraining this trend is evidently an inseparable part of the broader debate over the complexion, status, and functions of the welfare state. To choose the direction in which the personal social services will develop in the future, an unambiguous stance in this controversy is needed.

3. Privatization of Personal Social Services

The issue of privatization in the social services will probably command increasing attention in the next few years and will take up a central position in the debate over the development and complexion of the personal social services. Even today, nongovernmental organizations (NPOs and businesses alike) are playing a pivotal role in delivering a wide range of personal services for various population groups. All home-care services for disabled seniors under the Long-term Care Insurance Law are provided by privately owned nursing-care companies and by volunteer NPOs. Most children, teenagers, and mentally retarded and disabled citizens who live away from home with state funding do so in nongovernmental institutions (Eisenstadt, 1996; Katan, 1996). Much of the social services delivered by NGOs are paid for by the central government.

Moreover, most of the government budget for personal social services is implemented by means of these organizations, which have become agencies of the government in delivering services that the government wishes to offer to various population groups. However, the government's role as a leading player in funding the services, along with its monitoring and supervisory powers, allow it to apply a large extent of control over the activities of the NGOs. Therefore, central government and local authorities have an exceedingly important function to discharge in the mixed economy that typifies the personal social services in Israel.

Consequently, the question is whether the partial privatization process already under way should be encouraged and hastened, expanded in scope, and deliberately extended to new fields, or whether it should be impeded or even

downscaled by re-escalating the involvement of central and local government as providers, not only as funders, of social services.

Proponents of an accelerated transfer of responsibility for delivering personal social services to NGOs in Israel credit privatization for quite a few auspicious results, which grow in intensity commensurate with the comprehensiveness and completeness of the privatization. Since various studies (Lachmann and Keinan, 1991; Le Grand, 1991; Schmid and Sabag, 1991; Eisenstadt, 1996; Schmid, 1998; Wistow et al., 1998) describe these advantages, we will merely mention them briefly here.

First, privatization results in larger numbers of, and greater diversity in, the NGOs that provide services. It also encourages competition among organizations and creates the possibility of consumer choice, thereby strengthening the organizations and, in turn, helping the personal social services to adjust to various local requirements and to the expectations of many consumers who take vehement exception to uniform services doled out by government organizations. These consumers want the right to withhold their patronage from organizations that fail to meet their quality of service demands, in favor of alternative service entities that deliver in accordance with their needs and expectations.

Second, NGOs are much more efficient and flexible than government organizations and can deliver services at lower cost. These advantages are traced to their freedom from various limitations and constraints that government organizations have, such as political pressure from interest groups that channels resources to various uses, limitations on hiring of new staff, difficulties in firing inefficient employees, organizational rigidity, cumbersome mechanisms that impede rational decision-making, and so on.

Third, by helping to slow the growth of the governmental-public sector or even to reduce it, and by contributing to a downtrend in state involvement, privatization may lower the high and burdensome level of state-budget outlays for social services. Privatization also makes it possible to attract additional resources of nongovernmental origin (donations, private investments, involvement of NPOs, volunteer inputs, etc.) to personal social services.

Specific advantages are attributed to different kinds of NGOs. Private for-profit organizations are supposedly strongest in efficiency and the ability to adjust to changing ambient conditions. In NPOs, much emphasis is placed on high reliability, social commitment, and the ability to recruit and make use of volunteers. However, the advantages of privatization depend, in its supporters' opinion, on its intensity and scope. Gradual and limited privatization, implemented in narrowly defined fields within the boundaries of a mixed

economy, in which the state continues to play a central role, does not have the impact of a far-reaching privatization that prunes the government's strength and powers substantively.

The opponents of privatization of personal social services argue that its drawbacks rise commensurate with the intensity of the process and present a string of arguments that, in their opinion, show that the process must be slowed or downscaled (Doron, 1989; Gal, 1994; Katan, 1997; Schmid, 1998).

First, privatization is allowing for-profit organizations to become much more active in personal social services. Although these organizations already had a toehold in this field, the privatization process has given them further inroads and placed important segments of activity in their hands. The involvement of businesses in social services evokes questions about the possibility of a clash between concern for the population's well-being and the profit motive, the main impetus for these organizations' activity. Proponents of privatization deny the existence of a clash between making a profit and assuring high-quality services; they present many examples of positive correspondence between the two. Opponents of privatization base their case on incidents that point to poor quality of service by private social-service organizations, even if most of these events involved consumers in weak and vulnerable groups.

Second, the challenge to the existence of a positive correspondence between making a profit and delivering high-quality services sheds a different light on another main advantage attributed to the privatization process: allowing consumers to choose. For consumers to exercise this privilege and to make appropriate decisions, several factors must be present, e.g., a maximum quantity of accurate information on the activities of the various organizations and the quality of services they provide, access to this information, and the ability to analyze it and to draw the appropriate conclusions from it. These factors, which are essential for the adequate fulfillment of the right to choose, are often lacking. Furthermore, many consumers, especially those in weak and marginal social groups, rarely have the tools to function as wise consumers who can gather and analyze information and, on its basis, make decisions and exercise choices that will serve their needs adequately. Thus, in not a few cases, an asymmetry may evolve between social-service organizations, which control information on the services they provide, and consumers, who lack all or some of this information. This asymmetry, which impairs consumers' ability to choose, may be particularly blatant in the activities of business organizations that are driven by the profit motive. By causing a proliferation of businesses and NPOs that serve as service providers, the privatization process may actually make it harder for consumers to exercise the right to choose

appropriately. For example, the government's decision to task NGOs with the provision of services under the Long-term Care Insurance Law has brought hundreds of businesses and nonprofit organizations into this field (Ben-Zvi, 1993).

Third, privatization may lead to "residualization", i.e., the formation of separate systems of social services - one for those who can afford to pay for the services they need and another for people who cannot do so for various reasons, such as economic circumstances or place of residence. In response, the state provides those in the latter category with services in settings earmarked for them. This separation of services for population groups that are differentiated by demographic and social criteria has several negative outcomes. The creation of separate service systems for the poor may result in fulfilling a warning issued long ago by Richard Titmuss, one of the architects of the British welfare state, that services meant mainly for the poor will probably evolve into poor services. This may happen for several reasons, e.g., difficulty in raising resources due to inadequate public support for services that focus on population groups that are marginal and politically weak, and the tendency of capable and experienced professionals to operate in organizations that serve well-heeled consumers and confer greater prestige. The creation of separate systems may even aggravate disparities in the services offered to populations in different localities and, at times, in different parts of one locality, thereby destabilizing social cohesion and disrupting inter-group relations.

Fourth, nongovernmental organizations - especially private businesses - are disinterested in pursuing several social goals that social movements and various professional entities espouse, such as the individual and collective empowerment of consumers, encouragement of substantive consumer participation, and assurance of quality services for marginal population groups.

Fifth, one doubts the assumption that some adverse results of the privatization of social services, such as the possibility of detriment to weak population groups, can be overcome by the creation of appropriate governmental control mechanisms, because it is difficult to assure suitable and adequate control of the activities of hundreds of NGOs.

For the time being, as noted above, privatization of personal social services in Israel is only partial. Thus, it is hard to estimate the results for now. The government and municipal authorities have given NGOs responsibility for providing a wide range of social services but have retained responsibility for funding the services, determining their nature, stipulating the terms of eligibility, controlling the organizations' performance, and setting the level and price of services. This division of labor is meant to facilitate the fulfillment

of several advantages of privatization and the free-market milieu, such as competition among organizations, lower cost of service, various possibilities of consumer choice, and downscaling of the government apparatus. It also aims to mitigate several of the risks of privatization, such as reduced availability of services for weak population groups and a decline in service quality because the providers give the profit consideration highest priority. However, the proponents of privatization argue that although partial privatization does expand the activity of NGOs, it confines this activity to a framework that, for reason of its multiple constraints and limitations, curtails their ability to put their unique attributes to full use. In contrast, the opponents of privatization express concern that partial privatization, which refers consumers to NGOs for many social services and thereby severs the relationship between consumers and government authorities, is the first step down a path that will prepare the public consciousness for full privatization.

Thus we see that the acceleration of privatization may create many opportunities in the personal social services, such as possibilities of consumer choice, higher-quality service, efficiency, lower cost, and greater willingness to respond to consumers' demands.

However, this process also comes with possible risks: eradication of the state's commitment to citizens' social entitlements, detriment to consumers who have limited means and no real ability to choose, creation of disparities between services for different population groups, establishment of separate services for economically differentiated population groups, weakening of social solidarity and integration, and erosion of the public system's ability to control activities in the social services.

Summary

This article discussed three main issues that preoccupy the personal social services and that affect their structure and ability to cope adequately with the challenges they are facing. Its purpose in taking up these issues is to stimulate a thorough debate of their significance and possible implications, to encourage systematic research that will illuminate their various aspects, and to lead to a more lucid policy in respect to them. In the context of such a debate, various alternatives undoubtedly will be presented and their suitability in Israel's socio-political fabric will be explored.

This summary presents the principles of one possible alternative that tends to maximize the advantages and minimize the drawbacks of a policy that aims to decentralize the social services, expand the scope of legislation, and encourage the involvement of NGOs.

This alternative is based on two main principles:

(1) Stipulating a basket of personal social services and anchoring it in binding legislation. This list of services would meet the crucial needs of population groups that come into their ambit (children, youth, the elderly, families in distress, the disabled, and the mentally retarded). It may be harmful to settle for legislation that addresses itself to only some population groups and needs, since this may focus the attention of the personal social services on those needs to the exclusion of others. The basic needs to be included in the basket must be determined by professionals.

(2) Revising the division of labor between central government and local authorities to maximize the advantages of centralization and decentralization and minimize their disadvantages. In this division of labor, local social-service departments and, through their mediation, additional local players (NPOs, businesses, self-help groups, and informal social networks) shall be given a large degree of autonomy but the state shall retain responsibility for several functions.

In this division of labor, the central government shall make overall social policy and set compulsory national standards in respect to the scope, level, and quality of services. These standards shall be manifested in the compulsory basket. The central government shall also fund the services on the list, encourage research, help train professional and nonprofessional staff, disseminate successful social programs and initiate the development of new programs, and help communities provide services that are not included in the compulsory rubric. This assistance shall be directed especially to peripheral and socioeconomically weak localities. Local authorities shall deliver the services included in the compulsory rubric (directly or by means of other organizations), initiate and develop further services to meet special local needs, encourage local organizations (volunteer associations, businesses) to be active in the social-service field, raise resources locally, and encourage the formation of additional organizations.

The existence of the list of legally-mandated, state-funded services shall help provide equal services for different population groups. It shall also assure a basic but comprehensive level of services. Local authorities shall play a major and autonomous role in initiating and developing another stratum of services that will reflect local needs and priorities, the entrepreneurial abilities of local organizations, and the expectations of their population. The state shall provide important assistance in developing this stratum of service, especially in localities that are weak or situated in peripheral areas.

Again, this division of labor should be one of the possible alternatives to

examine in the crucially needed debates on the profile of the personal social services.

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FOR-PROFIT AND NONPROFIT HUMAN SERVICES: A COMPARATIVE ANALYSIS

by Hillel Schmid*

Introduction

The past two decades have witnessed major changes in the provision of human services. A "mixed economy" has developed, whereby the government agencies that traditionally provided these services have reduced their role, becoming supplemented by non-governmental associations, particularly nonprofit organizations (NPOs). Along similar lines, recent legislation, such as Israel's Long-term Care Insurance Law (1988) and the U.K.'s National Health Service and Community Care Act (1990), has encouraged the provider role of for-profit organizations (FPOs). Especially in Western countries, governments have viewed privatization and "contracting out" to non-governmental organizations as a strategy that bolsters competition, undermining the power of monopolies and thereby improving the quality and efficiency of service delivery. This trend has been accompanied by an attempt to encourage "greater pluralism in provision, with markedly greater roles for private and voluntary agencies; tighter specification of the links between purchasers and providers, especially via the introduction or extension of contracts; more systematic and better regulations of practice and assurance of quality" (Forder, Knapp and Wistow, 1996, p. 202).

It has even been claimed that, by transferring service systems to non-government sectors, particularly to FPOs, the government can reduce bureaucracy, better respond to their clients' needs and encourage innovation (Terrell and Kramer, 1982). As a result of these changes in the arena of human service providers, NPOs and FPOs have begun to compete for resources in an attempt to control larger market segments.

These developments have generated growing research on competition between FPOs and NPOs, as well as on the nature of their relationships with each other and with the government. Numerous comparative studies have investigated the ideology and declared goals and the relative operational,

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structural and economic advantages of organizations in each sector, as well as efficiency and effectiveness (Gidron et al., 1992; Kramer et al., 1993; Weisbrod, 1997; 1998). The studies have been conducted in many areas, such as health care services (Gray, 1986; Marmor et al., 1986), residential child care services (Knapp, 1986; 1989; Knapp et al., 1987; Krashinsky, 1998; Mauser, 1988; 1998), prisons (O'Brien, 1993), legal areas (Mansneurus, 1993), home care services (Schmid, 1993b; 1998) nursery schools (Badelt and Weiss, 1990); and elementary and secondary schools (James, 1987a; Downes, 1992). All of these findings have had important implications for policy-makers, as access to up-to-date performance data has enabled rational decision-making in regard to resource allocation and priorities for service provision.

There are those, however, who question the merit of these comparative studies. According to DiMaggio and Anheier (1990), evaluative reviews of research indicate that comparative findings are inconclusive or equivocal, owing, among other things, to the heterogeneity of funding sources, disparate organizational goals, and varied constituencies. Moreover, researchers have argued that it is difficult to identify general differences between the sectors. For any given variable, differences within sectors are often greater than between sectors, and conclusions reached for one industry or country may not be applicable in other contexts (DiMaggio and Anheier, 1990; Knapp, et al., 1990; Patel et al., 1993; Weisbrod, 1997; Krashinsky, 1998). Other researchers have claimed that the distinctions between sectors are becoming blurred; public and private suppliers of human services are subject to the same regulations, utilize the same service methods, employ the same types of staffs; and have become increasingly bureaucratic, professionalized, political and entrepreneurial (Bozeman, 1987; Douglas, 1987; Langton, 1987; Ostrander, 1987; Billis and Harris, 1992; Billis, 1993). Kramer (1994a, 1994b) adds the argument that the question of *who* provides the services is less important than *how* they are provided. It should also be noted that social scientists have become increasingly skeptical about the use of organizational form (NPO/FPO) as an independent variable, especially without taking the specific industry or field of service into account (Leat, 1993).

While the above claims are valid, they do not necessarily indicate that research should be discontinued. On the contrary, as the market of human services becomes tougher, it is important to learn about the relative advantages and disadvantages of the competing entities. Understanding the differences and similarities between the sectors allows governments and clients alike to gain better access to information and acquire a rational basis for choosing services. This in turn stimulates competition between organizations and ultimately

improves the quality of services. In line with this reasoning, the following comprehensive review of literature published over the past decade aims to provide a succinct picture of similarities and differences between for-profit and nonprofit human service providers, which are a "set of welfare agencies that provide care, cash, education, shelter, and support to people very often with significant personal interaction between the agency and the individual client or user" (Billis and Glennerster, 1998). Such an analysis may enable us to arrive at explanations for the dynamics of relations between these organizations and between them and their clients.

The following is an attempt to consolidate the results of studies conducted over the past two decades and arrive at distinctions between FPOs and NPOs. A review of the relevant literature yielded the following comparative variables: declared goals and objectives, clients, organizational strategies, organizational structure, human resource management, costs of operation, quality of services and client satisfaction. A summary of results appears in Table 1.

Table 1. Comparative Analysis of Nonprofit and For-profit Service Providers

Variable	NPOs	FPOs
1. Declared goals and objectives	Altruistic goals; social mission; focus on justice, equity and charity; service delivery based on the needs of consumers.	Maximization of profits; seeking from consumers the price they are able to pay and providing services that consumers can afford.
2. Clients	Minorities and lower socio-economic classes; clients with serious social problems.	Well-to-do clients; avoidance of clients with serious social problems who cannot afford the high costs of services.
3. Organizational Strategies	Specialist strategy focusing on provision of mandated services before FPOs entered the arena. Shift to a generalist strategy as a result of competition with FPOs.	Generalist strategy providing a variety of services and products.
4. Organizational Structure	Organic and informal in the first stages of the organizational life cycle; more formal and bureaucratic in the later stages.	Formal; centralization of authority.
5. Management of Human Resources	Emphasis on training and development; training viewed as investment rather than expense; higher fringe benefits.	Less emphasis on training and development, which are viewed as an expense; less opportunities for advancement.
6. Cost of Services	Findings are inconsistent and inconclusive.	Findings are inconsistent and inconclusive.
7. Quality of Services	Relatively high quality of services.	Relatively low quality of services.
8. Client Satisfaction with services	Higher level of client satisfaction with services.	Lower level of client satisfaction with services.

Declared Goals and Objectives

The focus of human service organizations is the well-being of their clients. This is particularly true of NPOs, which seek to fulfill altruistic goals and pursue a social mission aimed at promoting justice, equity and charity (Hasenfeld, 1983; Kramer, 1987; Mauser, 1998). Nonprofit organizations fulfill advocacy functions as agents of social control and social change (DiMaggio and Anheier, 1990), functions which are particularly important in the provision of human services. In these organizations, some of which are based in religious communities, directors often emphasize the need to aid and support others, in addition to the principles of citizen participation and neighborhood assistance. Their ideology reflects a community orientation and commitment to solving social problems. As part of their social mission, the directors of these organizations encourage community services as an alternative to institutional services (Gray, 1997). They view part of their role as coordinating the services provided by other NPOs in the same network, and they seek to achieve organizational and professional synergy so as to enhance the clients' quality of life (Schmid, 1993a; Schmid and Bar-Nir, 1999). The ideology and ethic underlying the operation of NPOs is to "accept from the consumers the price they are able to pay and provide to each consumer the service they need" (Lewis, 1989, p. 10).

