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SOCIAL SECURITY

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Jerusalem, Israel

Preface by the Director-General of the National Insurance Institute of Israel • The Role of Research in Social Security Policy Making: Theory and Application in the Israeli Experience • Trends in the Development of Personal Social Services • Definition and Measurement of Poverty – The Unsolved Issue • Obstacles to Change in the Structure of the Israeli Health Care Delivery System • Impact of Demographic and Socioeconomic Factors on the Changing Needs for Services for the Very Old • The Contribution of the Long-Term Care Insurance Law to the Welfare of the Severely Dependent Elderly • Psychogeriatric Clubs in Jerusalem • Voluntary Organizations — A Substitute for or a Partner to State Activity in the Social Arena • The Median Role of the Elderly Volunteers in the Services for the Elderly and Pensioners, The National Insurance Institute, Israel • Development of Applicants' Independence, Responsibility and Cooperation in the Treatment Process

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PREFACE

> On three things the world stayed —
> on the Torah, and on the worship and on
> the bestowal of kindnesses
> Jewish Sources (*Pirkei Abot*)

The National Insurance Institute of Israel is happy to present an additional issue of the Social Security Journal in English, to the professional community. This issue includes a selection of articles previously published in Hebrew (with an English summary) in recent issues of *Social Security*. The present volume is the second in the English series; the first appeared in 1988 and was devoted entirely to the topic of long-term care of the elderly.

The process of aging of the population in recent decades and expectations that this process will continue in the future have focussed public attention on the study, analysis and development of service networks for the elderly. Thus a considerable section of this volume too presents data from studies on the efficiency of services in attempts to deal with the problem of old age in this country. Preliminary lessons and conclusions are drawn from the implementation of the Long-Term Care Insurance Law, widely discussed and covered in the ISSA research meeting held in Jerusalem in April 1989.

An additional area which merits considerable coverage in this volume is that of the volunteer services and their contribution to the welfare of various population groups. In Israel extensive use is made of this tremendous reservoir of experienced, trustworthy and idealistic manpower. Perhaps the most striking example of such use may be found in the Counselling Service for the Elderly, operating in the framework of the National Insurance Institute, a service which contributes most significantly to the welfare of the elderly in Israel. One article is devoted to a description of the structure, activities and importance of this particular service.

I am convinced that the wealth of material appearing in this volume will help enrich our knowledge in the field of social security and contribute to international cooperation in this field.

I would like to extend my thanks to Dr. Arye Nizan, Chairman of the Editorial Board of this important and prestigious journal, and to Mr. Shlomo Cohen, the acting Director of the Research and Planning Administration of the National Insurance Institute, which publishes *Social Security*.

Mordechai Zipori
Director General,
National Insurance Institute of Israel

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THE ROLE OF RESEARCH IN SOCIAL SECURITY POLICY MAKING: THEORY AND APPLICATION IN THE ISRAELI EXPERIENCE*

by Shlomo Cohen and Yossi Tamir**

Introduction

The National Insurance Institute is Israel's main organization dealing with social security and transfer payments, the aim of which is the redisribution of the national income. The scope of the National Insurance Institute's activities in the social and economic fields is reflected in the sum of payments it pays to the entire population — approximately 8% of the G.N.P.

The Institute's major function is to carry out the government's social policy. However, due to its great public importance, rich experience in policy implementation and legal status as an independent and public body not belonging to any government Ministry, the Institute takes a considerable part in the formation of social policy in Israel. To a large extent, the activity of the National Insurance Institute is due to the exsistence of its skilled and well-known research function under the responsiblity of the Research and Planning Administration, comprising 2% of the Institute's total working staff.

The Administration's research work covers a wide range of research areas, from current information and administrative statistics on the Institute's input and output, which serves mainly the various directors within the Institute, to basic research meant to enhance the general thinking and legislation in the field of social security as well as to follow up the effectiveness of the Institute's activities regarding income redistribution, economic gaps and scope of poverty.

The research activity also includes a special research project aimed at increasing the data bank of various populations, in order to offer a general perspective for further development and planning of social security systems and procedures and follow up research of various experimental services offered to relevant population groups.

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* Paper presented at a conference on "The Role of Research in Social Security", held by the International Social Security Association in Cracow, Poland, in June 1987.

** The Research and Planning Administration, The National Insurance Institute, Israel.

Research projects carried out by the Research and Planning Administration hold much public interest and are quoted by members of the Knesset (Israel's Parliament) and public functionaries, and therefore have a tremendous impact on the introduction of reforms in social policy in general and in taxation and transfer payments in particular. These research projects in social security are a classic example of the impact of research on policy making.

The actual research work can be carried out by a wide range of factors, from the Administration's research workers exclusively to commissioned external bodies — individual academicians or research institutes. Often the research is a joint project of the Administration's staff together with those who are responsible for the actual planning and implementation of policies.

It is not always possible to evaluate direcly and precisely the project's function and impact on social security. As in any other area, basic research has more indirect influence on policy implementation than do specific research projects aimed at evaluating the ongoing activities, which are often commissioned by policy makers themselves. Nevertheless, in the long range, even the general attitude towards basic research, which is not necessarily applicable in itself, plays a most important role. It will suffice to mention the considerable and valuable influence of research projects dealing with poverty patterns and inequality in Israel on public opinion and on policy makers. This ongoing project, which is updated each year, makes the headlines, causes a stir and determines, to a large extent, the implementation of social security.

The first part of this paper deals briefly with the advantages and disadvantages emanating from a research body's being an integral part of the system responsible for implementing social security policy. We shall review some of the problems arising from this situation, including possibilities of improving the relationship between research and policy implementation and the role of research in policy making.

The second part of the paper will present an example of the impact of social research on long-term care insurance in Israel. It is not easy to select one such example, since almost all the major developments in Israel's social security system during the last 15 years, such as establishing new insurance branches and extending existing ones, were accompanied by research preceding, during and after their implementation. This was the procedure as regards the new insurance branches of Unemployment, General Disability and Income Support[1]. The example par excellence of a dominant

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[1] The Unemployment branch began functioning in 1973, General Disability in 1974, and Income Support in 1982.

research impact on policy execution are the studies on poverty and income distribution regarding children, on the basis of which the reform of 1975 in direct taxation and children's allowances were introduced[2]. However, we prefer to use as an example long-term care, which was implemented in Israel as a regular insurance branch in April 1988.