Although FPOs, too, espouse the goal of enhancing their clients well-being, they are thought to focus more on their own interests and on maximizing profits (Mauser, 1998). These organizations are guided by the ideology and ethic that "the organization seeks from the consumers the price they are able to pay, and provides to each consumer the service they, the consumers, can afford" (Lewis, 1989, p. 10). Unlike NPOs, for-profit organizations do not emphasize communal goals, increased citizen involvement in the provision of services, or the establishment of community support networks for their clientele (Schmid, 1993a). Nonetheless, aims other than the profit motive have been declared by directors, such as the attainment of greater technological efficiency than government or nonprofit organizations (James, 1989). Moreover, the goals of for-profit organizations often reflect the personal motives of entrepreneurs who seek to achieve functional autonomy and eliminate bureaucratic obstacles encountered by clients of government and nonprofit organizations. Sometimes founders of private profit-making organizations are also motivated by their own experience with disabled or handicapped family members who are dependent on personal and social services provided by government or nonprofit organizations (Schmid, 1993a).

Clients

NPOs usually serve minorities (Kegan, 1991), populations in severe distress for whom typical service technologies seem ineffective (Gibelman, 1989; Karoly, 1993), populations characterized by non-normative behavior (Netting et al., 1990; Smith, 1989), and uninsured clients (Gray, 1997), and persons who lose their jobs or are otherwise adversely affected by privatization (Abzug and Webb, 1996). These clients often lack information about the services for which they are eligible (Weisbrod, 1988). Private agencies, which are not dependent on public funds, shy away from such clients because of the high cost of serving them and the limited prospects for success. They primarily serve well-to-do clients who can afford exclusive and better quality services. This population is generally "white" and has a higher level of education than do the minorities (Hughes, 1983; Browne, 1985; Weisbrod, 1988; Gibelman, 1989; Kegan and Newton, 1989; Badelt and Weiss, 1990).

NPOs often treat clientele whose needs are not met by government services (Weisbrod, 1988). Nonprofit organizations are called upon to fill the gaps left by government failure and provide services to those who cannot afford to purchase services on the free market (Clarke and Estes, 1992). It should be noted, however, that Clarke and Estes (1992) did not find significant differences in the proportion of minority and low-income clients served by nonprofit and for-profit organizations. In this context, it has been argued that when governments contract out to FPOs and NPOs for provision of services such as home care, they are obligated to serve low and middle SES populations with limited means (Salamon, 1995; Schmid, 1998).

With regard to accessibility of services, nonprofit agencies are relatively tolerant of client selection procedures based on flexible standards of equity, both with regard to client self-selection and selection by staff. In contrast, private for-profit agencies tend to be more comfortable with self-selection (Smith and Lipsky, 1993). Moreover, it has been found that well-to-do clients prefer for-profits to nonprofits, as they believe FPOs offer a wider range of services and a higher level of expertise (Gray, 1997).

Organizational Strategies

Provider organizations can choose between several organizational strategies. The generalist strategy seeks to optimize existing and potential resources by developing a wide network of external relationships, and focuses on provision of a variety of products, services and programs. The specialist strategy, in contrast, concentrates on a distinctive competence, i.e., development of special

products or services in an attempt to achieve a relative advantage in a given niche (Brittain and Freeman, 1980).

Generalism enables organizations to provide more comprehensive services, to reach a broader range of target populations and to accommodate themselves to changes in service supply and demand. However, this strategy may result in reduced efficiency (Hannan and Freeman, 1977), as it increases administrative costs and requires constant quality control over a wide range of activities. Hence, organizations may compromise on service quality in order to achieve diversification. Moreover, generalism reduces the stability of the service network, as agencies pursue new funding sources and discontinue services with shrinking funds. This strategy also increases the risk of fraud, especially among proprietary organizations. Unscrupulous agencies that adhere to this strategy may bill clients for skilled care while providing unskilled services, or substitute one occupational title for another (e.g., home-health aide instead of home-care worker) in order to obtain higher reimbursement rates for services provided (Fine, 1988).

In contrast, the specialist strategy enables agencies to provide high-quality services to targeted populations, and it reinforces stable and predictable service networks. On the other hand, it produces fragmentation in the market, increasing the costs of coordinating various services. Organizations with a specialist orientation are slow to respond to changing market conditions and demands (Schmid and Hasenfeld, 1993).

The types of strategies adopted by NPOs and FPOs alike tend to be influenced by the characteristics of their environment. Numerous studies (e.g., Lawrence and Lorsch, 1967; Miles and Snow, 1986; Schmid, 1992) have indicated that in stable environments, organizations adopt a strategy of specialism which enables them to maximize use of available resources. On the other hand, in uncertain, turbulent environments, organizations usually adopt a strategy of generalism, engaging in different spheres of activity in order to reduce risks.

For-profit providers tend to adopt the generalist strategy (Midwinter, 1988; Badelt, 1989; Badelt and Weiss, 1990; Schmid and Hasenfeld, 1993). These services are developed and provided rapidly in diverse locations in order to ensure immediate return of capital which the organization needs for its continued operation. Nonprofit organizations, in contrast, tend to adopt a specialist strategy (Schmid, 1993a; Schmid and Bar-Nir, 1999) - at least, this was true when they were the major players in the service arena. However, they seem to have shifted to a generalist strategy as they encounter increasing competition, particularly from for-profit agencies (Reif, 1980; Salvatore, 1985;

Bargthold et al., 1988). Ultimately nonprofit agencies must either emulate proprietary providers or develop their own for-profit satellites in order to survive. Hence, nonprofit and for-profit organizations have begun to adopt similar strategies in recent years (Balinsky and Shames, 1985).

Regarding the strategy of cooperation vs. competition, NPOs are more inclined than FPOs to cooperate with other service providers. Such cooperative relations tend to be established with organizations that provide medical, psychological, social, counseling or advisory services (Winn, 1974; Hughes, 1983; Kramer, 1988; Gibelman, 1989; Kegan and Newton, 1989; Rose-Ackerman, 1990; Schmid, 1998). These organizations do not hesitate to exchange professional knowledge and information while coordinating service delivery (Rose-Ackerman, 1990). In contrast, FPOs are more reluctant to share knowledge, technology and programs which might expose them to competition for potential clients.

Organizational Structure

Like strategy, the pattern of organizational structure is often dictated by the arena itself. In stable environments, organizational structure is usually formal, whereas in unstable, uncertain environments, organizations develop a more organic, flexible structure which can respond to changing needs.

Findings on the organizational structure of NPOs are inconsistent. Some studies indicate that their structure is more formal and bureaucratic than that of FPOs (McCarthy et al., 1992; Kramer et al., 1993), while others have obtained different results. For instance, research by Schmid (1993a) on home-care service organizations in Israel found that the management of FPOs tends to be authoritarian and centralized, while that in NPOs is relatively democratic and participatory, with middle managers empowered and involved in the decision-making process. Similarly, a comparative study of residential boarding institutions in Israel for deprived children (Schmid and Bar-Nir, 1999) revealed that directors of NPOs delegate authority and emphasize empowerment, participation and autonomy for staff members in determining the care plan. However, the same study found a similar extent of formalism in both sectors, i.e., both for-profit and nonprofit organizations strictly adhere to formal norms and operational procedures; tight coordination was apparent, characterized by an extensive amount of written reports and formal meetings.

Human Resource Management

Human resource management encompasses a number of processes, including recruitment, selection and hiring of staff; placement, supervision and

professional development of workers; and management of such problems as absenteeism and turnover. Research findings have revealed differences between for-profit and nonprofit organizations in many of these areas.

Nonprofit organizations usually invest more than for-profits in the training and development of professional staff (Hughes, 1983; Mauser, 1998). They view training as an investment rather than as an expense, and believe that human resource development improves services. Wages and employment conditions (fringe benefits, sick leave, retirement benefits, health insurance, vacations) tend to be better in NPOs, which also provide more opportunities for advancement (Borjas et al., 1983; Whitebook et al., 1990; Kegan, 1991; Tuominen, 1991). At the same time, however, it has been found that executives in NPOs are often willing to work for lower pay than they would have received in FPOs (Roomkin and Weisbrod, 1994; 1997). In addition, findings indicate that even if NPOs pay a higher basic salary to executives, FPOs offer better fringe benefits and therefore pay higher overall salaries. It was also found that NPO employees usually have a higher level of education and are more committed to the organizations' espoused goals than their counterparts in FPOs (Kegan and Newton, 1989; Kegan, 1991). Moreover, there is evidence that professionals prefer to work in NPOs rather than in for-profit or bureaucratic organizations (Giandomenico, 1984). In this connection, it has been argued that NPOs are more successful in reducing the conflict between professional principles and institutional requirements, and that nonprofit providers include more ideologues than competing for-profit firms (Young, 1983; James, 1987, 1989; Rose-Ackerman, 1996). In addition, NPOs are usually more committed to serving clients and devote more work time to ensuring quality service (Hatch and Mocroft, 1979; Schiflett and Zey, 1990).

With regard to employee turnover, findings are inconsistent. Some studies have revealed comparatively low turnover rates and relative stability among the professional staff of NPOs (NCCSS, 1988; Tuominen, 1991; Schmid, 1993b; Gray, 1997), while others point to a high turnover in both sectors (Schmid and Bar-Nir, 1999).

Costs of Operation

The cost of providing services in NPOs and FPOs depends on a number of human, organizational and structural factors, such as the clientele (e.g., personality attributes, physical and mental state, age, level of dependence on others, level of disability); the range of services and programs provided; the degree of occupancy in institutions; the setting of service provision (the home, a community facility, an institution); and the size of the organization (Knapp,

1988). Research findings regarding the relative costs of operating services in the nonprofit and for-profit sectors are inconsistent and inconclusive (Knapp et al., 1987; Knapp and Fenyo, 1987; Knapp, 1989; Holmes, 1996).

Mainly, studies point to other variables as determining costs, particularly organizational size. It has been argued, for example, that small voluntary organizations are often more costly to operate, on a per capita basis, than are large-scale public organizations (Judge and Knapp, 1985; Knapp, 1986; Knapp, 1996). This may be attributed either to low volume, which increases costs per unit, or to the price of organized flexibility, which is inevitably higher than that of routinized programs.

Nonetheless, certain distinctions between FPOs and NPOs are apparent. For instance, Judge and Knapp (1985) found that the rates charged by private residential homes for the elderly are significantly lower than those charged in nonprofit homes (see also O'Brien et al., 1983; Knapp, 1988). Schmid and Bar-Nir (1999) found that for-profit boarding institutions utilized their resources (personnel, raw materials, care technologies) more efficiently than did nonprofits. Studies conducted in the U.S. have also shown that the expenditures of nonprofit nursing homes are higher than those of for-profit homes (Davis, 1993; Marmor et al., 1986; Arling et al., 1987). On the other hand, another study on day care showed that for-profits have no cost-efficiency advantage over nonprofits (Preston, 1993). NPOs are often able to reduce the cost of their services owing to subsidies from the government and tax exemptions (Gray, 1997). Moreover, the fact that they engage volunteers not only enables them to expand their activities but also contributes toward reducing their costs (Hatch and Mocroft, 1979). In 1993, the value of volunteer labor provided to NPOs was estimated by the Independent Sectors at $182.3 billion (Hodgkinson and Weitzman, 1994, Table 1.5, p. 23; Rose-Ackerman, 1996, p. 703). In this connection, it should be noted that in the U.S., volunteers are recruited and actively involved in for-profit hospitals, nursing homes, day care centers, schools, and a wide array of human services. Nonetheless, there are those who argue, contrary to the above findings, that since NPOs are not oriented toward profit, their directors do not have the incentive to cut costs (Weisbrod, 1998).

Service Quality

The quality of human services can be measured by a variety of indicators, including service technology, availability, precision of delivery, coverage, professional level of workers, worker-client relations, staff turnover rate, staff-client ratio, size of client groups, and experience and training of staff members

(Eustis and Fischer, 1991; Mauser, 1998). In most of these parameters, NPOs were found to have a qualitative advantage over FPOs.

On the average, for-profits were found to provide satisfactory but somewhat lower quality services than nonprofits (Kisker, 1991; Preston, 1993). Clients of FPOs tend to believe that the owners and executives of the organizations focus efforts on maximizing profits, even at the expense of service quality. In this connection, Rose-Ackerman (1996) argues that "nonprofits may have a quality advantage over for-profits and may in some cases have a cost advantage as well" (p. 720) (see also Weisbrod, 1983; Preston, 1989; Aaronson et al., 1994; Roomkin and Weisbrod, 1994). In a study of day care centers for children in Canada, Krashinsky (1998) found that NPOs have a qualitative advantage. At the same time, however, he claimed that the nonprofit nature of day care centers does not guarantee high quality in itself. In the same vein, Mauser (1998) found that the quality of care in day care centers is higher, on the average, in private and religious nonprofit programs than in for-profit ones. However, quality of care is no less variable in private nonprofit programs than in for-profit ones. In addition, religious nonprofit care providers were found to offer higher quality care, and parents appeared to trust them more.

In contrast, clients of NPOs tend to believe they offer relatively high quality services, as the directors and staff of those organizations are highly qualified, motivated, and committed to altruistic goals (Mauser, 1998). It is argued that high motivation and strong commitment raise performance standards and service quality, resulting in a relatively high level of client satisfaction (Rose-Ackerman, 1996). Indeed, NPO clients are more inclined to report that the care they receive contributes to their well-being (Riportella-Muller and Slesinger, 1982; Born, 1983; Hughes, 1983; O'Brien et al., 1983; Weisbrod and Schlesinger, 1986; Tuominen, 1991). Relationships between home-care workers and clients were found to be more stable in NPOs, contributing toward the relatively high quality of care and service there (Kegan, 1991). It was also found that nonprofit organizations have a longer waiting list (Rose-Ackerman, 1990).

Service quality is also reflected in the rate of complaints registered by clients, which are generally low in NPOs (Weisbrod and Schlesinger, 1986; Schmid, 1993a). For example, Riportella-Muller and Slesinger (1982) report that nonprofit homes for the elderly received fewer complaints than for-profit ones, although more violations were found in large nonprofit homes than in for-profit homes of the same size. Indeed, studies have indicated that "profits and quality of care may be antithetical concepts" (Fottler et al., 1981, p. 537). On the other hand, it is possible that people with more resources (who tend to frequent FPOs) are more likely to raise their voices.

Client Satisfaction

Client satisfaction appears to be relatively high in both sectors, but more so in NPOs. In a recent comparative study of nonprofit and for-profit home-care providers (Schmid, 1993b), 76% of the clients reported that their personal care plans were fully implemented, and 87% reported that their home-care workers visited them according to the care plan. Clients of nonprofits reported a higher level of adherence to the care schedule than did clients of for-profits (90%, as opposed to 80%). They also gave higher ratings with respect to the ability of workers to adapt to clients and the extent to which the given care plan and time schedule meet their needs. Client evaluations of worker performance and satisfaction with workers were also higher in that sector (Riportella-Muller and Slesinger, 1982; Newton and Kegan, 1985; Schmid, 1993b). In the study of nursing homes and facilities for the mentally handicapped, Weisbrod (1996) found that family members' satisfaction with services is significantly greater in church-owned nonprofits than in proprietary organizations. However, no significant differences were found between other nonprofits and proprietaries with respect to this variable. At the same time, no significant differences were found in client satisfaction with for-profit and nonprofit boarding schools for disadvantaged children (Schmid and Bar-Nir, 1999).

Discussion

Both for-profit and nonprofit service providers function in ecological niches in which clients have similar needs. Consequently, they tend to offer comparable services and establish similar bureaucratic mechanisms in response to problems in the task environment. In addition, they create a comparable organizational structure under conditions of turbulence, uncertainty and rapid change. Expansion of services has intensified competition between the sectors. In this connection, it may be argued that competition may affect patterns of mimetic behavior, because more competitive markets appear to add to the perceived legitimacy of profit-oriented behavior (Wolf and Schlesinger, 1992; Schlesinger, 1998). Thus, NPOs have begun to emulate the organizational behavior of for-profits in order to attain a competitive advantage, as well as greater effectiveness and efficiency (Clarke and Estes, 1992; Weisbrod, 1996). For example, NPOs have adopted commercial strategies such as marketing and advertising, in addition to introducing computerized information systems, accounting and financing techniques (Schmid, 1994). This explains many of the similarities that have been found between nonprofit and for-profit organizations.

Another factor that encourages similarity is that organizations in both

sectors are contracted by the government to provide human services. Although there are variations from one country to another, the government generally provides accreditation, finances some of the services and controls the quality of services delivered by NPOs and FPOs alike. The mutual dependence that develops between these organizations and the government plays a considerable role in determining their organizational behavior. Regulation may create "coercive isomorphism", i.e., increasingly similar provision technologies (DiMaggio and Powell, 1983). Organizations in both sectors tend to adopt "conformist" behavior and accept government regulations and by-laws in order to ensure a steady flow of resources. That often means that they fail to offer innovative programs that deviate from government policy (Smith and Lipsky, 1993).

The growing similarity between NPOs and FPOs can also be attributed to the large proportion of professional staff in both sectors. Professionalism causes normative isomorphism, as experts introduce ethics that cause both nonprofit and for-profit organizations to adopt similar service technologies (Larson, 1977; Collins, 1979; DiMaggio and Powell, 1983). Professionalism in organizations blurs distinctions between the two sectors due to the growth of professional communications networks, which allow for rapid dissemination of new patterns of behavior in organizations. As centers of knowledge and learning, universities and professional training institutions develop similar concepts of organizational forms and adhere to similar norms of professional behavior, commitment, and ethics. The provider organizations recruit executives and professionals from similar fields of specialization, expertise, and disciplines who have been trained to explore and respond to problems and needs from similar perspectives. As such, they are exposed to policies, procedures, processes, and structures that have been approved and legitimized by the organizations and are likely to adhere to common approaches for making decisions about implementation of service technologies. This explanation is further supported by empirical findings from Schmid's (1998) study of home care organizations, which reveal that as the proportion of professional staff increases, differences in implementation decline significantly among organizations in the two sectors (see also Krashinsky, 1998).