Advantages and Disadvantages in the Integration of Policy and Research

The integration of a research and planning system into a body of an essentially executive nature may give rise to a number of fundamental questions with regard to patterns of contact and mutual relationships between these two systems.

a. The Issue of Objectivity

How may we ensure the existence of a reasonable standard of research objectivity when the professional research evaluation of the executive body's activities is made by an organic unit of the same body? This question has occupied the Institute for many years, in the knowledge that pure scientific truth is liable to suffer, even subconsciously, as the researcher's identification with, and integration into, the executive system and policy lines of the Institute grows. The solution found to this problem was the separation of research from implementation by having all research carried out by a separate department outside the executive branches and without any administrative or organizational subordination between them. Furthermore, research projects of a basic kind, aimed at outlining long-term policy, are also carried out in the Research and Planning Administration by independent researchers who have no connection whatsoever with the Institute's day-to-day current activities.

Research projects of a broader and more comprehensive nature with implications for other systems outside the National Insurance Institute's sphere of responsibility were carried out jointly with other factors concerned and by means of neutral research bodies with pure professional research expertise, such as the Central Bureau of Statistics or the Brookdale Institute of Gerontology. This integrated system, even if it does not guarantee absolute scientific objeticvity, has proven itself in the course of time to be a reliable professional system whose data, information and know-how constitute the main professional and empirical basis for decision makers and social policy makers.

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[2] See Jack Habib, *Children in Israel*, The Szold Institute, Research Report No. 168, Jerusalem, 1974.

b. The Interrelationship Between Research and Execution

Another basic problem involved in the existence of a research body within a large executive body is that of the mutual relationships and extent of cooperation between them; the executive body sometimes feels that it is controlled by another body which is not always familiar with the mysteries of implementation and is perhaps unaware of the problems, difficulties and variabilities which are an integral part of dealing with such a broad and ramified system. This problem is liable to become more serious if these feelings are accompanied by a basic lack of understanding on the part of the executive level with regard to the importance, contribution and role of research in changing and improving systems and formulating short-term and long-term policy. Conflicts and misunderstandings between the two levels in the Institute have existed for many years, but in recent years, as a result of numerous persuasive activities, increasing consciousness on the part of the executive grades of the researcher's importance and, in particular, presentation of outputs, results and achievements in improving the system as an outcome of research activity, tension has lessened considerably and one may say that the research function occupies an honourable place in the Institute and is generally duly respected.

c. Determining Priorities

Nevertheless, at times of severe manpower shortage or need to cut human or other technological resources, the opinion is often heard from the executive level that in the Institute's scale of priorities, preference should be given to current implementation and service to the public at the expense of these functions which, despite their importance, can be temporarily reduced until the situation changes for the better. In recent years the National Insurance Institute has managed, despite various limitations, to prevent any serious harm to the research system and to preserve a high human-professional standard in this sphere. However, priority in technological means and computer resources has been granted, and rightly, to the system of payments to the public. This is one of the main disadvantages of the existence of a research function within an executive system, a disadvantage which is not apparent in bodies whose entire functioning, specialization and activity lie in the sphere of research only.

d. Applicton of Data Bases

Another question of special significance for the relationship between research and executive levels coexisting under one roof is that of other data bases and the possiblities of applying the researchers' findings. It seems to us that in this matter an integrated system has a great advantage and can make a considerable contribution. As stated, the National Insurance Institute encompasses almost the entire population of Israel both in the framework of its insurance and in the cycle of its beneficiaries within its various programs. As a result, the Institute possesses a tremendous personal data base on the whole population in various fields — demographic, medical, employment and the like — which constitutes a great potential for a widespread program of research. All this information is at the disposal of the Institute's research function and, for reasons of individual privacy, cannot be transferred to any external body. Furthermore, since these data bases are based on personal data received from each insuree claiming a right to benefit, researchers have a possiblity of inserting into the administrative forms additional data needed for developing the research system. This is done, of course, carefully, unassumingly and discreetly, in order to avoid unnecessary clumsiness of the administrative tools, which is liable to affect the nature and quality of the service to the public.

The experience of the National Insurance Institute shows that the cooperation of research staff in drawing up forms and various administrative instruments has enriched the Institute's data bases, helped to improve the quality of decisions and facilitated follow-up of implementation. Unfortunately, the possiblities of transferring personal data to external factors are very limited for legal reasons, but file processes which do not identify the individual's data which are produced from the Institute's files for the purposes and needs of various research and executive bodies make an important contribution to the development of research and welfare services in Israel.

e. Applicability of Research Findings

One of the principle issues raised in every discussion and which playd a part in every decision on the allocation of resources to research is the possibility of applying research findings to the formation of policy and their contribution to the efficient operation of this policy. Researchers are often attacked for enclosing themselves within the narrow confines of their theoretical research, without their being able to forsee the practical needs of the user due to their lack of acquaintance with the implementation system or with the "rules of the game" in forming policy. The result is liable to be the existence of a quantitatively and qualitatively rich reaearch system with limited practical use.

There is a grain of truth in this argument, and in certain cases there is indeed a rift between researchers and policy executers due to a mistaken concept of research workers that too close a connection between or identification with implementation processes are liable to affect the professional purity of research and distort its results.

Nevertheless, it appears that this subject is grossly exaggerated. The fact that many research reports lie like unturned stones due to lack of exploitation does not indicate lack of potential for application, but rather the unwillingness or perhaps inability of policy implementors to invest the required resources in thought, initiative and material means for the optimum exploitation of the possibilities offered by the research. It seems that the strengthening of the ties between the researcher and the user, greater familiarity with the needs, limitations, and possibilities of the other party, involvement and cooperation between them in the course of the research work with a certain degree of flexibility and readiness to make changes in accordance with the developing needs, can all improve the level of applicability and exploitation in policy formation and execution.

Other factors that determine the extent to which the research data are used are the nature of the research and the initiating body. Research projects of a continuous nature which accompany the implementation process or are intended to provide a solution to a limited and defined problem have the greatest chances of application and use, in contrast to long-term research projects in which the element of uncertainty regarding the future is greater. Research projects initiated by policy makers or by executive levels in order to study an issue or problem that arose in the course of implementation are more precisely definable, being based on empirical data that are familiar to the user, so that there is a greater chance of a stronger connection between the research findings and their potential applicability and use. On the other hand, research projects carried out on the initiative of researchers are based more on suppositions, assumptions, forecasts and theoretical professional models which are not always known to or understood by the policy executors. Thus their level of exploitation is liable to be affected, although from a merely professional viewpoint they contain great possibilities for developing correct policy.