Notwithstanding the above similarities, certain differences between these two sectors are evident (e.g., in client satisfaction, service quality). An explanation of these differences can be found in Hansmann's (1980; 1987) theory of contract failure. According to this theory, consumers feel that they cannot accurately evaluate the quantity or quality of services provided by an organization. Thus, there is considerable information asymmetry, where the

organization holds more information than it makes available to clients. Under these circumstances, for-profit firms have both the incentive and opportunity to take advantage of clients by providing them with less services than were promised and paid for. In contrast, directors of NPOs have less motivation to dissemble than their counterparts in the private sector, so that clients are less vulnerable (Schlesinger et al., 1996; Bradley and Walker, 1998). Lack of a profit motive may reduce the benefits of misrepresentation; moreover, the non-distribution constraint prevents NPO managers from deriving personal gain from the provision of low-quality services (Weisbrod, 1989; Steinberg and Gray, 1993; Rose-Ackerman, 1996).

The greater trust that clients tend to place in NPO can also be ascribed to the perceived commitment of staff to altruistic goals and the ideology of promoting client well-being. Conversely, many clients believe that the owners and executives of FPOs focus efforts on maximizing profits, sometimes at the expense of service quality.

In a changing environment, with increased contracting out and privatization of service providers, research focusing exclusively on the question of *how* services are provided may underestimate the distinctive features of NPOs and FPOs and how one complements and balances out the other. The intensification of competition caused by the entrance of for-profit concerns into the arena has forced NPOs to improve their efficiency and attractiveness. On the other hand, the availability of nonprofit organizations provides an alternative to clients who lack the resources to take full advantage of FPOs. Ongoing collection of data on these organizations, so as to better assess their performance, will allow policy-makers to encourage those advantageous aspects of each sector by means of resource allocation. It is therefore important to continue exploring the function of these organizations and the dynamics of their behavior in order to gain a better understanding of their unique characteristics, their relative advantages and how their service technologies can be utilized to improve service quality.

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FOREIGN WORKERS IN ISRAEL: THEIR ELIGIBILITY FOR WELFARE PROGRAMS AND THEIR ACCESSIBILITY TO SOCIAL SERVICES

By Uri Yanay and Allan Borowski*

"You shall have one law for the stranger in your land and for the citizen." (Lev 24, 22)

Introduction

Tens of thousands of foreign workers are currently employed in Israel - men and women, young and old, heads of families, and single people. They have come to Israel from Asian, African, and East European countries out of a desire to improve their material standard of living.

Although foreign workers have been visible in the city streets and neighborhoods of Israel since the early 1990s, there was, until recently, little public awareness of their presence. Some viewed them as a transient phenomenon - foreigners doing the jobs traditionally performed by commuting Palestinian workers who, because of border closures following a series of terrorist incidents within Israel, became an increasingly "unreliable" and hence smaller source of unskilled labor.

Only in the summer of 1996 did the existence of foreign workers in Israel penetrate the public consciousness. Public reaction was anxious and fearful, perhaps because of sensationalist media coverage on the one hand and the seemingly indifferent response of the authorities on the other (Borowski and Yanay, 1997). One of the first issues raised in response to the belated recognition of the presence of foreign workers in Israel was their formal status and their eligibility for health, education and other human services in Israel.

It is important to note that not everyone who lives in Israel is entitled to the full range of services that the state provides to its citizens. Entitlement is differentiated according to one's residency status. The status of the foreigner in Israel derives from the Entry to Israel Law, 1952. A foreigner in Israel can be

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either a tourist, a temporary resident, a permanent resident or a new immigrant. Most foreigners in Israel are tourists. Some of these tourists are considered temporary residents, including kibbutz volunteers, volunteers at institutions for the disabled and the elderly, and students at educational institutions. Other foreigners, such as scientists and members of the clergy, are considered permanent residents. And some temporary residents are eligible for Israeli citizenship under the Law of Return, should they choose to settle in Israel permanently.

The residency status of the foreigner determines the rights to which he or she is entitled, particularly with regard to welfare services. A citizen of Israel has rights that differ from those of a permanent resident, and a permanent resident has different rights than those of a temporary resident or passing tourist. Any one living in Israel, whether permanently or temporarily, is at risk of being involved in an accident, falling ill or suddenly being in need of some form of assistance. In circumstances such as these, questions regarding entitlement to welfare services, the availability of these services, and under what conditions, invariably arise.

This paper explores the rights of foreign workers and their accessibility to public welfare services. The scarcity of systematic research and official information about foreign workers obliged the authors, in conducting this exploratory study, to utilize a variety of sources including observation, interviews, and content analysis of documents and articles. The views presented here reflect solely the authors' interpretation of these findings. The purpose of this paper is to portray the current situation regarding foreign workers' eligibility for and accessibility to public income security provisions and personal social services and to examine what this reflects about Israeli social policy vis-a-vis foreign workers.

"Documented" and "Undocumented" Workers

The population of non-Palestinian foreign workers employed in Israel is, surprisingly, unknown. Some estimates place the number at 150,000 or more (Ministry of Labor and Social Affairs, 1997), and some claim (Condor, 1997, p. 68) that approximately a quarter million foreigners arrived in Israel since 1990, most of whom continue to live and work here as either "documented" workers or "undocumented" workers.

The regulations of the Entry to Israel Law, 1952, allow the Minister of Labor to establish the conditions under which work permits will be issued to foreign workers. According to these regualtions, an Israeli visa and work permit are granted to each worker for one specific employer only. If this condition is

violated, the work permit is revoked, together with the workers' visa. The significance of this regulation is that it binds the foreign worker to his or her employer. This condition was intended to ensure that the employer or employment agency who brought the worker into Israel would guarantee his or her timely departure upon expiration of the work permit and visa. To ensure that this obligation is met, the employer or the employment agency must deposit a bond.

Some of these workers arrived in Israel as part of organized groups recruited by employment agencies, either foreign or Israeli, in their country of origin (the Philippines, Thailand, China, Turkey, Romania, etc.). These agencies arrange visas and work permits, and then link the workers up with employers in Israel. These are ""documented" workers" who have legal permits to work in Israel.

To prevent their workers from "escaping", some employers confiscate their passports in order to guarantee their employees' "loyalty". Even though passport confiscation is illegal (Amendment to the Penal Code of 1977, parag. 376a, August 1 , 1995), this is a common practice among employers. As a result, most "documented" foreign workers lack any readily accessible identifying documents.

Another category of foreign workers is those who come to Israel on their own, not as part of an organized group. Most of the workers in this category come from Eastern Europe, African states (Ghana, Nigeria), and bordering countries with which Israel has signed peace agreements (Jordan and Egypt). These people enter Israel as either tourists or pilgrims (individually or as part of a group), remain after their tourist visas have expired, and then find employment illegally. Some of these "undocumented" workers" come to Israel with their families; others bring their families over after they have settled down. Lacking visas and work permits, these workers are considered "illegal".

Some of the "documented" foreigners who enter Israel as part of an organized group seek to escape the constraints of the employment agency or employer who brought them in by abandoning their employer. They do this during the course of their work in Israel or just prior to the time that they are due to return to their home country. After leaving the employer to whom they are contracted, these foreigners continue to reside in Israel as "undocumented" workers who lack a visa or work permit, and they live off odd jobs, short- or long-term.

The departure point of this paper is that foreign workers have human needs that can be met institutionally in Israel. These needs are by and large normative - some are expected (health, education, and housing) and others are not and arise during the normal course of life of individuals and families. In what

follows, we seek to address such questions as: Do "documented" and "undocumented" foreign workers have the right to access Israel's personal social services (health, education and welfare) and public income security provisions? Which services and income security provisions are available to the foreign workers in Israel, and which are offered to them? Which official body is in charge of addressing the needs of foreign workers and their families who, like anyone, sometimes need care and assistance?

What the Situation Should Be

Israel's constitution guarantees every person living in Israel entitlement to basic, elementary welfare rights. Where existing laws do not specifically grant these rights, they can be derived from the international conventions to which Israel is a signatory. Since even non-working foreigners in Israel have welfare rights granted by virtue of their presence in the country, this should also be true of those who earn their living in Israel, whether on a temporary or permanent basis. Even if the state were not obliged to provide services to foreign workers, it would clearly be in its self-interest to nevertheless do so. Thus, for example, although the state denies entry visas to foreigners who are ill, if a foreigner with a contagious disease (tuberculosis, leprosy, etc.) does enter its borders, the state has an interest in providing health services, if only to prevent spread of that disease. Further, if a foreign workers' children are not integrated into the local education system, their loitering on the streets will not have a beneficial effect on the host country. Therefore, the good of the host country mandates the provision of elementary services to the foreigner, if only to safeguard and protect itself.[1]

As well as being a matter of self-interest, it is also one of fair compensation. Thus, many foreign workers, especially those who are "documented", pay direct income taxes. Indeed, the level of taxation on foreign workers is actually higher than that levied on Israeli citizens. They are obliged to pay a 10% income tax on their earnings and are not eligible for the tax credits or disregards available to Israeli residents. Indeed, even if they earn only the minimum wage, they must pay taxes on every shekel. Further, all foreign workers, "documented" and "undocumented", pay indirect taxes on the many goods and services that they purchase in Israel on a daily basis. It seems only fair that those who legally pay taxes be recognized as eligible for appropriate

1. One of the considerations in favor of instituting universal health coverage in England (NHS) was that the health services would be accessible and free, thus benefiting the health of the public at large.

social benefits. In addition, those who pay indirect taxes also deserve to have some recognition accorded to them in relation to access to basic social services and income security provisions.

Over and above these considerations, Israel has some particular obligations to the strangers in her midst. A central tenet of the Jewish tradition is to provide assistance and welfare to the stranger in time of need. Many of Israel's foreign workers, at varying times and to varying degrees, find themselves in need. Perhaps more so than other nations, Israel has a special moral imperative that derives from the basic character of the state as a Jewish state to address these needs.

International Law Regarding the Employment of Foreign Workers

From time immemorial, countries have imported and exported "human capital", be they professionals, experts, or laborers searching for a better life in a new place, whether on a short- or long-term basis. Some foreign workers are interested in permanently settling in the country in which they have found employment while others see their work, even when it lasts for many years, as merely a way to accumulate savings before returning to their country of origin.

After World War II, the countries of Europe, including France, Austria, Switzerland, and Germany, absorbed those who came, with or without their families, seeking work and a livelihood. Different patterns evolved in these countries concerning the treatment of foreign workers and their families, reflected in various legal, economic, and social (including welfare) arrangements (Fisher, 1996). In August 1991, the state of Israel, as a member of the family of nations, signed the International Covenant on Economic, Social and Cultural Rights (1966). By virtue of her ratification of this covenant, Israel, as of 1 January 1992, cannot disassociate itself from this covenant.

Thus, the rules governing the employment of foreign workers are not exclusively local creations. The United Nations and the International Labor Organization (ILO) have established clear standards (or "Recommendations") for the treatment of foreigners in general and foreign workers in particular. Although the principles of these international conventions are not binding on the countries that ratify them until they are enacted by their own national legislatures, nevertheless they are significant at the level of international relations. International covenants are also an important context within which to interpret laws and formulate policy. Thus, the ILO's "Recommendations", although not binding, nevertheless provide guidelines for desirable, acceptable policies.

There is presumably a distinction between the rights of "documented" and

those of "undocumented foreigners". Although this distinction may be important with regard to the residency status of the foreigners and their rights as employees, it has little bearing on their other rights. Although "undocumented" foreigners are at risk of expulsion, they are entitled to basic rights for as long as they remain in the country by virtue of the many international conventions that address the status of foreigners and their families, conventions that protect them from exploitation and abuse, and seek to ensure their basic human rights. Thus, those who claim that "undocumented" workers have no rights at all are simply incorrect.

Foreign workers are generally referred to as "migrant workers" in international law. Israel is a member of the International Labor Organization (ILO) and Article 10 of ILO Convention 143 obligates every state that ratified it "to declare and pursue a national policy designed to promote and to guarantee, by methods appropriate to national conditions and practice, equality of opportunity and treatment in respect of employment and occupation... for persons who as migrant workers or as members of their families are lawfully within its territory."

ILO Recommendation 151 details some of the rights derived from this policy. It asserts, *inter alia* (parags. I-2:d-f), that migrant workers have the right to equal opportunity and treatment with respect to employment security; the provision of alternative employment, relief work and training; equal remuneration for work of equal value; equal work conditions, including hours of work, rest periods, annual holidays with pay, occupational safety and occupational health measures; as well as social security measures and welfare facilities and benefits provided in connection with employment. In addition, this "Recommendation" establishes the right of migrant workers to organize in trade unions, and stand for office in trade unions and labor-management relations bodies (parag. I-2:g).

Based on this and other international human rights conventions, in 1990 the United Nations passed the "International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families". This "Convention" declares that migrant workers must be ensured appropriate living conditions, including housing and equal access to welfare, education and health services (parag. 43). This is further underscored in parag. 25(1) of this "Convention", which states that all migrant workers, whether in the country legally, "undocumented", or in extraordinary circumstances, "shall enjoy treatment not less favorable than that which applies to nationals of the State of employment in respect of remuneration and other conditions of work... [including] terms of employment". Thus, this UN convention does not

distinguish between "documented" and "undocumented" workers, and calls upon the host country to provide the same basic conditions that are given to citizens who are in the workforce.

Furthermore, foreign workers have the right to file a complaint about violations of these standards, which may be submitted through the same channels that are open to citizens of the host country. Article 6 (1,d)(2) of ILO Convention 97 (1949) stipulates that migrant workers shall be ensured recourse to labor courts and other courts in the host country, with absolute equality in legal procedures concerning migrant workers and their families (Boehning, 1997, p. 53).

The State of Israel ratified ILO Convention 97 (1949) on March 30, 1953. Article 6(1) of this convention obligates the host country to ensure the treatment of migrant workers to be "no less favorable than that which it applies to its own nationals in respect of... remuneration, including family allowances where these form part of remuneration, hours of work, overtime arrangements,... minimum age for employment,... women's work and the work of young persons", and ensuring proper accommodation. In addition, the state must allow for "membership of trade unions and enjoyment of the benefits of collective bargaining".

Article 6 (1) b of this convention stipulates that under defined conditions, the host country must include migrant workers in the customary social security programs that it applies to its own nationals. These provisions are itemized to include "employment injury, maternity, sickness, invalidity, old age, death, unemployment and family responsibilities". Coverage of these programs must include all the benefits intended for the employee and his or her family.

In January 1963, the State of Israel ratified ILO Convention 48, which obligates it to establish the same pension rights for migrant workers as those which are applicable to citizens who are employed.

With regard to the termination of employment of foreign workers and their return to their country of origin, the UN Convention of 1990 stipulates that "Migrant workers and members of their families shall not be subject to measures of collective expulsion" (Article 22), even if their presence in the host country is not legal. Articles 56(2)(3) explicitly states that "Expulsion shall not be resorted to for the purpose of depriving a migrant worker or a member of his or her family of the rights arising out of the authorization of residence and the work permit... [Further,] in considering whether to expel a migrant worker or a member of his or her family, account should be taken of humanitarian considerations and of the length of time that the person concerned has already resided in the State of employment".

Recommendation 86, which accompanies ILO Convention 97 (1949), states that, "...in principle no migrant shall be removed who has been there [in the host country] for more than five years" (parag. 18(2a)), (Boehning, 1997, p. 60).

These conventions and accompanying "Recommendations" define the responsibility of the host country toward the migrant workers. In practice, the conventions do not address the issue of how the foreign worker and his or her family arrived in the host country. Some workers, especially the "undocumented", came either independently or by means of various intermediaries. According to Boehning (1997), these intermediaries serve as middlemen, service providers, or representatives, and should clearly be viewed as a relevant party or indeed the direct employers of the foreign worker, even though one must distinguish between different levels of responsibility of these intermediaries based on the nature of their connection with the foreign worker they brought to Israel (Boehning, 1997, p. 22).

Israel: Current Practices

Analysis of the various sources on which this article has drawn strongly suggests that the Israeli government's policy in relation to addressing the human needs of her foreign workers has been to set no policy at all regarding the rights to personal social services and public income security provisions. This appears to be based on a belief that social policies designed to address the needs of foreign workers would somehow entaii recognition of foreign workers as a social group which has legitimate claims to make on the state (Borowski, 1991). Thus, this "non-policy" is an attempt to deny foreign workers access to personal social services and income security payments. The state has sought to place responsibility for the foreigners upon both their employers and the employment agencies which brought the workers to Israel. Indeed, both employers and the employment agencies are presented to the public as responsible for the well-being of these workers and their families.

1. The Employment Agencies

In the section on private employment agencies (Article 65), Israel's Employment Service Law of 1959 states, "A private firm shall not engage in hiring activities outside of Israel, or on behalf of people outside Israel, without the express permission of the Minister to do so, and within the conditions set by that permit". Thus, the law grants only a few the right to bring foreign workers into Israel.

Indeed, Article 10 of the Law for Hiring Workers by Employment Agencies, 1996, states, "No person shall serve as an employment agent for hiring the

services of workers who are not residents of Israel or of workers in Israel for a place of work outside Israel, without a special permit to do so from the Minister. According to the terms of the permit... the Minister is authorized to... set conditions as noted in the permit, taking into consideration, *inter alia*, the obligation of the employment agency to discharge its obligations toward its workers, and to provide personnel services for workers who are not residents of Israel during their employment in Israel".

Special conditions are placed on the employment agencies that are given these permits to ensure the rights, welfare, and safety of the workers they bring to Israel.