To sum up this section, we would like to stress that any expectation of full and unequivocal use of research data and research recommendations in policy making is impractical. There always were and always will be irrelevant considerations in the decision making process originating in the global, political and public aspects of the issue, which are inconsistent with the objective professional findings. Yet despite these limitations, there is no doubt that research helps to moderate these trends and at least place the professional findings at the basis of the discussions leading to policy decision-making, ao that it may be assumed that the decisions reached are based also on professional and pertinent considerations.

Case Studies

1. The Case of Establishing the Long-Term Care Insurance Branch[3]

The State of Israel established a new insurance system in the framework of the Long-Term Care Insurance Law, which was passed in April 1986 after five years of preparation, fruitful both intellectually and scientifically. In our opinion, this law, in its evolutionary process, embodies all the elements relating to the mutual relationships among researchers, policy makers and policy executors, and serves as a concrete example of the role of research in social security. We shall briefly illustrate the above relationships as they were expressed in the process of legislation and preparation for the implementation of the law.

a. Objectives of Research and the Motivation Behind it

Israel too, like other countries in the world, faces the problem of the growing old-age population. In 1950, two years after the State of Israel was established, the old-age population amounted to 3% of the population. Towards the end of this decade it is expected to grow to 10%.

Awareness of the old-age population has increased, not only as a result of its tremendous growth, but also due to the change in the demographic structure of this population. At the beginning of the 1970's the 75 plus age group amounted to almost 27% of the old-age (65 plus) population. Towards the end of the decade the expected percentage is 74. This increase necessarily creates new needs for social services, especially for those too disabled to carry out regular daily functions on their own.

The idea of solving the problem of distress of elderly people with serious functional disabilities by placing them under State responsibility appeared at first in the 1970's at the initiative of the National Insurance Institute and with the inspiration of the Minister of Labor and Social Affairs. The lack of basic and systematic data on the scope and components of the phenomenon led the National Insurance Institute to the conclusion that it was necessary to carry out a comprehensive basic research among a representative sample which would present a general picture of functional disability, its dimensions, solutions that existed or were lacking in the community, the division of responsibility for care among formal and informal services, a draft supplementary care program for the disabled who did not benefit from proper assistance etc.

The research was carried out in two representative settlements in Israel,

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[3] The Israeli Long-Term Care Insurance Law, as a case study of linking policy and research, was first presented in a joint conference held in Miami by Israel and the State of Florida in December 1986.

under the auspices of hospitals which served the population and with the participation of the medical and nursing staff of these hospitals. The findings of these surveys became, in the course of time, the main source of data for studying functional handicaps and they underwent a long series of processing, analysis and research which helped to crystalize a set of rules and principles for eventually passing a Long-Term Care Insurance Law.

In the course of these years a multi-professional public committee operated with the participation of representatives of the government, the public and experts in the field of long-term care. The committee was appointed to formulate rules, principles and procedures for the introduction of a Long-Term Care Insurance Law in Israel. The committee's discussions lasted longer than usual due to the absence of basic and reliable data on the long-term care system in Israel and to its aspiration to base its conclusions on a professional basis. The professional requirements of the committee, which was coordinated by the National Insurance Institute in consultation with the best research forces in the country, gave a tremendous impetus to research in the field of long-term care. At times, the committee ceased discussions for long periods while it waited for the results of research projects which had been commissioned and without which it was impossible to advance. Research projects carried out jointly by the National Insurance Institute and the Brookdale Institute on the distribution of long-term care services, the process of care of the disabled elderly in the community, costs of long-term care services in the community compared with their costs in nursing institutes, quality of care in nursing institutions and surveys on the experience of other countries in the field of long-term care of the elderly — all these supplied the committee with a stream of important data and determined to a large extent the patterns of the system that it finally recommended.

b. Results and Impact of the Research

It seems that the Long-Term Care Insurance Law can serve as a classical example of the useful and fruitful influence of research on the decision-making process. The fact that the discussions took place against the background of a serious lack of data as well as the open and professional approach adopted by most of the participants created fruitful ground for the crystalization of a system on the basis of professional and scientific data. Thus, for example, the first concept which was accepted as self-evident by most of the participants, namely that the Long-Term Insurance Law should concentrate mainly on providing institutional solutions to the disabled, gave way to an entirely opposite approach of a community law which would provide long-term care solutions for the population dwelling within the community, in its natural surroundings. This revolution in thinking was the result of research findings which clearly proved the lack of symmetry between community and institutional care, with relatively large resources being diverted to institutional care in contrast to lesser resources being devoted to community care. The economic research projects on the costs of institutional care compared with the costs of community care and the findings that indicated the family's involvement and functioning in devoted care and support for the elderly, led to the conclusion that the Long-Term Care Insurance Law should regard the family as a central link in the elderly person's care in the future as well while formal services should be intended to encourage and reinforce the family's ability to continue to bear the burden of care. The research also exercised a strong influence on the formulation of the aims of service development both in terms of order of priorities in developing services and in terms of their distribution over the country's various regions, all in accordance with the findings which attempted to locate foci of distress and shortage of services.

Much research effort was invested in the construction of organiztional models for the process of testing entitlement to long-term care and the way in which it would be materialized. Survey and studies of existing systems and patterns of cooperation between the various bodies led to the conclusion that the Long-Term Care Insurance Law should be based on existing local systems while strengthening and promoting the ties between them and delegating authority to joint local committees to determine the care-for-the-aged program, as a statutory body operating under the law.

The legislative process in the Knesset and the discussions of the Labor and Social Affairs Committee which finally formulated the law constitute another good example of the dynamics existing in the content of various bodies with rival interests and budgetary and organizational limitations which are not always consistent with a crystalized ideological concept. The Long-Term Care Insurance Law, in its final form, is not fully consistent with the recommendations of the public committee; it constitutes a compromise between the committee's purely professional approach, devoid of any irrelevant considerations and the more pragmatic approach, influenced by budgetary considerations, which aimed at reducing the amount of public expenditure to a minimum. However, it should be noted that in the course of all the discussions held by the Knesset's Labor and Social Affairs Committee, great weight was attached to the professional approach and the objective research data, and the researchers of the Brookdale Institute, the National Insurance Institute, and the universities were active in all the discussions. There is no doubt that the strong research base aquired in the course of recent years helped to preserve the basic principles of the law as recommended by the public committee, even if economic considerations caused a reduction in the number of beneficiaries and the level of benefits provided for by the law.

The Long-Term Care Insurance Law was gradually implemented. Preparation towards operation of the system of personal rights which came into effect in April 1988 necessitated the systematic construction of an organizational and administrative network for determining entitlement and supplying services, the final crystalization of the professional issues and an operative definition of all the law's articles. It also necessitated construction of the tools required to materialize entitlement in the various stages of the process, construction of instruments of control and a system of reporting and carrying out of a series of experiments to examine alternative models for the process of determining entitlement and to create patterns of activity for the local community that will decide on a long-term care program.

These activities were accompanied by current and systematic research on the collection, analysis and feedback of information to the system until its optimum crystalization. This stage was carried out mainly by means of research forces in the National Insurance Institute. Implementation of the Long-Term Care Insurance Law also opened the way to more basic research activity with more global implications beyond the narrow sphere of current follow-up activity. Since expectations of a change in the structure of services and development of modern integrated work patterns centered on the elderly and his problems and needs have been met, then there is definitely room for analyzing these processes and evaluating the contribution of the Long-Term Care Insurance Law to changes in the system of long-term care in Israel. Research bodies which have proven their ability and efficiency in recent years in developing available research systems which help to crystalize policy, such as the Brookdale Institute and the Central Bureau of Statistics, are able to integrate into these research programs and contribute their professional skills to improving the systems and guiding them to more effective lines.

2. The Case Study of the Income Support Benefit Law

The various aspects of the role of research in social security can be seen rather clearly in the process which led to the enactment of the Income Support Benefit Law in Israel which came into effect in 1982 and united in one legal and organizational framework, under the responsibility of the National Insurance Institute, all the major financial programs for guaranteeing a living. The law creates a continuum of all social security programs, acting as a "safety net" for the population not covered by national insurance whose income from benefits (for guaranteeing income) is not sufficient for a minimum living.

Income guarantee for the population exposed to serious economic risk attracted permanent attention of the researchers and policy makers. In the beginning of the 1970's the Bureau of Research and Planning of the National Insurance Institute started an extensive research on income distribution and patterns of poverty in the Israeli economy. Thanks to this research a new approach to the minimum income guarantee was developed, its principles being a. the determination of a minimum level as percentage of the average wage in the economy and in accordance with the family dependents' composition; b. the linking of the minimum level to developments in the wage level, so as to guarantee the weak population's relative standard of living.

The approach advocated by the National Insurance Institute recommended that the entire responsiblity for guaranteeing the weak population's income should be in the hands of one and only one body rather than left in the hands of numerous authorities who were until then in charge of it, mainly the welfare bureau and the National Insurance Institute. The unification of all services in this sphere within one framework could provide a more efficient administration, avoid duplication and offer a better service to the individual. The research also led to the conclusion that eligibility for minimum income should be determined by law, and that equal eligibility conditions and a determined benefit level should be guaranteed to the various needy groups.

The preparatory work for the unification of the services started in the National Insurance Institute in 1975 with the setting up of a committee which submitted a preliminary draft of its proposal regarding the income guarantee program. Following this draft the additional preparations included more research as well as the testing of the program's principles in two settlements.

In the light of this experiment and following the lesson drawn from it, the proposal was submitted in 1978 to the Knesset which gave its final approval in 1980. According to the enacted law all the basic programs for income guarantee were unified in one legal and administrative framework under the responsibility of the National Insurance Institute. Eligibility conditions were anchored in the law, which also determined one level of benefit to the entire population.

In spite of the recommendations given on the basis of research, the alimony program was not included in the new law and remained under a separate one. This is an example of the sometimes limited effect which research has on policy making in the field of social security. Political constraints, pressure groups and various compromises of policy makers breed deviations from the research recommendations.

The Income Support Benefit Law came into effect in 1982, after the period preceding its final enactment was used for further preparations toward its implementation for the entire population and for a gradual extension of the research and the experiments.

3. *The Case of Child Allowance*

Another example illustrating the impact of research on policy makers in the sphere of social security is that of child allowances and their relationship to the direct tax system in Israel.

For many years Israel struggled with the problem of helping families with children. Until 1975 the system supporting families in terms of in-cash income guarantee was operating in several areas. There were exemptions for children in the direct tax system, and at the same time uniform allowances were paid to each child in families with 3 children and more. Whenever prices rose, low wage earners received special grants from their employer as compensation, and a minimum wage was determined in the economy.

Various research projects carried out in the late 60's and early 70's indicated that the poverty incidence and distress were highest in families with many children. 40% of the families with 4 children or more lived in economic distress with an income lower than the poverty line. Research also showed that 80% of the poor children lived in families whose head was employed, and in which the combination of a low wage and a high number of children led to a low income level per capita.

Exemptions in the direct tax system did not alleviate the distress of these families, since in the frequent cases due to the low income these exemptions could have no effect.

The determination of a minimum wage in itself somewhat improved the relative situation of a rather large number of families with children, but exemption of the minimum wage in itself showed that this wage does not satisfy the need to guarantee income to families with many children.

Research based on field surveys showed that the system of grants paid when prices rise had only a limited impact on the economic situation of families with many children. At least one third of those entitled to these grants did not materialize their right, and about 15% of those who received the grant were not entitled to it.

In 1972 the Prime Minister's Committee for Children in Distress was set up. In its framework sub teams were formed, including one for income guarantee. This sub-team adopted the principle according to which child allowances should be at a rate which will prevent the income decline of a family with only one breadwinner earning the minimum wage to a lower level than that of the minimum guaranteed income.

In 1974 the Minister of Finance set up a professional committee to examine possibilities for reforming the direct tax system in the economy. In 1975 the committee submitted its recommendations, suggesting, inter alia, to reform not only the tax base but also the exemptions and child allowances system.

Following the research and work done by other committees, the specialists' committe concluded that the exemptions for children within the income law framework and the entire system of benefits paid to families with many children should be substituted by a unified and integrated system of equal child allowances paid according to family size. This system has a twofold role. On one hand child allowances serve as tax relief (replacing the previous exemptions in the tax system), thus contributing to an increased horizontal equality between families. On the other hand, child allowances are a kind of "negative income tax" aimed at supplementing the income of low income families, mainly families with 3 children or more, up to a certain minimum.