2. *Illegal Workers*

A Foreign Workers Law (Illegal Hiring) was enacted in Israel in 1991 which defines "foreign worker" as a worker who is not a citizen or resident of Israel. According to Article 2 of this law, anyone who employs a foreign worker who has not entered Israel in accordance with the Entry to Israel Law, 1952, or who hires this person in violation of the Employment Service Law of 1959, is subject to fine and imprisonment. A similar sanction is imposed on anyone who serves as a go-between for a foreign worker whose employment is illegal (Article 3 of the law).

To enforce this law, a temporary order was passed in March 1996 according to which "illegally providing shelter" also constitutes a legal offense: Anyone who knowingly provides shelter to a foreign worker, serves as an intermediary, or assists in any other way in obtaining shelter for a foreign worker is liable to punishment that includes a fine and even imprisonment for 6 months. To eliminate any doubt, this regulation notes that it is incumbent upon the person providing shelter to ensure that "the foreign worker has documents according to which he entered Israel legally, is legally resident here, and works here under a valid work permit" (Article 2(a)(b)). The Minister of Labor and Social Affairs, with responsibility for implementation and enforcement of this and other labor laws, has an enforcement unit of 70 people, about half of whom deal only with foreign workers. This enforcement unit is responsible for ensuring the legally sanctioned work and safety conditions (Bar Zuri, 1996, p. 32).

The Foreign Workers Law and the temporary order enacted with it reflect the intent of the government of Israel to try and control the influx of foreign workers, especially those who remain in Israel illegally. In this context, the question arises as to whether someone whose stay in Israel is illegal should be

denied access to welfare services, if only the minimum prescribed by the UN and the International Labor Organization as described above.

Entitlement to Social Services

In theory, foreign workers should be served by at least six government agencies, viz., the Ministry of the Interior, the Ministry of Labor and Social Affairs, the Ministry of Health, the Ministry of Education and Culture, the Ministry of Internal Security, and the National Insurance Institute. Some of these authorities are charged with providing financial help (pension, welfare allowances) and some are charged with providing personal social services (education, health, rehabilitation, personal safety). Moreover, it is the responsibility of the authorities to ensure that the rights of the "documented" foreign workers are protected. By virtue of the fact that the State of Israel provided an entry visa and work permit, the state is obliged to ensure the rights of the "documented" foreign worker in Israel.

Based on international conventions, the state clearly also has a responsibility that it cannot shirk for any "undocumented" foreign worker who is employed in Israel and has not been expelled from the country. If the State does not want foreign workers in Israel, it should deny them entry or work assiduously to get them out. This is not currently the case, or is happening in a limited way (*Ha'aretz*, May 4, 1997).

It is doubtful if the state can signal to these foreigners that it is not pleased with their presence by ignoring their needs and rights and those of their families. Our observations have not revealed any differences in the way "documented" and "undocumented" workers are treated. The rights of neither group to personal social services and income security provisions are being safeguarded, even by the ministry that is responsible for issuing their permit to remain in the country. We now turn to looking at how the various Ministries deal with foreign workers.

1. The Ministry of the Interior

The Ministry of the Interior is required to check the identity of every foreigner who wishes to enter Israel, either as an individual or a member of a group, and has the power to authorize or deny entry to the country. To carry out this task, the Ministry must be able to monitor entry points and give instructions to the Ministry of Internal Security, which staffs the border crossings, to allow or deny entry on a case-by-case basis. The entry of foreigners into Israel is supposed to be "documented", and this documentation should provide evidence of their presence in the country.

This documentation has another aspect related to foreign workers who enter Israel by permit, and this concerns the intermediary or organizer who assumes legal responsibility for the workers it brings into Israel for the duration of their stay, and guarantees that they will leave Israel at the end of their legal sojourn.

As noted, the Ministry of the Interior is authorized to permit the entry of foreign workers into Israel under specifically defined terms. This Ministry must ensure that the agency which organizes the import and entry of foreign workers into Israel will, in accordance with the terms of the permit, assume responsibility for these workers and abide by the obligations of the employment agency or employer as defined in the concession it holds.

Thus, the Ministry of the Interior has indirect, if not direct, responsibility for ensuring that the terms set for the foreign workers prior to their arrival are met, including the obligation that the employer provide the workers with a range of basic welfare services in accordance with the terms of their entry visa into Israel. For example, every employer undertakes to provide the workers with appropriate housing and medical coverage, and to provide the employee with a copy of the contract in his or her own language so they will understand their contractual rights and whether the employer is complying with the agreed upon terms.

It seems *prima facie* that the Ministry of the Interior is obligated to ensure that the minimal terms are met according to which it authorized entry of the foreign workers into Israel, since these are part and parcel of the visa granted to the employer. If the employer does not meet these conditions, the Ministry of the Interior should revoke the license granted to this intermediary or employer to bring foreign workers into the country.

It is doubtful, however, that the Ministry of the Interior actually cares about or invests energy in enforcement of the social provisions in the visa that the "importers" or employers of foreign workers are under obligation to fulfil, including minimal services to the foreign workers whose entry into the country it allowed.

The claim that the sole responsibility of the Ministry of the Interior is to approve the entry of foreign workers into Israel is correct, but only part of the picture. The Ministry of the Interior is a governmental authority that presumably stands behind the licenses it issues. Hence the Ministry also has the authority and responsibility to deny this license to any employer who does not keep his or her commitments with respect to the living conditions of the workers, or who does not abide by the terms in the employment contract of these workers.

Given the above, it is not at all clear that the body authorized to approve the

entry of foreigners into Israel is actually willing to or capable of ensuring that the terms of their presence in Israel are met, which are also the terms under which their entry was approved.

Furthermore, the Ministry of the Interior should presumably expel anyone who enters and works in Israel illegally from the country. In practice, however and in the absence of sufficient resources - the Ministry of the Interior cannot enforce the expulsion orders, leading to reports like the following: "An individual designated for expulsion was incarcerated for five months because the Ministry of the Interior did not have money for the airfare." (*Ha'aretz*, November 21, 1997).

By virtue of allowing their presence, the Ministry of the Interior should assume responsibility for those who remain in the country, but this is not always the case. For example, the Ministry is supposed to ensure that whoever enters Israel legally, including tourists and foreign workers, will receive a gas mask during times of emergency. And yet, according to a report in *Ha'aretz* (November 20,1997), foreign workers are not included in the list of those who are to receive gas masks. Instead, it was suggested that they and their employers purchase these masks at full price on the open market.

In summary, the Ministry of the Interior has the authority to act on two levels: First, to ensure that only foreigners with a valid visa enter Israel and to deny entry or expel those who lack one; and, second, to ensure compliance with the terms of entry for those who enter Israel legally, and to safeguard their rights.

2. The Labor Arm of the Ministry of Labor and Social Affairs

For purposes of analysis, a distinction will be made in this part of the paper between the two arms of the Ministry of Labor and Social Affairs.

The Ministry of Labor and Social Affairs has the responsibility for ensuring that every employer, whether employing Israelis or foreigners, abides by the labor laws of the land, including those that call for safeguarding the safety and security of the workers and protecting them from dangerous materials, situations, and circumstances that might bring about injury, damage, or illness. This task is not fully or adequately performed, as evidenced by the relative high number of injuries among foreign workers. According to data published in *Ha'aretz*, 49 construction workers were killed in Israel in 1996, most of them foreign workers "who, since 1993, have replaced the workers from the territories. Some of them never received proper instruction about the risks at construction sites, and some have never before worked in construction." (June 25, 1997).

Furthermore, it is the job of the Ministry of Labor and Social Affairs to enforce laws that concern the employer-employee relationship. The Ministry of Labor and Social Affairs must ensure that employment conditions conform to the law for work and rest hours, and that the employer abide by the law in all matters concerned with workers, even if they are foreigners. For example, it is the Ministry's obligation to ensure that the workers, whether Israeli or foreign, are paid at least the minimum wage and in its entirety.

In this spirit, the Ministry of Labor and Social Affairs should be called upon to inform foreign workers about their rights and wage entitlements, to ensure that the agreed upon salary is paid on time and not withheld by the employer. Such "wage withholding" also refers to the withholding of salary increases that are due, and to the deducting of payments from the salary that were not agreed upon in advance.[2]

The Ministry of Labor and Social Affairs appears to be providing minimal, if any, services of this type for foreign workers. Building contractors, for example, tend to be late in their salary payments to foreign workers (*Ha'aretz*, December 5, 1997), who have no idea what their rights are. It is doubtful whether the Ministry of Labor and Social Affairs provides any help whatsoever to alleviate the plight of foreign workers in this regard.[3]

Several employers, to avoid paying out the full wages, have gone so far as to bring about the arrest and expulsion of foreign workers in their employ, sometimes on the grounds of being in Israel illegally (*Kol Ha'Ir*, January 26, 1996). These workers cannot claim their elementary right to wages because the Ministry of Labor and Social Affairs does not provide this basic service to them. It is also unlikely that the Ministry of Labor enforces two relevant laws for which it is responsible - the Foreign Workers Law (Illegal Hiring), 1991, and the Law for Hiring Employees by Employment Agencies, 1996. The enforcement of both laws would contribute immeasurably to the welfare of the foreign workers.

The claim of the Ministry of Labor and Social Affairs - that it does not have

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2. With regard to Palestinian workers, the Ministry of Labor and Social Affairs via the Employment Bureau, devised a mechanism whereby it collected the salary of the Palestinian worker from the employer, checked its components including additions and deductions, and then transferred the money. Thus, the Ministry of Labor and Social Affairs guaranteed not just a fair wage, but the rights of the Palestinian workers employed in Israel. No such mechanism exists for payment of foreign workers in Israel, and the previous system might be a viable option.
3. The Workers' Hotline, Kav LaOved, distributes a newsletter to foreign workers that gives the toll-free number of the Employment Bureau, which is supposed to provide information to them about their rights. The extent that this telephone number is disseminated and used among the foreign workers is unknown, but their communication difficulties undoubtedly reduce the usefulness of this service.

the resources and tools to enforce these laws - indicates that although it recognizes the importance of foreign workers, the State does not provide the financial wherewithal to enforce the law and protect their rights.

3. Health Services

The National Health Insurance Law of Israel, 1994, came into effect on January 1 ,1995. It covers only Israeli citizens. Foreigners in general, and foreign workers in particular, are not covered by this health insurance scheme. Through their employers, "documented" foreign workers are obliged to pay for private health insurance that provides the minimal coverage stipulated by the work permit given to the employer of the foreign worker.

The foreign worker alone (with no help from the employer) pays for health insurance. On the average, the cost of the health insurance sold to the foreign worker through the employer is one US dollar a day per worker. For this, the worker receives basic health services, including doctor visits, routine medicines, and sometimes also several days' worth of hospitalization. This insurance does not cover work accidents, which are covered by the National Insurance Institute. It also does not cover chronic illnesses (diabetes, ulcers, high blood pressure, etc.), regardless of whether they were first diagnosed in the country of origin or in Israel.

The employer is supposed to deduct the amount of the insurance premium from the worker's salary and transfer all of it to the private health insurance company. There is sufficient anecdotal evidence that clearly indicates that while some employers deduct "health insurance" premiums from their employees' wages - sometimes well in excess of the actual cost - this is not always transferred to the insurance companies. In some cases, a portion of the premium is withheld and treated as a surcharge for transferring the sums. Thus, the amount submitted to the insurance companies is smaller than what the worker paid, and provides less protection against health care costs.

This practice is even more scandalous in light of the fact that some health insurance companies give large discounts to employers, discounts which the employers do not always pass on to their workers, who continue to pay the full premium. Still more disturbing is the failure of employers to pass on a discount that is sometimes given to employers whose foreign workers make infrequent use of the health plan. Thus, the employers have a financial incentive to make it difficult for their workers to access health services. Hence it is unlikely that foreign workers receive the health services to which they are entitled by virtue of the health insurance payments they have made from their own wages (*Ha'aretz*, May 4, 1997).

As with any group of people, foreign workers also suffer from various physical ailments, some transitory and others chronic. In the absence of full medical coverage, they are forced to see private doctors or any medical institution that will take them and to pay high private patient fees out of their own income or savings.

If a worker becomes ill or disabled and returns to his or her country of origin, the employer is entitled to bring in another foreign worker in his or her place. It is clear, then, why even "documented" foreign workers with work permits avoid medical care in Israel. For mild problems, "undocumented" foreign workers go to private doctors under a false name. In cases that require hospitalization, they often use Palestinian health organizations in the Palestinian Territories or East Jerusalem where - although they have to pay for treatment - the prices are lower and they are not obliged to identify themselves, register, and risk expulsion if they are caught.

"Undocumented" workers" face special problems when they need medical attention for illness or non-work-related accidents (as already mentioned, work accidents are covered by the National Insurance Institute). Most of these workers have no medical insurance whatsoever. According to a 1997 report by the Social Work Department of Ichilov Hospital in Tel-Aviv, anyone who shows up in the emergency room is treated and then, if necessary, referred to ongoing treatment. In 1997 this hospital alone had 500 emergency ward patients and 500 days of hospitalization that were not financially covered by anyone. These were mainly foreign workers who received treatment although they lacked medical insurance, or their insurance did not cover the costs of hospitalization.

Thus, currently, all "undocumented" workers and some ""documented" workers are not covered by comprehensive health insurance. If a foreign worker contracts a contagious disease such as tuberculosis, typhus or AIDS, it is unlikely that he or she will seek medical treatment at a clinic or hospital. As a result, Israeli society is exposed to the illnesses of foreign workers who are not properly treated, followed-up, or registered in Israel. Claims about the benefit of universal health coverage for the entire population are true for every country that wants to protect the health of its citizens.[4]

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4. Foreign workers brought to Israel by employment agencies must by law undergo health examinations in their country of origin and prove that they do not have any contagious diseases. Illegal foreign workers do not undergo this examination. The head of the AIDS Treatment Center in Israel was quoted as saying (*Ha'aretz*, June 24, 1997), that most of the foreign workers who tested HIV-positive came from Africa. In reaction, the Ministry of Health warned of the spread of AIDS among foreign workers because of the lack of proper and adequate treatment by the national health system.

Another problem derives from the fact that preventive health services were once provided by the Ministry of Health, but today upon passage of the National Health Insurance Law they are provided by Health Maintenance Organizations (HMOs), i.e., Israel's sick funds [Kupot Holim]. Because foreign workers and temporary residents are not members of these HMOs, they cannot benefit from public health services, and preventive health services do not apply to them. Epidemiologists warn of the many health hazards to which these workers and those in contact with them are exposed (*Ha'aretz*, September 10, 1997).

Note that the National Health Insurance Law of 1994 established that "The Minister of Health is authorized to make special arrangements for those persons in Israel who are not insured under this law to the extent and conditions that will be set by him." (Parag. 56-a-1(d)).

The fact that the Minister of Health has still not made any special arrangements for foreign workers under this law, despite the lobbying of health and human rights organizations (*Ha'aretz*, August 26, 1997), further points to a public policy stance of not recognizing foreign workers and avoiding establishing firm policies concerning them.

4. The National Insurance Institute

According to the National Insurance Law, anyone employed in Israel, whether "documented" or not, is covered by work accident insurance and required to prove only that the accident was a result of and took place during the course of work for an Israeli employer. The insurance obligation falls upon the employer. In addition, a "documented" worker is also entitled to maternity insurance and guarantee of payment of statutory workers'-rights in the event of bankruptcy or dissolution by the employer.

So far, foreign workers have probably made little use of the insurance in the event of bankruptcy of the employer. Regarding maternity insurance, estimates at the time of this writing indicate that in Tel-Aviv alone there are 15 to 20 births a month of women who are workers or the wives of foreign workers. These women are entitled to hospitalization for the birth, a grant given to every woman who gives birth, and an allowance paid to every woman wage-earner after she gives birth.

Regarding work accidents, the National Insurance Law, as noted, stipulates that everyone employed in Israel (regardless of the legal status of the worker), who is injured as a result of and during the course of work, is covered by the National Insurance Institute. This includes comprehensive medical treatment, medicines, convalescence, rehabilitation, travel for medical treatment inside Israel, and financial compensation - injury and disability allowances where

relevant, sometimes for life. In the event of death of the wage earner, his or her survivors are eligible for a "dependency allowance" - a monthly stipend paid even if the survivors live abroad.

And indeed, anyone injured at work should be given the appropriate form by the employer and receive medical treatment. In reality, however, most employers cut off contact with injured foreign workers the moment the worker enters a medical institution. Sometimes the employers do keep in touch because they intend to replace injured workers as quickly as possible with other foreign workers.

Some employers refuse to acknowledge that a worker was injured on the job if they fear an investigation into the accident or a civil suit for damages. To obtain confirmation of a work accident - required for medical treatment - workers must personally (or through the institution in which they were hospitalized) initiate proceedings at the Labor Ministry to prove legally that the event was a work accident.

Following hospitalization, two problems arise with regard to ongoing medical treatment. The first is that medical rehabilitation and follow-up for the foreign worker, as for the citizen of Israel, should be provided by an HMO ("Foreign Workers: Foreign residents injured in work accidents during their employment in Israel". National Insurance Institute, August 1994). Even if most of the ""documented" workers have private health insurance, they are not insured by one of Israel's four authorized HMOs (i.e., the Clalit, Maccabi, Leumit and Meuchedet Sick Funds). Thus, even though the National Insurance Law provides foreign workers with the right to the required medical treatment and rehabilitation without further payment, no one is able to provide this service to them!