It is beyond doubt that the preliminary research had a decisive impact on the creation of a universal child allowances system which proved to be effective both in content, i.e. reducing quite considerably the poverty incidence in families with many children, and administratively due to the simple procedures and the low cost involved in operating this universal system.

To sum up, the experience accumulated in the National Insurance Instituite as a body which combines within itself all aspects of social experiences, which generates information and at the same time uses it and participates in crystalizing social policy whilst being responsible for its implementation, indicates the tremendous importance of the existence of a strong scientific basis for the creation of a consolidated social system based on sturdy foundations. A necessary condition of this is the coexistence of a direct and uninterrupted connection between the researcher and the decision maker, the openeness of the researcher to the needs, circumstances, considerations and framework of activity of the decision maker and the policy executor and the existence of a certain degree of flexibility in adjusting the findings of research to the needs of the user while preserving the professional principles of research.

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TRENDS IN THE DEVELOPMENT OF PERSONAL SOCIAL SERVICES

by Yaakov Kop*

The Demographic and Economic Background

This conference** deals with the reform of the local welfare bureaus and its evolution over the late 1970's and the first half of the present decade. My contribution will be a survey of the development of services during the above period in two contexts: First, in the wider context of social and welfare services; secondly, in the context of needs or — as a proxy for them — of changes in the demographic and economic structure that affect social needs. With regards to the time horizon, it is worth examining the development not only between the two ends of the period surveyed but also between this period as a whole and the preceding one, i.e. the first half of the 1970's.

In Israel's demographic history, the period in which we are is characterized by the declining growth of the population, the growing contribution of the natural increase to the overall population growth, the improving of qualities such as the rise in the average level of education. The most important indicators relevant for our discussion are: (1) the decrease in the number of large families and (2) the increase in the number of old people. The change in the first indicator — size of family — is not fully expressed in a variable such as "average number of persons per family" which is now 3.6 as compared with 3.8 in 1970 — a decrease of 5 percent; it is expressed more sharply in the distribution of families by size. The principal change took place in the weight of large families; the number of families with 7 or more persons (i.e. 5 or more children) fell from 11.4 percent of all families to 7.8 percent. In the Jewish population separately, the fall was almost to half — from 8.3 percent to 4.5 percent. In absolute figures — in the 1972 census there were still 14,000 Jewish families with 10 or more

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** Based on a lecture delivered at a conference devoted to the reform of social service bureaus, held at the Paul Baerwald School of Social Work, The Hebrew University, Jerusalem, on March 17, 1987.

persons (8 or more children), whereas in the census taken ten years later there were only 5,000 such families.

The second important change in the demographic structure is the aging of the population. The proportion of old people increased from less than 7 percent in 1970 to approximately 9 percent of the population. This measure is quite known; however, I would like to draw attention to a less common dimension — the change in the number of families for whom social problems emerging from the aging process has immediate relevance: Between 1970 and 1985, the number of old people almost doubled (the increase was actually 80 percent). In the same period the number of households increased less than 50 percent. In other words, the incidence of families who are responsible for an old person increased considerably in the previous decade.

More data on this issue are based on the 1983 census in which 360,000 old people were found in 260,000 households, most of them — 190,000 — constituted separate households of old people. The others lived with relatives in 70,000 households. Census indicate that at least one third of the households in Israel are connected family-wise to an old person, and this is an underestimate.

The two main developments described above reveal a shift of emphasis, from social pressures connected with large families (families with many children) — a phenomenon which was still quite common at the beginning of the previous decade — to pressure arising from the opposite end of the generation continuum.

In the economic sphere, significant changes have taken place since 1970. To mention the main ones: a transition from a rapidly growing economy to a stagnating one. This obviously had both a direct and an indirect impact on the development of social services as part of the changes in the development of the general public services. Another change, that occurred mainly in the first half of the previous decade, took place in the sphere of taxes and transfer payments which no doubt left its mark on the social services, particularly in the field of income maintenance. The second part of the period was characterized by accelerating inflation. In the course of time, with the introduction of programs for economic restraint, uneployment increased and even though its dimensions did not approach those existing in similar situations in western countries, severe local pockets of unemployment were found in some segments of the population, especially youngsters and residents of development towns.

On a more general plane it should be noted that 1977-85 were years of sharp vicissitudes in the economic regime: the "open economy" reform of Finance Minister Erlich followed by the restraining policy of Finance Minister Horwitz and again a change of direction under Finance Minister Aridor; a change back to Horwitz's policy during Finance Minister Cohen-

Orgad's short term as Finance Minister and then a chain of package deals which continued in the economic stabilization program of 1985.

Social and Welfare Services

Against this background of demographic and economic developments the social services underwent important processes. Personal social services are part of the wider "set" of social services — education, health, income maintenance, housing, etc. The development in each of these spheres has consequences — sometimes direct, sometimes indirect — for the specific needs of the weaker population groups. Full employment and prevention of unemployment are likely to reduce the incidence of social problems; suitable education may have the same effect, and so on. In any case, even a generous network of social programs does not necessarily mean that it covers appropriately the specific personal social needs of distressed groups.

I have referred on various occasions to the rapid growth of social services in the 1970's which was the combined result of maturation of programs drawn up previously and increased social consciousness of such problems, especially in the pre-Yom Kippur War period from which we still remember the motto of "hoisting of two flags, that of security and that of welfare, at one and the same time". In the second half of the 1970's, economic conditions changed and the expansion of the services was gradually halted. It is reasonable to assume that the accelerated development of services in the previous period had brought about a certain saturation, at least temporarily, but there is no doublt that economic problems caused a transition from a policy of expansion to one of slowdown, if not contraction.

Table 1 describes the path of the social budget in the 1980's against the background of the rapid increase which characterized most of the 1970's until around 1977. This year marked the beginning of the period of the reform of welfare bureaus with which we are concerned: 1977-1985. Data on expenditure in nominal terms are naturally meaningless in Israel's condition of accelerating inflation and they must therefore be converted into real terms. Without entering into the technical details of the differences between the two series of data presented in table 1, it should be mentioned that the second column does not rely solely on the accepted common index — the consumer price index — but resorts to a specific index which indicates the physical quantity of resources which could be activated by the services with the money allocated to them[1].

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[1] The price index of public consumption is a good indicator of the cost of inputs which produce the direct services (education, health, etc.). We combined this index with the

Table 1. Development of Total Expenditure on Social Services (Fixed Prices of August 1985, Billion NIS)

	Deflated by Consumer Price Index	Deflated by Combined Index
1970	1.7	2.1
1975	3.3	3.9
1977	4.1	4.5
1978	4.4	4.7
1979	4.6	4.8
1980	4.8	5.0
1981	5.3	5.3
1982	5.5	5.5
1983	5.3	5.4
1984	5.5	5.3
1985	5.1	5.4
1986	5.4	5.7

Source: *Israel's Social Services 1986-87*, The Center for Social Policy Studies in Israel, Jerusalem, June 1987.

It can be clearly seen that in the 1980's the process of growth was halted and a period of standstill set in. As already hinted, this may have been made possible, to some extent, by "reserves" accumulated in the preceding period. But the data reveal a certain downwards rigidity and even in recent years, when a policy of cuts was adopted, real expenditure remained on quite a stable level. This stable level in absolute terms, when it exists in an economy in which there is some — even slow — growth, automatically leads to a decrease in relative terms when a comparison is made with the national product, for example. Indeed, since the last quarter of the 1970's there has been a certain fall in the level of expenditure vis-a-vis the GNP.

The stability in the level of expenditure in absolute terms does not apply equally to all components of the services. Special consideration should be given to the distinction between services in cash, i.e. the payment of

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consumer price index which is relevant to the use by families of income maintenance receipt. Therefore, the combined index expresses the real volume of inputs allocated to social services of both types.

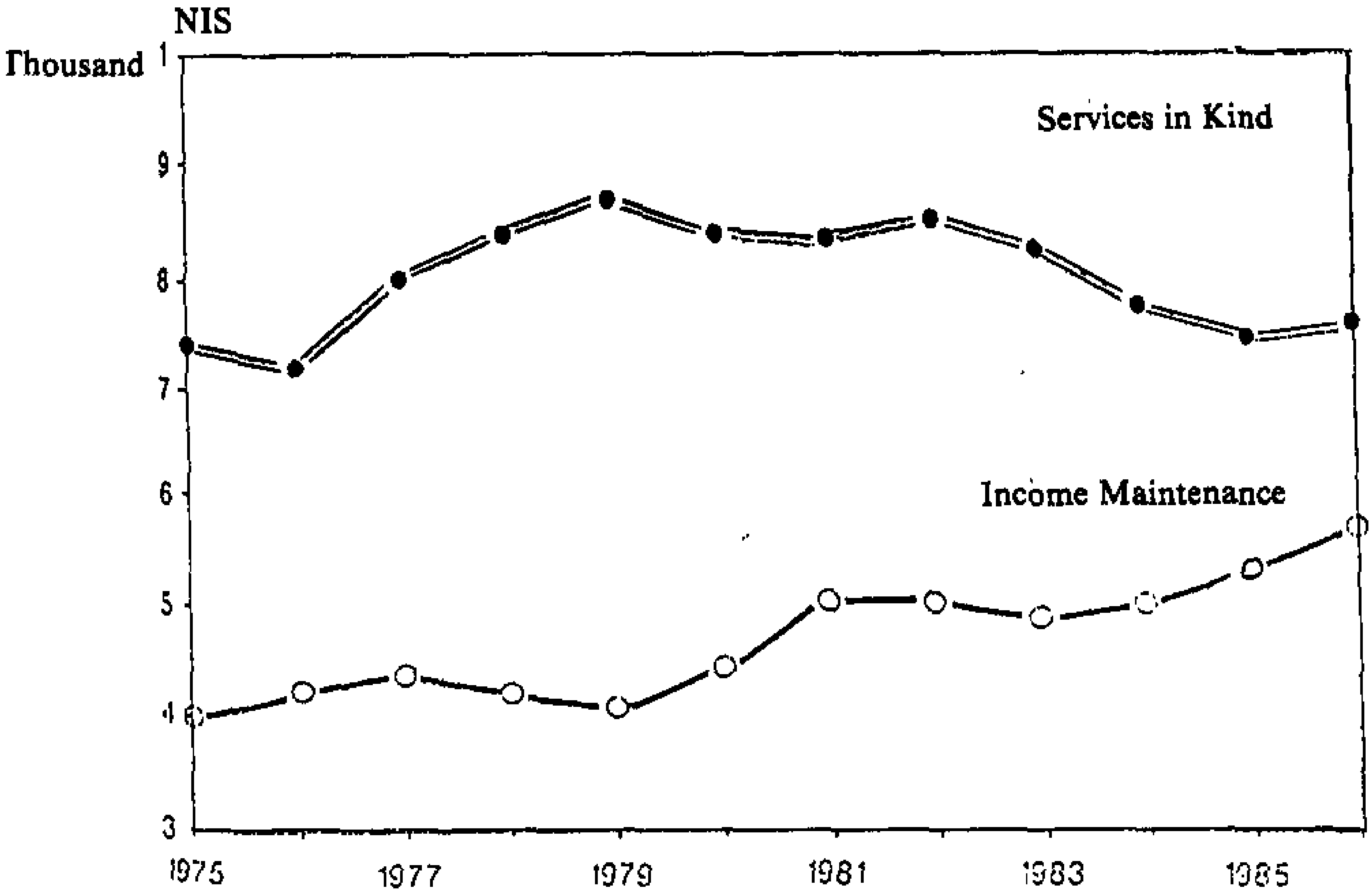
pensions within various frameworks of income maintenance, and services in kind such as education, health, various social personal services and the like. Figure 1 shows that, whereas income maintenance payments continued to grow at a rather rapid rate in the 1980's, there was a certain drop in services in kind; and when we examine expenditure per capita we shall see that there was a drop of approximately 10 percent. As for the education and health services, this decrease was slightly offset by an increase in the private and non-profit sectors.

Social Services vs. Selective Services in Income Maintenance

These data naturally raise the central question of our discussion — to what extent does the general picture given above apply to the rather tiny sector of personal social services? There is hardly an explicit identification and definition of this sphere, but I will try to characterize the subject by referring to the services supplied in the various frameworks and under the auspices of the Ministry of Social Affairs. I shall refer to services for the aged, for the disabled, families in distress and the like.