Another problem could arise in light of the heavy load of claims in the work injury program in the National Insurance Institute. The process of approving a claim made by someone who suffered a work injury can take more than two months (Uzi Stern, branch director, on IBA national radio program "Yoman HaShavua", May 24, 1997). In other words, in the absence of official authorization that the accident was related to work, any medical treatment (if such is available outside the HMOs) will be delayed.[5]

The National Insurance Institute does not bear the cost of returning the

5. The Jerusalem weekly *Kol Ha'Ir* (April 18, 1997) described the case of a foreign worker whose hand was amputated at work and reconnected during a lengthy operation. The man does not have follow-up physical therapy, however, because he is not a member of a sick fund which is responsible for ongoing rehabilitation paid for by the National Insurance Institute. As a result of lack of treatment, there is severe jaundice in the hand.

foreign worker to the country of origin. This expense falls on the employer. Some employers want to arrange this quickly, as the return of injured workers entitles them to bring in replacement workers. As a result of being able to exchange an injured worker for a healthy one, employers sometimes encourage, and even pressure, an injured worker to leave Israel quickly, even before having received all the required medical treatment and rehabilitation to which they are entitled by virtue of Israel's social insurance provisions for those injured in work accidents.

The problem is even more severe in the case of "undocumented" foreign workers who are injured during casual work for a random employer who can no longer be found. In most of these cases, workers will find it hard to prove that they were injured as a result of and during the course of their work, and it is unlikely that they can identify or provide information about the employer. Thus, they are denied the right to medical attention accorded victims of work accidents by the National Insurance Institute. When this happens, the workers themselves must finance any needed medical treatment and rehabilitation. If they cannot afford this, which is usually the case, the expense will be borne by the medical institution that accepts them for treatment or, if the institution manages to pass on the expense, by the public purse.

Work disability allowances granted to foreign workers are small, even relative to their already tiny salaries. To reduce taxes for both employer and worker, employers often choose to divide the wages of a foreign worker into two parts: the salary, on which taxes and national insurance payments are paid, and reimbursement of out-of-pocket expenses on which no tax is paid. Together, these two payments must, at the very least, reach the level of the legally prescribed minimum wage. In the event of a work accident, the National Insurance Institute will recognize only the salary portion - and not the reimbursements - for the purposes of work injury compensation. Thus, any work disability compensation, if the worker is eligible at all, will be correspondingly small.

Employers often make this arrangement without the knowledge or consent of the workers, who then end up paying national insurance on only part of their salaries. The National Insurance Institute is also party to this problem as it is willing to insure a full-time worker who is earning a salary reported to be below the legally prescribed minimum wage (*Kol Ha'Ir*, November 7, 1997).

5. The Welfare Arm of the Ministry of Labor and Social Affairs:

Everyone, especially someone separated from home and family and living in difficult, often crowded conditions, can run into serious problems. And yet

there is no evidence that the Ministry of Labor and Social Affairs has allocated any resources to address the problems of foreign workers. Indeed, the population of foreign workers and their needs seem to be completely ignored.

Nevertheless, from time to time the Ministry of Labor and Social Affairs is called upon to provide assistance when professional authority and expertise are needed in emergency situations. Although most instances are not made public, especially when minors are involved, this phenomenon can be illustrated by two cases that were reported in the print media.

An article in *Ha'aretz* on May 23, 1997 reported that "A citizen of Zaire is suspected of multiple rape of the small daughter of someone with whom he shared an apartment". Because of the criminal aspect and the involvement of minors, the Ministry of Labor and Social Affairs and the Police Youth Investigations Department were required to intervene. Similarly, intervention was required after a citizen of Ghana was arrested "under suspicion of having caused the death of a baby by negligence" (*Ha'aretz*, January 5, 1997). The latter case concerned a foreign woman who ran a daycare center in Tel-Aviv for the children of families from Ghana. One of the babies was injured as a result of the crowded conditions in the center: Her neck was caught in the bars of her crib and she choked to death. Here, too, welfare services should have known of the existence of the daycare center and ensured that safety regulations were met for licensing purposes, as required by law. But because this population and their problems are ignored, no attempts were made to ensure compliance with child care regulations and the result was disastrous.

These examples show the intervention of the welfare services in cases of crisis. There is no evidence of early, preventive services having been established or offered to foreign workers.

In view of the failure of the national government to meets its obligations in relation to foreign workers, some municipal governments, unwilling to ignore the dire needs of some of their residents, albeit foreign ones, have made some effort to "pick up the slack". Thus, for example, in May 1997, the Tel-Aviv municipality requested an allocation of NIS 10 million (approximately $3 million at the time) from the Israeli government for funding services to foreign workers who reside within the municipal boundaries of Tel-Aviv. As a first step, the city welfare department hired a community worker whose main task was to investigate the needs of the foreign workers and to suggest ways to address these needs.

6. Police Services

Although one does not usually conceive of the police as offering a service to

citizens, it is both possible and appropriate to do so (Yanay, 1994). Indeed, it is important to think of the police as a service provider in any discussion of the personal security of a vulnerable and defenseless population such as the foreign workers in Israel.

Because many foreign workers lack a work permit and a valid visa, they are more vulnerable to exploitation, maltreatment and injury both by Israelis and other foreigners. Much of this takes place after working hours, when many foreign workers meet for conversation and a drink. These social gatherings occasionally end in heated arguments and even violence. The crowded living conditions of the foreign workers and the distance from home and family often create highly charged situations, which sometimes erupt into violence and crime.

The police find it difficult to deal with complaints filed by foreign workers. In their frustration, the authors of this paper have learned, the police have even arrested those filing complaints on the grounds that they have no identifying documents with them. The police enter the picture primarily in cases of serious violence. It is clear, however, that the security of the foreign workers does not currently head the list of priorities of the Israel police, and the motivation and ability of the police to safeguard these workers are complex issues.

The police also find it hard to deal with other forms of contact with foreign workers, such as investigations, presentation of documents and permits, identification, detention for purposes of investigation, expulsion, etc. As noted, some employers insist on keeping the personal documents of their foreign employees as security that they will continue to work for them. Some foreign workers conceal or destroy these documents and the police have great difficulty identifying and investigating a worker who has no documents. Even if the foreign workers have papers, the police experience communication problems with them due to language and cultural barriers. In addition, the police are limited in their ability to register foreign workers, because the computerized system of registration cannot handle foreign passports (especially those combining numbers and digits in the passport number), not to mention the elementary problems raised by reading, recording and following-up foreign names.

As of this writing, there have been no serious cases in Israel of assault perpetrated by foreign workers, although Palestinians and Israelis are apprehensive of them. The Palestinians from the territories fear that the foreign workers, whose wages are even lower than theirs (see Workers' Hotline: Kav LaOved, *Protection of the Rights of Workers*, Information Sheet, February

1997), are displacing them from employment and thus threatening their livelihood. These fears are also shared by some Israelis.

Amir (1997), who studied the incidence of crime among foreign workers, believes that Israel is in the throes of a moral panic. Amir notes that the incidence of crime among foreign workers in Israel is, so far, very low and that, if police intervention is required, it is mainly to protect foreign workers from organized crime in Israel, which views them, especially foreign women, as easy prey.

7. Educational Services

As noted above, international conventions stipulate that the laws of the host country must apply to its foreign workers. If these conventions insufficiently address the matter of education, the UN Convention on the Rights of the Child (1989), ratified by Israel in 1991, obligates Israel to ensure that the children of foreign workers are integrated into schools as provided by Israel's Compulsory Education Law, 1949. In this area, at least, Israel's local government-run schools have permitted the children of foreign workers to enroll. The question, however is whether the schools are geared to dealing with this young student population.

Denying this critical service to children of foreign workers, whether "documented" or not, is a breach of international agreement. In June 1996, the Tel-Aviv-Jaffa Municipality established a committee to study the needs of foreign workers, and when the school year opened that Fall, the committee announced that "The municipality will continue to provide the foreign workers who live in this city all the services called for by international agreements education, welfare, public health - and also to operate municipal units for them in an emergency". This means that the Tel-Aviv-Jaffa Municipality acknowledges its responsibility for the welfare of the foreign workers who live there, especially their children (*Ha'aretz*, September 10, 1996).

Clearly, the municipality of Tel-Aviv-Jaffa, in which the largest number of foreign workers in Israel reside, has adopted a policy that the State of Israel has not yet embraced, despite the latter's moral and legal obligations to do so. Other municipalities across Israel are, generally speaking, yet to integrate the children of foreign workers into their schools.

Concluding Comments

Foreign workers came to Israel because of the higher earnings they could command there than in their country of origin. Israel sought foreign workers because of labor shortages arising from the reduced number of Palestinian

workers in the wake of border closures following a waves of terrorist incidents. These incidents also contributed to a decreased sympathy for and heightened anxiety about the presence of Palestinian workers in Israel.

The need for a labor force to take the place of the Palestinians was viewed as urgent. To meet that need, the door was flung open to tens of thousands of foreign workers. For various reasons, public awareness of the existence of this population was limited until the summer of 1996, when the public began to react with trepidation to their presence.

Foreign workers are likely to remain a part of the Israeli landscape for many years to come. The policy of expelling "undocumented" foreign workers has encountered major implementation problems. The financial, social, moral and political costs of identifying, rounding up, arresting, obtaining expulsion orders, and expelling foreign workers from Israel is very high, and the political will does not seem to exist for carrying out these severe measures. Moreover, the Israeli government is being pressured by employers and other interested parties to refrain from expulsions, to issue permission to stay, and to allow the entry of even more workers for certain sectors of the economy - primarily construction, agriculture, industry, and services.

The evidence presented here indicates that, although the State acknowledges that there are tens of thousands of foreigners working in Israel, it substantially ignores their human needs: No clear policy has been established for providing basic personal social services to foreign workers and ensuring their access to income security payments, even for those who are "documented".

The Israeli government seems to fear that a clear articulation of the rights to which foreign workers are entitled will somehow legitimate them, result in additional claims on the public purse, and make the country more attractive both for the foreign workers already in Israel and for others who may follow.

Even though Israel has signed and ratified the international covenants that define the rights of migrant workers, these covenants are not honored in Israel, and foreign workers have no access to education, health, welfare, income security payments or other social services they may need. No official body is in charge of ensuring that these workers' rights, wages, or terms of employment are protected and honored. They are vulnerable to exploitation and completely unprotected institutionally.

The intention of the government seems to be to intimate to these workers, whether "documented" or not, that they are fundamentally unwanted in Israel. On the other hand, their Israeli employers insist to everyone, including the authorities, that given the employment conditions that these foreigners are prepared to work under, their presence in Israel is vital to the economy.

Voluntary organizations are the primary agencies providing individual help to the foreign workers. The most prominent among these is Workers' Hot Line, which began as an organization devoted to protecting the rights of Palestinian workers from the West Bank and Gaza and preventing their exploitation. The Hotline today, through its volunteers, addresses the needs of foreign workers and their families. Other sources of support are the Physicians for Human Rights, the Association for Civil Rights in Israel, and others.

Simple logic would suggest that the exploitation of foreign workers would be detrimental to Israeli workers (not to mention the moral fabric of Israeli society). The status of the Israeli worker will not improve so long as employers can hire foreign workers at low wages and without union protection or rights. If the work conditions of foreign workers improved, if all of their rights were actually protected under the various international conventions, if they were included in the collective wage bargaining agreements of the Israeli labor market, their salaries would increase and even equal the salaries paid to Israeli workers. As a result, however, Israeli employers would find it less attractive to hire foreign workers.

The traditional position of labor unions is to oppose the hiring of non-union employees (especially unskilled and temporary new immigrants and women), who compete with union members for jobs in the labor market and threaten the achievements of the unions. The Histadrut (the General Labor Union), Israel's largest labor union, has not yet formulated a clear policy about the hiring of foreigners in Israel, and despite its declarations has so far done nothing to protect their rights (Bar Zuri, 1996, p. 36).

Although the Histadrut claims that it wants to protect the rights of foreign workers and ensure that they receive all the benefits that Israelis receive, there is little evidence of this. If the Histadrut was really committed to seeking to ensure that labor laws were also applied to foreign workers and improving their working conditions to the level enjoyed by Israelis, the advantage of employing foreigners would presumably diminish and the rights now protecting Israeli workers would be enhanced.

In the absence of official policy regarding foreign workers, the local municipalities are left to set their own, and they tend to do so with a view toward ensuring the well-being of the local community. The recognition that one local community has given to the children of foreign workers by integrating them into the municipal educational system is a vital step toward promoting the good of all residents. Providing medical treatment to foreign workers who need it is crucial to the health of the public in general, and integrating foreign

workers into Israel's social safety net will serve to fulfil Israel's commitment to the international covenants she has ratified.

Indeed, the experience of most Western countries with foreign workers is that, over time, the temporary stay of some of these workers becomes permanent. Further, many are ultimately given the status of resident and even citizen, and they and their families often integrate into the host society (Castles and Miller, 1993, p. 229; Fischer, 1996). But even if they become integrated through work, many continue in low-level jobs and earn low incomes. In a market economy with high unemployment, the foreign workers are the first to be fired and to require financial and other kinds of aid.

Therefore, careful attention should be given to the range of problems, and the direct and indirect challenges foreign workers pose for Israeli society and its institutions. The policy of ignoring the foreign worker phenomenon can only be detrimental to Israeli society. It is unclear whether the foreign workers will ultimately be beneficial to Israeli society or harm its sensitive social fabric. The government would be wise to give careful consideration to the short- and long-term costs of ignoring the human needs of foreign workers in Israel, form an unequivocal social policy and programs to address these needs, or be ready to address those challenges for Israeli society that will inevitably arise by virtue of ignoring these needs.

Israel is on the brink of a period of decisive importance in its history. It behooves us to continue to monitor the scope of the problems confronting foreign workers in Israel, and their economic, political and social ramifications, while continuing the struggle to protect their rights. These rights reflect not only the character of Israel as a welfare state, but also the character of Israel as a Jewish, sensitive, and progressive country.

Epilogue

This article captures a stage of history in which Israeli society has become aware of the plight of the foreign workers in her midst. The moral panic that followed the seemingly sudden recognition of the foreign worker phenomenon confused and worried the authorities. One can only wait and see what changes, if any, occur in how Israeli society treat its foreign workers and addresses their needs for welfare, health and education services.

A television series produced by Hayim Yavin (screened in June and July 1997) brought the story of the foreign workers into the homes of many Israelis. The newspapers wrote reams of investigative reports about the living conditions of the foreign workers and how they are treated by their employers. The picture painted by the media was a sad and troubling one. Also troubling

were the foreign workers who were involved both as victims and perpetrators in cases of fraud, property crimes, violence and even murder. The press continues to alarm the public by such headlines and stories as "Foreign Workers, 20% of the new AIDS carriers in the past four years" (*Ha'aretz*, June 24, 1997).

The Ministry of Health confirmed (*Ha'aretz*, August 27, 1997) that since 1997, 51 foreign workers have died in Israel: 30 from Romania, 5 from Russia, 4 from Thailand, 3 from Turkey, 3 from Bulgaria, 2 from China, 1 from Poland, 1 from Ghana, 1 from the Philippines, and 1 from India. According to this report, 18 foreign workers died as a result of illness and excessive alcohol consumption, 10 in car accidents, 9 in work accidents, 6 drowned, 5 committed suicide, and 3 were murdered. In parallel, data from the Ministry of Health indicate that half the organ-transplant donors this year were foreign workers who died (*Ha'aretz*, July 11, 1997). This suggests the ambivalence wrapped up in the presence of foreign workers and their employment in Israel.

Interestingly, self-help, foreign workers' unions have already been established to advocate for their living conditions and rights in Israel. Representatives of the African foreign workers met with Israeli Knesset members to propose that, in exchange for improved living conditions and basic rights and if they receive legal entry visas and work permits, they will pay full taxes and leave Israel upon completion of their employment period (*Ha'aretz*, July 15, 1997). This union has begun an important process which has not yet been politically accepted (*Ha'aretz*, August 21, 1997).

Another attempt to organize foreign workers became public after approximately 200 Romanian workers prevented the evacuation of the body of their friend who was killed on a construction site in Modi'in (*Ha'aretz*, August 20, 1997). They agreed to the removal of the body only after the employment agency that had hired the worker promised to pay $1,000 in compensation to the family of the deceased. This "uprising" began only after, according to the workers, three foreign workers had died from pneumonia on the same job (*Ha'aretz*, August 24, 1997). Following these incidents, the Romanian parliament planned to file suit to demand that Israel provide proper working conditions for Romanian citizens employed in Israel (*Ha'aretz*, September 4, 1997).

Furthermore, dealing with legal rights, the judiciary does not usually deal with the issues of foreign workers, and in fact there is no one who oversees their arrest and imprisonment (sometimes for long periods) pending their expulsion.

It is often reported that upon the intervention of the authorities, several hundred foreign workers are expelled each month, while others leave Israel of their own accord to avoid and conflict with the law.

The trend, according to officials in the Ministry of Labor and Social Affairs, is "to crack down on enforcement vis-a-vis the employer, not the worker... We'll be careful to respect the rights of the workers, and to ensure that their employers pay them their wages before they leave Israel" (*Ha'aretz*, December 30, 1997). It was publicly reported that the Ministry of Labor and Social Affairs is cracking down on employers who have not provided adequate living conditions or paid their employees at least the minimum (ibid.).

It can be said, in general, that while a few Israelis are raking in the short-term profits from the employment of foreign workers in Israel, Israeli society as a whole will pay the social costs of their employment in the country. These costs, with all their social ramifications, are not yet fully known.

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JUVENILE DELINQUENCY IN ISRAEL AND ITS TREATMENT: BACKGROUND, POLICY AND FUTURE TRENDS

By Meir Hovav*

Introduction

In this article the various aspects of juvenile delinquency in Israel will be discussed, and the unique situation will be presented in which treatment of delinquent minors (ages 12-18) is provided by the social services, as opposed to law enforcement or justice department agencies, which is the case in many countries (such as the United States), or agencies of the Interior Ministry (such as in the U.K.).

This article will describe the services provided for delinquent minors: the Juvenile Probation Service and the Youth Protection Authority, which are part of the social services network. It will not discuss the State of Israel Police or Prison Authority, which are subordinate to the Minister of Internal Security. Nor will it describe the work of the Juvenile Courts, which are part of the judicial system.

Later on, this article will present the development of the phenomenon of juvenile delinquency since the establishment of the State of Israel and the trends for the future, based on police and Juvenile Probation Service data and studies conducted in this area (Amir and Hovav, 1970; Fishman and Argov, 1980; Vozner and others, 1993; Hassin, 1997).

The area of enforcement and treatment of juvenile delinquency in Israel is based on a unique conception, which is derived from legislative development in Israel from the time of the British Mandate, the governmental structure and the distribution of functions between the governmental ministries.

The State of Israel was established in 1948 on the groundwork of the British Mandate in the Land of Israel. On the governmental level, the new state adopted the laws of the Mandate until the passing of new Israeli legislation. The governmental structure of the Mandate had been a centralized system which derived its authority from the High Commissioner, and this authority was replaced by the Government of Israel. As a result of this historical

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background, the Israel Police, the Probation Services, the Youth Protection Authority, the State Attorney's Office and the judicial system are national bodies which are not managed by the local or regional authorities, as is the case in the U.K.[1]

According to Mandatory legislation, which exists alongside Israeli legislation, there is no difference between a minor and an adult in the definition of a criminal act. The difference is in the criminal process alone, according to which special courts, a separate probation service and protected homes are available for juveniles. This situation is different from that of the United States, for example, in which most states regard juvenile delinquency as running away from home, truancy from school and disobeying parents.

Until 1948 the Jewish *Yishuv* (Pre-State Jewish Settlement) established extensive social services, including services for youth in distress and juvenile delinquents, which paralleled the social services given by the Mandate government to the Arab population. These services are the basis of the social service network operating in Israel today. (See a chronological listing of the relevant laws at the end of this article).

Upon the establishment of the State of Israel, the Provisional Government organized governmental law enforcement functions. A special Police Ministry was established, which included the Prison Service. At that time the Ministry of Welfare provided treatment to juvenile offenders through its Juvenile Probation Service and Youth Protection Authority, as well as services to minors needing care and supervision.

Today the functions of law enforcement and treatment of juvenile offenders are divided between the following agencies:

- The Juvenile Probation Service and the Youth Protection Authority, which are under the auspices of the Ministry of Labor and Social Affairs.
- The local Social Services Departments, whose welfare officers care for delinquent minors who are not criminally responsible (minors to the age of 12, and mentally ill delinquents.)
- The Ministry of Internal Security, which includes the Israel Police and the Prison Services. The Israel Police operates units which specialize in handling youth, submitting charges to Juvenile Court and running detention centres for minors. The Prison Service operates a separate wing for minors convicted by the courts.

1. To this day there is a differentiation between Mandatory legislation, which has validity in Israel, and which is called an "ordinance", and Israeli law, which is called a "law".

- The Ministry of Justice, which operates the judicial system, including the Juvenile Courts and State Attorney's office, which prepares the indictment in cases involving minors, and the public defender.

In Israel, as opposed to the United States, the parole system is not used. Nor do we use the method of electronic surveillance of criminal offenders.

The present structure of law enforcement and treatment of juvenile offenders creates a special relationship of mutual interdependence, on the one hand, and of independence of sub-units, on the other hand. This dualism requires clear and formal working procedures, together with personal and informal relationships (Hovav, 1977).

In light of this general policy in the area of law enforcement and treatment of delinquent minors, in the opinion of this writer, the following can be expected in Israel:

(1) Independent development, expansion and growth will continue in each one of these agencies: the Israel police, the Law Courts, the Public Defender, the Juvenile Probation Services and the Youth Protection Authority (Vozner et al., 1993).

(2) The need for integration and cooperation between the above agencies will grow, while formal procedures and informal relationships will be developed (Hovav, 1977).

(3) Therapeutic, correctional and protection services will be integrated and will operate more frameworks together with other agencies. Multi-professional teams will also be organized to cope with problems of delinquency.

(4) Legislation will be passed to advance the rights of minors and limit the authority of law enforcement and therapeutic agencies.

Later on, this article will discuss the Juvenile Probation Service and the Youth Protection Authority, while changes in the scope of juvenile delinquency will be analyzed in the following areas: background and historical development, the reality today, policy and future developments.

The assumption of this writer is that the entire system of law enforcement and treatment of juvenile delinquents and their sub-networks are the product of historic development. Elements have remained from the past, while some of these will also affect the future. Future development will be based on present reality and on new and changing trends that are expected in the future.

The Juvenile Probation Service

1. Background and development[2]

The system of probation in Israel was instituted in 1922 by the Mandatory

2. Based on Reifen, 1978; Melamed, 1983; Sharon, 1987; Eden, 1989; Ministry of Labor and Social Affairs, 1991.

government, based on the contemporary law in the U.K. In 1932 a probation officer from the U.K. was appointed for the first time to organize the Service. In addition, a Jewish probation officer was also appointed by the Jewish Agency, who worked in Jerusalem. Later, an Arab probation officer was appointed for the Arab population.

In 1937 the Juvenile Delinquents Ordinance was published, which determined modes of treatment. In 1944 the first probation ordinance was published, to be amended in 1953 after the establishment of the State of Israel. In 1959, operational regulations were added, while in 1969 it was adapted to Israeli legislation and formed the basis of the work of the probation services, particularly the Adult Probation Service. The legislation is based on the traditional role of the probation officer: to perform psycho-social interrogations, to submit a report to Court and to implement probation orders. In 1971 a special Israeli law was passed on treating young offenders, the Youth (Trial, Punishment and Modes of Treatment) Law, which also defined the work of the Juvenile Probation Service. As mentioned above, when the State of Israel was established, it was decided that the Juvenile Probation Service would employ Jewish and Arab probation officers, while the Arab probation officers would exclusively deal with the Arab sector. It was also decided that the Probation Service would be part of the social services and not part of the judicial or public security system.[3]

Upon the establishment of the State, the age of criminal responsibility for minors was 9-16 for boys and 9-18 for girls. In 1971 one age was set for both boys and girls: 12-18. Since then, the age was raised to 13 and lowered again to 12.

In the Juvenile Delinquents Ordinance of 1937, reference was made to the need for treatment and supervision of minors in need, and not only juvenile delinquents. The Probation Service attended to both population groups. In 1960 care and supervision was separated from the criminal domain, and the Youth (Care and Supervision) Law, 1960, was legislated. At first, probation officers would intervene with cases based on this law, but within a few years responsibility for these cases was transferred to welfare officers who were specially appointed for this law among social workers, who were employed by local authorities.

In 1997 a new detention law was passed which added three new functions to the Juvenile Probation Service: (a) submitting a detention report on a youth

3. In 1951 the Juvenile Probation Service was separated from the Adult Probation Service.

about to be detained by the Court until the completion of the judicial process; (b) supervising a detained youth who was released on bail by Court order (this became law in January 1998); (c) submitting a detention report on a youth detained for more than five days (in effect only in 1999). This legislation expanded the functions of the juvenile probation officer in areas beyond traditional treatment following a Court decision. Its purpose was to constrain the powers of the law enforcement agencies and ensure that the civil rights of a detailed youth were upheld.

It should be noted that in 1995, a law was passed requiring the submission of a report on a victim of a sexual offense.[4] This function was supposed to have been filled by a public worker or probation officer who at the same time did not submit a report on the criminal offender. In deliberations on the law's implementation, the Juvenile Probation Service refused to accept this function without the addition of new workers. Instead, the role (in the case of minors) was assumed by welfare officers working according to the Youth (Care and Supervision) Law, 1960.[5]

In addition to the above-described functions, the Juvenile Probation Service undertook (in 1984) the interrogation of children according to the Law of Evidence, Revision Protection of Children Law, 1955. According to this law, child interrogators are the only persons authorized to interrogate minors up to the age of 14, who are victims, witnesses or suspects of sexual offences. The child interrogator has the authority to: (a) decide whether a child can testify in Court, or whether he or she should testify in his place; (b) decide whether an identification parade can take place; (c) decide whether a medical examination can be carried out; (d) approve any activity needed by the police for the purpose of the criminal investigation (Hovav, 1993a and 1993b). In the Punishment Law Amendment, 1989, it was legislated that only child interrogators can question minors to the age of 14, who are victims or witnesses of their parents' violence.

2. Functions of Juvenile Probation Officers in 1998

The Probation Service in Israel is a therapeutic social service, and in keeping with its policy, it assigned to the role of probation officer social workers who are university graduates and listed in the Social Workers Registry, in accordance with the Social Workers Law, 1966.

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4. At the initiative of the Feminist lobby, which claimed that during the handing down of the verdict the consequences to the victim of this serious offence should be raised in Court.
5. The Adult Probation Service assumed the function with regard to adult victims.

The following are the main functions of the Juvenile Probation Service according to the different laws, and as directed by the Attorney-General, as well as functions initiated by the Service because of its therapeutic-rehabilitative nature:

(a) Functions according to the Youth (Trial, Punishment and Modes of Treatment) Law, 1971.

The probation officer fulfils the role of parent when a minor is arrested, when the head of the police station, who must notify the parents about the arrest, decides instead that there is fear that the notification is liable to harm the minor's well-being, in which case, he will only notify a probation officer (Section 11 of the Law).

- Regarding minors up to age 13, they are not to be tried in Court, except after consultation with a probation officer (Section 2(b) of the Law).
- Temporary supervision is provided to a minor who is charged of a crime, if the Court believes that this is in the best interest of the minor. The period of supervision can continue until the handing down of a Court decision (Section 20(a) of the Law).
- The probation officer submits a report to Juvenile Court after a verdict has been handed down (Section 22).
- Modes of treatment are implemented for the benefit of a minor (Section 26).
- A probation Court order is implemented.
- Other Court orders are implemented for the purpose of treating a minor.
- A psycho-social investigation is conducted for the purpose of submitting a recommendation to the Israel Police or District Attorney on the modes of treatment of a minor in a criminal incident, and recommendations are given on whether to file away the material without opening a criminal file or bringing the minor to trial (non-prosecution), or to open a file and bring the minor to trial (Section 12a of the Law) (Peled and Krause, 1994).

(b) Regarding detention, the Criminal Procedures (Enforcement Authority - Detention) Law, 1996, has assigned to the Juvenile Probation Service the following functions: preparing a report prior to detaining a minor until the completion of the judicial process; supervising a release on bail; and preparing a report on minors detained for more than five days.

(c) Reports are written on minors living in the area of the Palestinian Authority who commit offences in Israel, in accordance with Extension of Validity of Regulations for Times of Emergency (Judea, Samaria and the Gaza Region - Trial and Legal Assistance) Law, 1967, Section 5a.

(d) Child interrogations are conducted according to the amendment to the Law of Evidence, Revision (Protection of Children Law, 1955), for children up to

age 14: suspects, witnesses or victims of sexual offences and victims or witnesses of their parents' violence.[6]

(e) According to a special directive (no. 51997) of the Attorney-General pertaining to minors who use drugs, a non-prosecution decision is conditional on the minor and his parents receiving treatment, if so decided by a probation officer.

(f) In a few juvenile detention centres, the Probation Service voluntarily oversees a social worker and volunteers who meet with detained minors.

(g) The Probation Service participates in the treatment and release committees of the juvenile prison.

3. Implementing Policy

The Juvenile Probation Service, like the other agencies which treat delinquent minors, is familiar with the theory of criminology, whereby labeling or stigma is regarded as a main cause of delinquency. According to this theory, delinquency and social deviance are defined by those who make the law. The scope of the delinquent population is determined by the law enforcement authorities in a selective manner vis-a-vis the different groups, while the authorities stick the label of criminal on a person who is been caught. The offender who enters this process internalizes the label that is stuck to him and continues with the criminal behavior (Akers, 1997).

The need to respond to this theory, which emerged in the 1960s and 1970s, brought about changes in the policy of the law enforcement network and Probation Service, as follows:

(1) The Probation Service moved from its traditional role of submitting reports to Court following verdicts and implementing probation orders to functions derived from its policy, according to which minors should be spared from going through the law enforcement and judicial systems whenever possible. This is to prevent labelling and ensure that the juvenile received treatment without having to endure a prolonged judicial process and thereby avoid the learning and adoption of delinquent behavioral patterns. This is done by submitting opinions to the police, District-Attorney and Attorney-General in cases in which a minor is involved in a criminal incident.[7] The report usually includes a

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6. The scope of interrogations increased through the years, which reflects greater public awareness of this subject and increased readiness to submit a complaint to the police or give information to the social services (Ministry of Labor and Social Affairs, *Child Interrogations, 1996 Annual Report*).

7. If a minor is convicted, the Court and the Juvenile Probation Service are entitled to use

recommendation that the minor continue treatment, that the minor be tried in Court, that the file be closed (if opened by the police), that the incident be filed away because of a non-prosecution decision, or that the closing of the file be conditional on receiving treatment. Other possibilities are to prepare a report following a petition to delay the judicial process, therapeutic intervention during interrogation and placing a probation officer or volunteers in detention centres.

The question of whether non-prosecution will influence the minor's behavior preoccupies the police, probation services and others in the law enforcement network. Recently the Youth Department of the Israel Police examined data on minors who committed first offences from 1990 to 1995, whose file was closed because of non-prosecution (Moore, 1997). The findings showed that generally speaking, the labelling theory was not validated. The choice of non-prosecution did not prevent a repeat of the criminal offence. The researchers also noted that the non-prosecution policy of the police was not carried out to the letter. The findings require a fundamental re-examination of policy implementation on this subject.

(2) Intervention took place at an early stage of the police investigation, and alternatives to detention were sought by the preparation of a detention report on detainees before being brought to Court or for those detained for more than five days.

(3) Change took place in the attitude towards children involved in sexual offences and violence in the family, in order to ensure their continued normal development and to minimize the mental harm caused to them by the investigation process and the Court hearing (Hovav, 1993).

4. Future Trends

Future trends of the Juvenile Probation Service in Israel will affect and expand all areas of activity, while the following new areas will be added:[8]

(1) *Law enforcement*: Increasingly greater involvement of the Juvenile

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note 7 continued:
all the sanctions and means at their disposal today in the judicial system intended for adults. In these cases, the sanctions and punishments have a greater social importance than do treatment or rehabilitation.

8. Based on the 1997 proposed amendment to the Youth (Trial, Punishment and Modes of Treatment) Law - 1971, the programme of the Ministry of Labor and Social Affairs to treat children at risk and violence in the family (1997), and the study of probation services around the world (Hovav, 1989; Shapiro et al., 1993; Klein, 1997; Hamai et al., 1995).

Probation Service is expected, which will focus on the first stages of the criminal process involving a minor. Detention reports will be prepared in all cases of a minor's detention by Court order.

- In order to uphold the minor's rights, notice will be given to a probation officer upon the arrest of a minor at a police station, if the police chief believes that notification to parents will compromise the investigation or the minor's well-being.

- In order to help minors adjust to the special situation of detention, a probation officer will be present in all detention centres for minors, will attend to the minor's physical and psychological state and family relationships and will ensure that the conditions of detention are reasonable.

- The Probation Service will operate a suitable adult network that will arrange for the presence of an adult during the minor's interrogation by police, if the parent is unable to participate.

- The Probation Service will participate in the supervision of alternatives to detention and imprisonment, such as: electronic supervision (Cohen, 1995), house arrest, appearing in a day centre, mediation and rapprochement (Klein, 1997).

- The Probation Officer's activity and the pre-sentence report will be more exposed to the juvenile, his family and his legal counsel.

(2) *Community involvement*: A probation officer will be increasingly involved in representing a victim before the law enforcement and therapeutic agencies, by means of rapprochement programmes and presenting the victim's case before the Court.

- There will be greater participation of the probation officer in social service activities for children at risk and improved cooperation and coordination with the local Social Services Departments.

(3) *Therapeutic intervention*: The Probation Service will have to undergo changes and adjustments to a more complex network of social work services and changing target populations of criminal offenders. This will require professionalism, specialization (Freiberg and Hovav, 1994) and development of new modes of treatment for special groups, such as: group therapy for sexual offenders; treatment for drug offenders; treatment for offenders of crimes of violence; treatment through the use of authority (Vozner, Golan, Hovav, 1994); and independently operating the community work option.

(4) *Organization*: At the organizational level, the Juvenile Probation Service will adapt itself to the above-described changes and will work according to the need and characteristics of the client population. These changes will enable the Service to act with greater operating flexibility, expand its specialized services

and employ unused resources, including additional workers. This will also enable the Service to give responses to the rising number of referrals and the changing characteristics of the offenders.

- Operating separate units for conducting psycho-social interrogation for the purpose of preparing reports; and operating separate units for treating and interrogating children, which will meet the need for specialization and professionalization, to which the Service aspires.
- Employing auxiliary assistants without social work training or appointments as probation officers to perform follow-up and supervisory functions that do not include direct treatment. This kind of employment is paid for by the Service's activities budget, in the absence of additional job positions for probation officers.
- The use of paid private and public social services and purchased services (privatization) in the areas of interrogation and treatment.
- Use of volunteers.
- Developing a computerized technological system and instituting a decision support network (Eden, 1994).
- Strengthening cooperation between special probation officers in the Arab sector and probation officers in the Jewish sector.

The Youth Protection Authority - Residential Treatment for Juvenile Offenders and Minors Subject to Severe Distress

1. Background and Development[9]

The original legal basis for operating homes for youth protection is the Juvenile Delinquents Ordinance of 1937, according to which the Juvenile Court has the authority to act on behalf of a youth brought to Court: to send the offender to a correctional school for juvenile delinquents or to another institution intended for this purpose (section 18e). It was also determined that the minor can be placed in detention for the purpose of evaluation. Upon the establishment of the State of Israel, responsibility for correctional schools for juvenile delinquents, which were separate for the Jewish and Arab populations during the Mandatory period, was transferred to the Ministry of Welfare (today part of the Ministry of Labor and Social Affairs).