Table 2 shows the development of expenditure on personal services by

Figure 1. Per Capita Expenditures on Social Services



Source: The Center for Social Policy Studies in Israel, *Allocation of Resources for Social Services, 1986-1987*, Jerusalem, January 1987 (in English).

Table 2. Expenditure on Personal Social Services by Main Component (Fixed Prices of August 1985, Million NIS) Deflated by the Public Consumption Price Index

Year	Total	General Activities	Community Services and Bureau Activities	Rehabilitation Services	Services for the Aged	Services for the Retarded	Services for Children and Youth
1970	86	20	13	11	2	14	26
1971	95	25	10	10	3	15	33
1972	113	21	17	10	4	16	45
1973	132	23	23	10	6	20	49
1974	155	31	28	13	10	24	50
1975	153	25	31	12	9	26	51
1976	173	21	40	14	12	27	59
1977	200	24	40	14	10	29	83
1978	218	34	48	13	10	32	81
1979	207	30	32	17	10	32	85
1980	210	30	42	14	12	34	78
1981	205	28	35	15	14	35	78
1982	194	26	42	17	13	31	64
1983	203	26	46	14	16	32	68
1984	188	27	34	13	14	32	68
1985	184	27	36	15	14	30	63
1986*	188	21	40	15	15	31	67

* Original Budget, including breakdown of reserve by items
Source: See Table 1

its components. The "Total" column reveals that the general pattern of accelerated expansion up to 1977 and the contraction following it applies to personal social services too. In absolute terms, expenditure doubled in the course of the 1970's up to 1977, from 100 million NIS (1985 values) to 200 million NIS and following a further increase accompanied by certain fluctuations, the 1980's began at an expenditure level of 190 million NIS.

The largest item of expenditure was on care of children and youth (including corrective services). In 1986 a sum of 67 million NIS was devoted to various frameworks in this sphere and it constituted about one third of the total "Social budget". Nevertheless, over a number of years one can discern the slowdown that occurred in two stages: in the first, the weight of this sphere dropped from 42 percent (of all personal services) in 1977 to 38 percent in 1981; in the second stage, a further decrease took place to 32 percent. Here one can see the adaptation of expenditure to the demographic development described above. This finding may support the contention that the assumption that there is some correlation between demographic development and budgets for child and youth services.

This connection, with an opposite result, also appears at the other end of the age continuum — services for the aged. In this sphere there was an increase from about 10 million NIS at the end of the 1970's to about 15 million NIS in recent years. This development reveals only part of the increase in expenditure on services for the aged. It should be especially recalled that elderly patients in need of long-term care are treated in institutions that operate in the framework of the Ministry of Health. On the other hand it should be noted that the 10 million NIS expenditure level had already existed since 1974; this fact merely reinforces the information regarding the lag in the development of services for the aged which began to be coped with only in recent years.

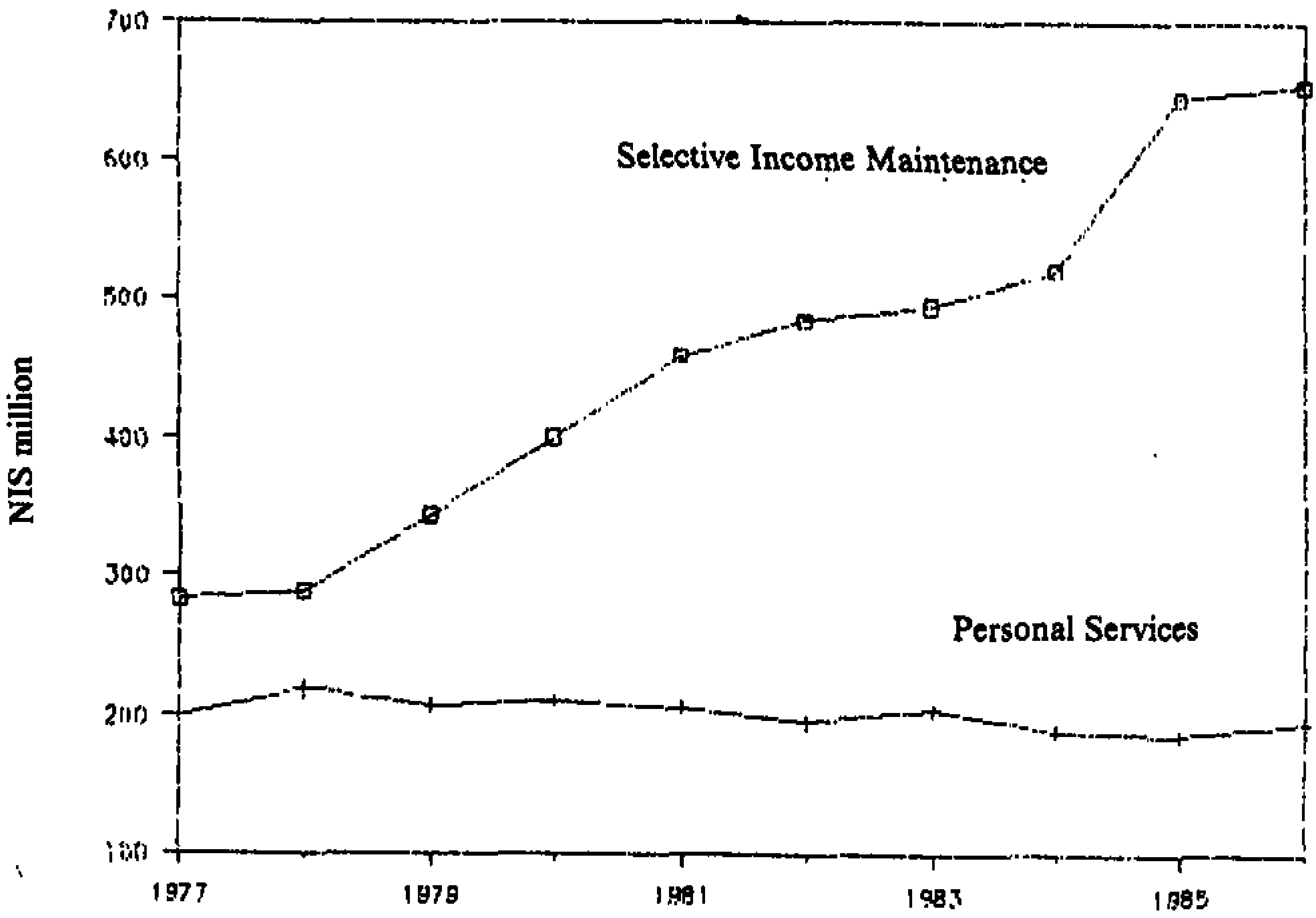
Continued stability with slight fluctuations can be seen in the Services for the Retarded and the Rehabilitation. Expenditure of 13-15 million NIS has charcterized the rehabilitation activities since the mid-1970's or even before, whereas expenditure in the Service for the Retarded has been 30-32 million NIS per annum (with two exceptions) since 1977.