In 1955 the Ministry of Welfare set up a special correctional homes unit and published the Youth Protection (Homes) Regulations, which regulated the subject of institutional placement. The name was changed to "home", and a

9. Based on Reifen, 1968; Reifen, 1987; Ministry of Labor and Social Affairs, 1995.

person living there was defined as a protectee. It was determined that the placement of a protectee in a specific home, which was intended for a specific protectee, was under the authority of the Superintendent of Homes. The regulations set up a supervisory council and specified the authority and functions of the Superintendent of Homes, who was responsible for the care of protectees in all the homes under his auspices.

During this period treatment of delinquent minors in residential care was given by the same department that cared for wayward youth, mentally retarded persons and foster families, supervised the work of the home and trained its workers.

In 1960, even though the civil law in the form of the Youth (Care and Supervision) Law, 1960, was separated from the criminal law, the Youth Protection Authority continued to take minors into its residential homes according to the civil law.

In 1971 the Juvenile Delinquents Ordinance of 1937 was annulled with the passing of the Youth (Trial, Punishment and Modes of Treatment) Law, which provided important definitions in this area: the home, the locked home, the superintendent of homes and the after-care officer.

According to the new law, the Protection Authority's relationship with the Courts was regulated and principles were determined, according to which, following submission of an indictment, the Juvenile Court may refer a minor for observation to a home or to a locked home as a mode of punishment (section 25) or treatment (section 26).

In addition to the above, the law regulates the subject of the early release from homes, vacations and follow-up treatment of graduates.

Later on the Youth Protection Authority expanded its work by establishing crisis intervention centres for runnaways and homeless youths who were roaming the streets. The first such facility, Makom Aher ("another place") was opened in Tel-Aviv in 1994, and the second one, Etnahta ("time-out"), was opened in Jerusalem in 1996. These are the only frameworks of the Youth Protection Authorities that accept boys and girls in one house, though they engage in separate activity. They are flexible in accepting residents and give responses to most of their problems (Peled et al., 1995; Peled and Shapiro, 1996). This action supplied an answer to a population for which there was no solution for many years (Hovav, 1977a).

The Youth Protection Authority is an out-of-home therapeutic and disciplinary framework for juvenile offenders who are tried according to the Youth (Trial, Punishment and Modes of Treatment) Law, 1971, and for adolescent boys and girls in severe distress, who are placed according to the

Table 1. Protectees in Homes According to Court Orders

Home order	33%
Locked home order	17%
Youth (Care and Supervision) Law, 1960	25%
Assessment order	10%
Without order	5%
Total	100%

of population composed of 65% boys and 35% girls.

Youth (Care and Supervision) Law, 1960, or under the "shadow" of the law. In addition, it serves as shelter for runnaways and homeless youth for a limited period of time (Table 1).

Present policy is based on the comprehensive approach that was already determined by the Youth Protection Authority's first director, Rachel Hutner, who said: "The specific services (residential homes and probation) provided for *juvenile offenders must participate in the development of social policy and* create tools of its own in order to help in the implementation of this policy." (Ministry of Welfare, 1967, p. 65). Furthermore: "In a home that is a therapeutic framework, integration between the minor and his surroundings should be achieved. The fundamental components of the institutional treatment are: community of residents, democratic atmosphere, cohesion and integration with family and surroundings" (ibid., p. 51). During that same period, the use of authority was not stressed in treatment as it was to be later on, when it became the component which separates residential care of the Service for Children and Youth from that of the Youth Protection Authority.

Today the Youth Protection Authority runs various kinds of homes, as follows (Wagshal, 1989; Ministry of Labor and Social Affairs, 1995):

(1) The comprehensive home, which provides a maximum amount of educational and therapeutic services and resources, including: a secure (locked) wing, a preferred wing and an integrated wing (Meonit - "little home"), which is a branch of the home in the community in preparation for returning to the community.

(2) A central dormitory and surrounding Meoniot ("little homes").

(3) A variety of out-of-home frameworks in the community: hostels, housing arrangements, family-style homes, foster families, centres for homeless adolescents, patrol cars and counselling centres.

Placement is through the authority of the Superintendent of Homes, whereby

protectees may be transferred from one home to another, from a more to less controlled facility according to need, and finally to a preparatory stage before returning to independent life in the community, all in order to ensure the success of residential treatment. It is also used in order to prevent the forming of delinquent sub-cultures, one of the main drawbacks of residential treatment for delinquents, since delinquent sub-culture reinforces delinquent behavior of protectees (Polski, 1962). This makes it possible for the superintendents to disband the groups.

Today the Youth Protection Authority cooperates with the educational system, which is responsible for implementing compulsory education, and with the vocational training network for youth, run by the Ministry of Labor and Social Affairs.

In recent years, the Youth Protection Authority has undergone a process of privatization, after which most of the homes which it directly ran in the past were transferred to the management of public associations (Eisenstadt, 1996; Katan, 1996). Among those homes still run by the State, many areas of activity were privatized. As a result the Youth Protection Authority is economically and functionally assisted by public associations. Today, of the 40 homes, 10 are run by the government, 29 by public associations and one by a private owner.

2. Policy

Since the Youth Protection Authority first belonged to the Ministry of Welfare, which later became the Ministry of Labor and Social Affairs, it passed from the traditional role of correctional schools for juvenile delinquents, as defined during the Mandate period, to a network of out-of-home services to a varied population, characterized by severe distress, need for disciplinary frameworks with various levels of authority and need to be separated or integrated into the community (Vozner, 1996).

The Youth Protection Authority defines itself as a social, educational, therapeutic and diagnostic service and not as a punitive facility. This is expressed by the employment of staff members from educational or therapeutic fields. This conception is also accepted by the law enforcement network, which from time to time refers minors who need punishment or short detention, and not treatment, to Protection Authority homes. In a Supreme Court decision (Criminal Appeal no. 622/78), it was determined that a protected home consists of an educational-therapeutic framework for the protectees who live there and is not a punitive facility.

During the years, the Youth Protection Authority changed its policy in favour of more openness towards the community and the protectees' families

(Elitzur, Tenne, Wagshal, 1994; Golan, 1995). To this purpose, the Protection Authority cooperates with public and community bodies and associations.

3. Future Trends

In light of the background and development of the Youth Protection Authority and its policy, as described above, and the disposition to expand its unique therapeutic and community servicess, in the author's opinion, the future trends will be as follows:

- Development and expansion of out-of-home services will continue for all population groups in deep distress who need authoritative intervention.

- The scarcity of places in locked and diagnostic homes will continue.

- Cooperation will be extended to more law enforcement agencies, whereby the Israel Police will run detention centres for minors and perform the security role, while therapeutic-educational services will be given by the Youth Protection Authority (Efshar, 1997). Towards the end of a prison term, the Prisons Service will also transfer youths to locked homes, and from locked homes they will return to the community. Conversely, a minor convicted by Court who is referred to a locked home but fails to adjust to it may be sent to prison as long as the Court order has not been carried out in full.

- In the future, the Youth Protection Authority will arrange for treatment for populations of special social needs and criminal behavior background, such as: alcohol and drug consumers, borderline mentally ill or retarded persons, various immigrant populations and the ultra-Orthodox sector.

- The trend of privatization in managing homes and purchasing of diagnostic and therapeutic services will continue.

- The development of out-of-home community facilities will continue, which will require a clearer definition of the overlapping boundaries of community treatment between the homes of the Youth Protection Authority and the other facilities in the community, such as: shelters for children at high risk, shelters for girls in distress, transition homes and therapeutic day-centres.

- A technological and computerized network will be introduced in order to supervise treatment of protectees and graduates, and for the purpose of examining the output of the therapeutic network.

- The trends described above will also provide responses to the rise of juvenile delinquency and to its changing character and makeup, which will be presented in the next chapter.

Juvenile Delinquency in Israel

1. Background and Development

Statistics on juvenile delinquency are based on the number of criminal events in which minors are involved, as recorded by the Israel Police and the annual statistics of the Juvenile Probation Service, and on the work of Amir and Hovav; 1970; Fishman and Argov 1980, and Hassin; 1997.

These statistics should be regarded with scepticism and criticism for the following reasons:

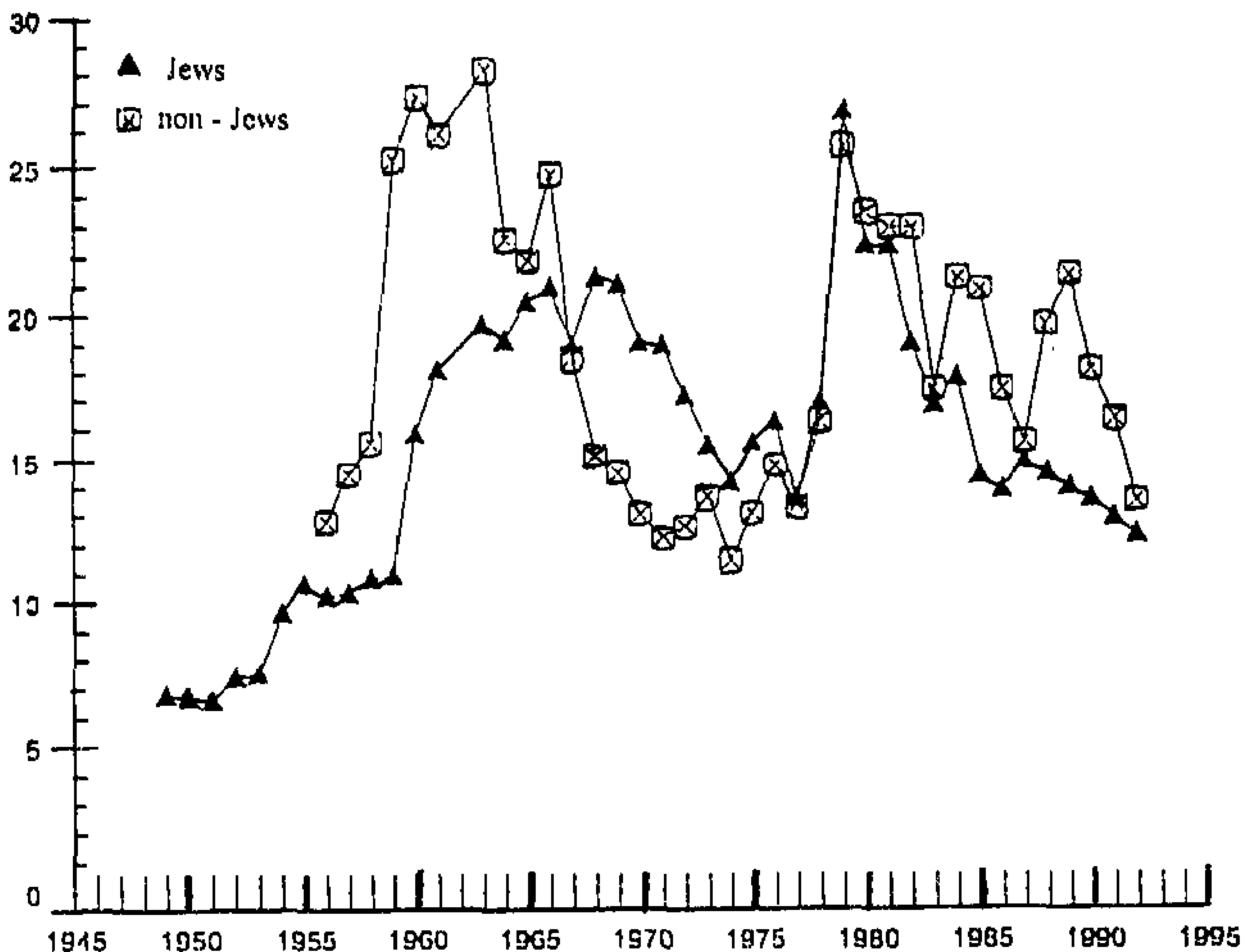
- They relate only to criminal incidents that are known to the Israel Police. This number is dependent on the percentage of crimes solved in all the complaints of the public, which in turn is affected by the crime-solving ability and efforts of the police. The percentage of revealed criminal incidents upon the establishment of the State was higher than in recent years, and it stands at about 30%.
- Statistics on criminal offences can be determined only in open cases. The percentage of minors involved in cleared criminal incidents was low immediately after the establishment of the State, and it rose until it reached 33% in the 1970s. Afterwards, it began to drop and reached 8.1% in 1996.
- Changes took place in police policy regarding the opening of criminal files (which are statistically recorded) and the closing of a criminal incident without the opening of a file (non-prosecution). In cases of non-prosecution, the police did not enter these into the statistical record. Only in 1990, when these minors were referred to the Juvenile Probation Service, were they represented in the statistics of the Probation Service. In about half of all incidents, a file was opened and the case was brought to Court. In the other half, the file was closed without further intervention.
- Changes are taking place in the public's complaint-filing habits and in the scope of police exposure of criminal offences. There is a rise in the number public complaints against offences of an economic nature, which are mostly for the purpose of receiving insurance payments for property, while the percentage of police exposures in these kinds of offences is going down. In offences between one person and another, mainly in cases of violence in which the offender is known, the percentage of exposures is stable (see: Fishman and Argov, 1980). In an analysis of the relevant 1991 statistics, no changes were found.
- There are changes due to the introduction of new laws, such as: the rise in 1971 in the age of criminal responsibility of male minors from 16 to 18.
- The ramifications of criminal behavior due to the immigration of minors to Israel, according to accumulated experience, come to the fore only three or four years following their immigration.

- There are changes in police work priorities. During these years we were witnesses to the fact that priority in Israel moved from criminal investigation to securing public events, maintaining order and preventing terrorism.

Despite the descrepancies of statistics on delinquency, in general, and delinquency of minors, in particular, we can learn the following developments from the statistics (Figure. 1):

The first decade and a half of the State of Israel (until 1965) was characterized by a rise in juvenile delinquency and the establishment of special police units to treat youth. In the Arab sector this was the period of the military government.

Figure 1. Jewish and Non-Jewish Juvenile Delinquents 1949-1995* (Hassin, 1997)
(Referrals in thousands to the Juvenile Probation Service)



* Distribution of delinquent minors is calculated according to their rate per thousand, which takes the size of the poplation into consideration. The intention here is the number of delinquent minors with criminal files per thousand minors in the population to which they belong.
Source: Annual reports of the Juvenile Probation Service.

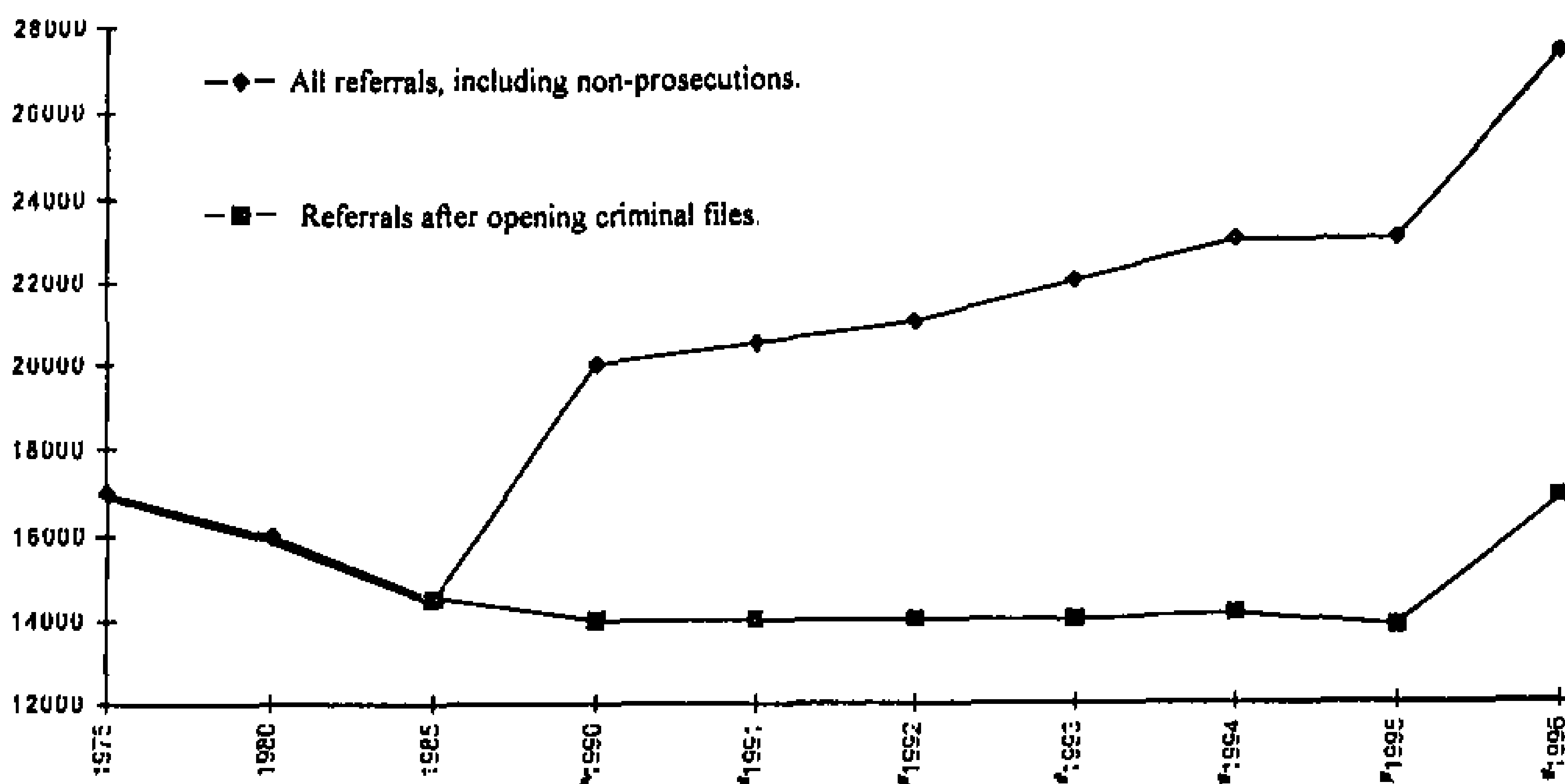
In the second period (1967-1976), there was a drop in juvenile delinquency in the two sectors, but at an even greater decrease in the Arab sector. During this period the economic situation in Israel improved. Many immigrants adjusted to life in Israel, while it can be assumed that the investments in education and social services were contributing factors. As for the Arab sector, the decrease in juvenile delinquency can be attributed to the removal of the military government.

From 1977 to 1979, juvenile delinquency increased due to the rise in the age of criminal responsibility from 16 to 18. Delinquency in this age group is more concentrated than in younger age groups.

From 1980 there was a drop in delinquency due to the continued development and strengthening of the Israeli society and economy and the expansion of educational and social services. At the same time it should be noted that there was a change in police policy, according to which more criminal files were closed as a result of non-prosecution and went unrecorded in the statistics.

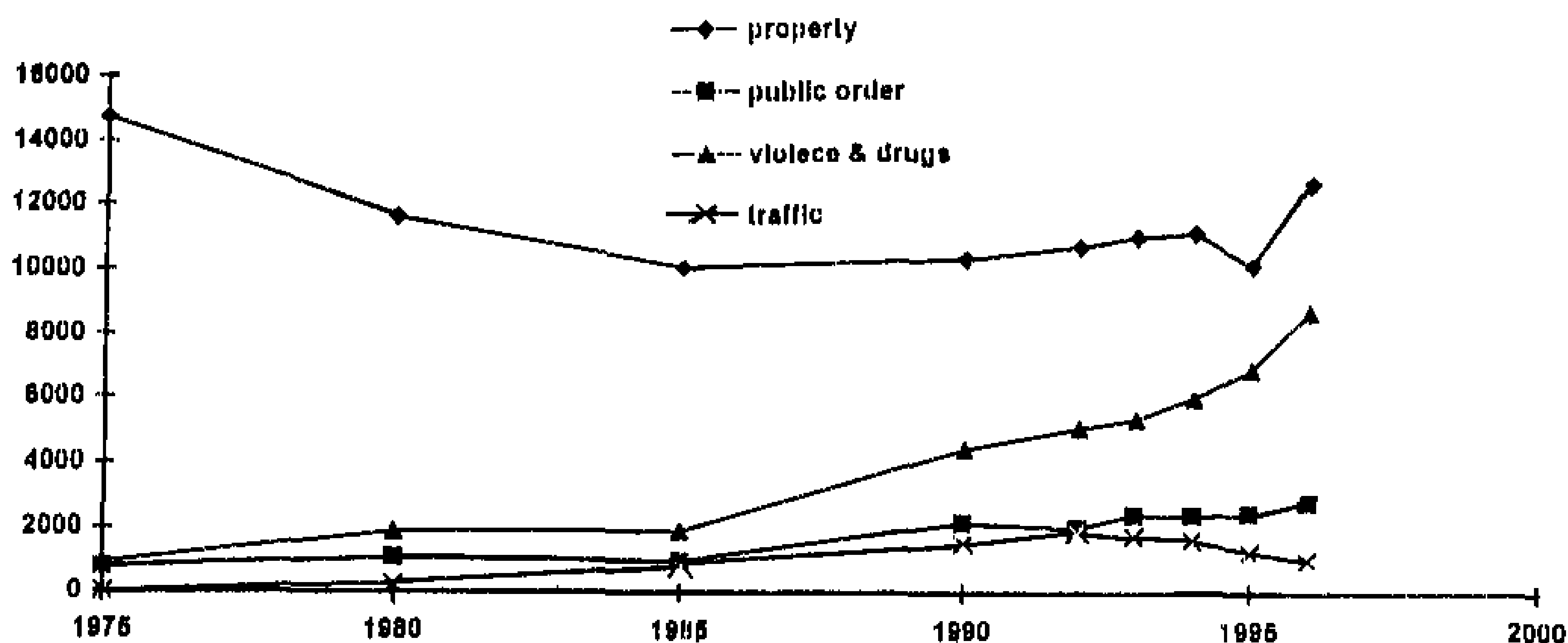
Recently a rise in juvenile delinquency was registered by the Juvenile Probation Service. Since these statistics also include police referrals due to non-prosecution, statistics on the opening of criminal files of minors point to the stability of their numbers, which means a relative decrease, considering the increase in population (Figure 2).

Figure 2. Referrals to the Juvenile Probation Service 1975-1996
(Juvenile Probation Service)



* Including "Non-Prosecution".

Figure 3. Number of Minors Referred to the Juvenile Probation Service, According to the Kind of Offence, 1975-1995
(including non-prosecutions)



From the point of view of the kinds of offense perpetuated by minors, the following trends can be noted (Figure 3):

There is a drop in crimes of property and a rise in crimes of violence, use and trafficking of drugs and traffic violations. The reasons for this are related to society's different attitude towards property and economic development, whereby less complaints are lodged with the police on mild offences committed by minors. The percentage of exposures of these offences is small. On the other hand, there is of course a different attitude towards the phenomenon of violence, which is more often revealed to the police, and the attacker is known. In the past there was a more forgiving approach towards the violence of minors, and there was a tendency to close files in this area, so that it appeared less in the statistics. At the same time, there was a rise in the consumption of drugs and alcohol among juveniles and their illegal use of motor vehicles due to increased motor traffic in Israel.

2. Characteristics of Juvenile Delinquents

The main roots of juvenile delinquency in Israel, particularly in its first two decades, lie with immigration to this country and problems of adjustment to society and its laws. Later, in the 1980s and 1990s, an additional wave of immigration arrived and affected delinquency. The distribution of immigrants

throughout the country was not uniform, and sub-cultures of immigrants developed in certain places (Hassin, 1985).

There are a few general phenomena associated with criminal behavior, in general, and in Israel, in particular (Shoham, 1993, Chapter 4):

- Juvenile delinquency associated with the process of growing up.
- Juvenile delinquency associated with street groups and gangs which react to one another.
- Juvenile delinquency which is violent and excels in vandalism.
- Emphasis on drugs and alcohol.
- Use of motor vehicles without permission.
- A family situation of social and economic distress, in which it is hard to educate children to respect social norms and develop mechanisms of self-control, thus contributing to juvenile delinquency. The background to this kind of delinquency is similar to other groups of minors at risk in Israel (Habib et al., 1997).

As for delinquent minors from Arab groups, there are roots and characteristics unique to them, and they should be regarded as two groups: (a) Arab minors who are citizens of Israel from 1948; (b) Arab minors living in East Jerusalem, who have been attended to by Israeli services since 1967.

There are several causes contributing to the delinquency of minors who are Arab citizens of Israel since 1948:

- Upon the establishment of the State, the Arab population was directly exposed to Israeli society, which possessed Western behavior patterns. In the Arab sector the traditional frameworks of family and authority of the father and small community were undermined, which created identity problems among minors.
- In the first years of the State until 1966, the Arab sector was confronted with a military government which imposed limitations not encumbent upon the Jewish population. Some of the offences consisted of violations of regulations of the military government, and many of the violators were minors.
- The Arab sector in Israel was transformed from a rural society to an industrial, technological and modern society. The transition generally required that minors adjust to different social norms, especially those who worked in Jewish industrial areas. This diminished the close social supervision and control of the family and society over the minor and prevented the acquisition of internalized supervision based on tradition and legal norms.
- The Arab sector is coping with the issue of national identity, which received expression in conflicts between Jews and Arabs and in situations of peace. The 1967 war created the opportunity for contact between the Arab populations in

the territories and in Israel, which until 1948 had been one population. The Lebanon War (1982) emphasized the problem of Palestinian identity and sharpened the conflict between Israel and the Palestinian population. The peace treaty with Egypt, the Oslo Accords, the establishment of the Palestinian Authority and the peace treaty with Jordan, give expression to the desire for co-existence between Jews and Arabs, while preserving the identity and uniqueness of each sector.

- There are also socio-economic causes which affect delinquent minors in the Arab section: large families; crowded housing; low income in comparison with the Jewish sector; low educational level, small number of supplementary educational frameworks; and low social services' level in terms of numbers of workers and amount of resources.

Arab minors in East Jerusalem engaged in greater incidents of juvenile delinquency during the period of the Intifada (insurrection, 1987), when they took part in disturbances and undermining of public order and dominion. It was easy for these minors to commit offences of this kind because of social pressure, being unmarried with no family responsibilities and the close exposure of adolescents to ideology and political and social involvement.

3. Future Trends of Juvenile Delinquency

On the basis of past trends of juvenile delinquency and subsequent general social developments (Vozner et al., 1993), the following trends can be expected:

(1) In the future, distinction will also be made between incidents in which a criminal file is opened and those in which the police close the file (non-prosecution). The rate of files opened will remain low, while the rate of closing them will grow. The police and the Probation Service plan to reassess criteria in this regard and apply them more effectively.

(2) The level of juvenile delinquency in the population will remain stable or decrease.

(3) The kinds of offences committed by minors will also change:

- The number of violent offences will continue to rise.
- The number of drug offences will continue to rise.
- Offences of using vehicles without permission will remain the same.
- Delinquency of Jewish minors towards Arabs and Arab minors towards Jews based on ideology or politics will be affected by peace or conflict in the region.

(4) In the different sectors of Israeli society, the following trends can be discerned:

- The level of delinquency of minors in the Arab sector will be equal to that of the Jewish sector, or will be lower.

- The representation of delinquent minors from ultra-Orthodox, pioneering settlement and immigrant groups will grow in the coming decade, and later on will decrease and reach the level of the general population.
- Delinquency of minors among children of foreign workers in Israel will grow.

Summary

This article has analyzed the background and development of the Juvenile Probation Service and the Youth Protection Authority since their establishment and described their present activities and trends for the future. At the same time, the background, characteristics and trends of juvenile delinquency in Israel were also discussed.

The Juvenile Probation Service was established during the British Mandate period, when it engaged in the traditional functions of preparing reports to Court and the implementing of supervision orders. In 1971 the Youth (Trial, Punishment and Modes of Treatment) Law was passed, which redefined the functions and activities of the Service. Furthermore, in 1984 the Juvenile Probation Service assumed the role of child interrogation according to the Law of Evidence, Revision, Protection of Children Law, 1955. From 1998 the Service also began to prepare reports on detainees and supervise minors' release on bail until their Court hearing.

The past developments of the Juvenile Probation Service and its present policy will lead it to future activity in further areas: greater involvement in the first stages of the criminal process involving minors; assisting in the provision of alternatives to detention or imprisonment; greater exposure of the probation officer's work and the contents of the Court report to the scrutiny of a minor, his family and the public; greater involvement of the local social services; and professionalization of methods of intervention. These developments, to be accompanied by an addition of financial resources and workers, will require specialization and the establishment of sub-units, such as for child interrogation, and the use of private and public social services.

The Youth Protection Authority developed mainly since the establishment of the State, when its administration was organized in 1955 as a department in the Ministry of Welfare (now the Ministry of Labor and Social Affairs), while the Youth (Trial, Punishment and Modes of Treatment) Law, passed in 1971, defined its powers and functions that continue to this day.

The Youth Protection Authority serves as an out-of-home authoritative framework for the population of juvenile delinquents, as well as minors in need and in severe distress who did not commit criminal offences, but rather referred by the Youth (Care and Supervision) Law, 1960. Its affiliation with the

Ministry of Labor and Social Affairs emphasizes that its homes are for educational and therapeutic, and not punitive, purposes.

The future development of the Youth Protection Authority will be in the area of expansion of out-of-home services for youths in distress, who need authority and disciplinary residential treatment, and development of frameÙ works in common with the Israel Police, the Ministry of Health and the social services. The target population will be extended to include drug and alcohol users and borderline cases in need of psychiatric attention.

Regarding juvenile delinquency in Israel, we discussed the past changes and trends related to developments in Israeli society, such as the waves of new immigrants, the changes in the Arab sector and the inclusion of the East Jerusalem population in the area of Israel. The statistics of juvenile delinquency are very much dependent on the habits of the complaining public and the decisions of the Israel Police on whether to open or close files of juvenile offenders and bring their case to trial.

Future trends in this area: A distinction will continue to be made between kinds of criminal offences, on the basis of which a criminal file is opened or the incriminating material is filed away and the case closed. The public will complain less about property offences and more about violence. The police will expand its activities in areas related to drug abuse and trafficking.

From the point of view of the population sectors, we expect that delinquency levels in the Arab sector will be commensurate to those of the Jewish sector, and after a period of adjustment the delinquency levels of immigrant minors will also be similar to those of youth in Israel as a whole.

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Laws Mentioned in the Article according to Year of Legislation

Juvenile Delinquency Ordinance, 1937.

Placement of Delinquents in Probation Ordinance, 1944.

Correctional Services for Juvenile Delinquents Law, 1953.

Youth Protection Authority (Homes) Regulations, 1955.
Evidence Amendment (Protection of Children) Law, 1955.
Youth (Care and Supervision) Law, 1960.
Extension of Validity of Times of Emergency Regulations (Judea, Samaria and the Gaza Region, Trial of Delinquency and Legal Assistance) Law, 1967.
Probation Order (New Version), 1969.
Youth (Trial, Punishment and Modes of Treatment) Law, 1971.
Penal Law, 1977, Sections 37 and 38: Probation Officer Interrogation and Report; Section 71; Community Service.
Criminal Judicial Process Law, 1982, Section 187(b): Preparing a report on a victim of a sexual offence.
Penal Law (Amendment 26), 1989, Section 7: Law of Evidence, Revision Protection of Children Law, 1955.
Criminal Judicial Process (Enforcement Jurisdiction - Arrest) Law, 1996: Detention report, supervision of released on bail until trial.
Social Work Law, 1996.
Proposed Amendment to the Youth (Trial, Punishment and Modes of Treatment) Law, 1998.

Legislation and Court Judgements

SOCIAL SECURITY LEGISLATION ENACTED IN THE PAST FOUR YEARS

Compiled by Ruth Horn*

1. Amendment no. 7 (passed on February 27, 1996) and Amendment no. 32 (passed on January 26, 1999).

A housewife (a married woman who does not work outside her home), is insured in the old-age branch in her own right (prior to the amendment, the husband received an increment to his pension on her behalf).

Amendment no. 32 determines that a housewife will entitle her children to survivor's pension.

2. Amendment no. 14 (passed on April 2, 1997).

A worker who was injured in the course of his work is eligible for injury allowance for the days of work he missed due to this injury (except for the actual day of injury).

The payment is implemented by the National Insurance Institute.

The amendment determines that payment for the first nine days of eligibility shall be reimbursed to the Institute by the employer.

3. Amendment no. 18 (passed on July 29, 1997).

The Women's Labour Law (1954) determines that a female employee who gives birth is entitled to a 12-week maternity leave.

It was recently determined in the Women's Labour Law that the husband too may be eligible for a "maternity leave" (if at least 6 weeks have elapsed since the day of birth, and on condition that his wife is not on maternity leave for the same period).

The National Insurance Institute pays the employee, for the period of her maternity leave, a sum equivalent to the wages paid her previous to her leave.

The amendment determines that a husband who takes up his right to "maternity leave", will be also entitled to payment of "maternity allowance" at the rate of his wages prior to this leave.

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4. Amendment no. 19 (in effect as of June 1, 1998).

Under the situation existing prior to the amendment, benefits paid in arrears were linked only partially, so that there was a certain degree of erosion in their value.

The amendment determined that a claim for benefit may be submitted up to four years late, and that a benefit paid in arrears shall be linked in full.

5. Amendments no. 27 and 31 (passed on June 28, 1998 and November 30, 1998, respectively).

The National Insurance Institute pays a study grant for every child from the age of 6 to 14, under certain conditions stipulated in the law.

Under the above amendments, the scope of population eligible for this grant was broadened, and it was determined that low-income families having 4 or more children are also eligible.

It was further determined that a family in custody of an orphaned or abandoned child will be eligible for study grant.

6. Amendment no. 28 (passed on June 30, 1998).

The National Insurance Institute pays old-age pensions to every insured man from the age of 70, and every insured woman from the age of 65.

In the 5 years preceding the age eligible for old-age pension, the Institute pays a pension only to those whose income is particularly low, and if the insuree had income from work during that period, this income is deducted from his pension.

Amendment no. 28 determines that the income deduction will be partial: for every shekel of gross work income, only 0.6 shekels will be deducted. Previous to the amendment, the income deduction was full; that is, every shekel of gross work income was deducted from the pension.

7. Amendment no. 30 (passed on November 30, 1998).

The Israeli law determines a minimum wage to which every employee is entitled.

Some of the national insurance benefits are paid as replacement for wages; it was determined that the basis for calculation of these benefits would be no lower than the minimum wage, even if in practice the employer pays his employee a salary that is below the minimum wage.

(The above rule has been in effect in the unemployment insurance branch for several years already. Amendment no. 30 applies this rule to the benefits paid in the other wage-replacing benefit branches as well).

8. Amendment to the National Insurance regulations (maintenance allowance, help with studies and arrangements for disabled child).
The regulations reorganize the various grounds, or categories, of entitlement to benefit for a disabled child. In their previous version, the regulations included a list of physical impairments which constituted the conditions of entitlement to benefit. Following a change in the medical perception of this matter, the list of impairments was replaced by a list of types of medical treatments; Those who require such treatment are eligible for benefit for a disabled child.

9. Amendment no. 13 to Income Support Law (in effect as of January 1, 1999).
An income support benefit is paid to those whose income from all sources is particularly low, as well as to those who have no income. The law determines the method of taking into consideration income from capital sources (such as real estate assets, savings accounts etc.).

The amendment determines that a sum of money in a bank account which is not over four times the average wage - or over six times the average wage for a person who has a spouse or child - will not be taken into consideration for purposes of income support benefit.

10. Benefits Law (child orphaned due to violence in family) 1995 (in effect as of June 1, 1998).
The law determines that a child who has been orphaned due to violence on the part of one of his parents (directed against his spouse) will be entitled to a monthly benefit.

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