The picture in the second branch of the social services — services in cash — is considerably different. Before turning to the expenditure data, I wish to stress that this part of the study does not refer to total transfer payments — which were mentioned at the beginning of the article and most of which are universal-demographic (such as child allowances, old-age pensions, maternity payments), but to specific payments made on the basis of means testing. Thus, for example, we included the supplement to the old-age and survivors pension which is granted to pension recipients for whom the pension is their only or main income, unemployment payment, social welfare benefits and other payments due to general disability. All of these may be regarded as a complement of the in-kind social services.

Figures 2a and 2b show the development of the two types of services. Figure 2a emphasizes the two main characteristics: (1) services in cash exceeded services in kind; (2) the gap between them has widened drastically in the period under survey.

Income maintenance payments will be presented again in the second version (Figure 2b) which does not include the disability allowance; A major development took place in the area of general disability during the period surveyed, and its inclusion would have obscured the general picture. Let us, therefore, focus on the second figure which, as stated, presents selective income maintenance payments without disability allowances. The general pattern is repeated again here, but the greater proportion of income

Figure 2a. Social Expenditures on "Selective" Income Maintenance and Personal Social Services



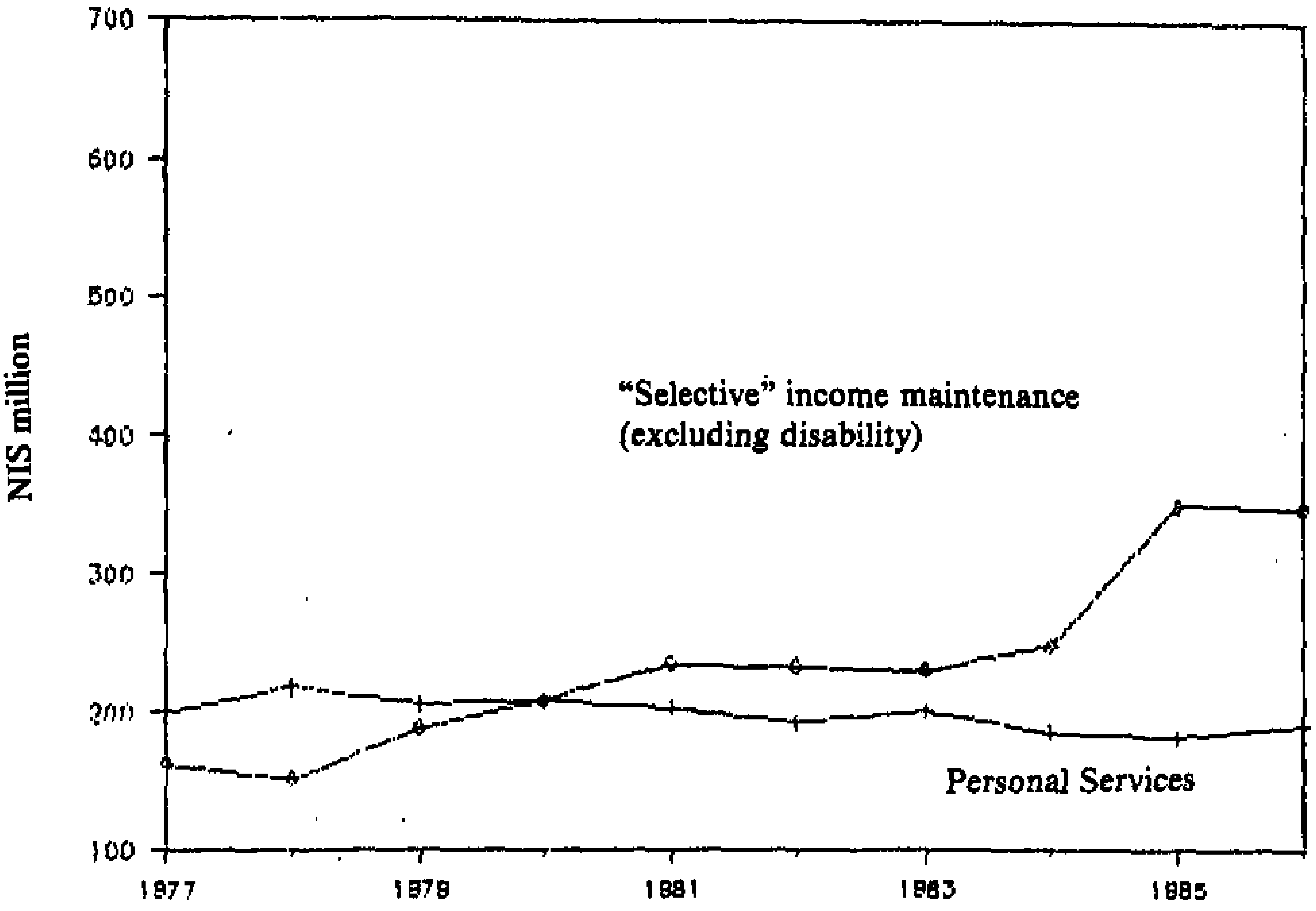
Source: Working tables of the Center for Social Policy Research in Israel

maintenance payments appears now only at the beginning of the 1980's. The general characteristic as shown in Figure 2b is stability of services in kind with light fluctuations throughout the period compared with continual and accelerated expansion in two stages in services in cash.

It must be stressed that this picture does not contain any bias connected with the reform. That is to say, the results may be influenced in one way or another by the reform which transferred the responsibility for income maintenance payments from the Ministry and the social workers to the National Insurance Institute, but the classification of expenditures between services in cash and in kind, was consistent, and was not affected by the organizational aspect. In other words, income maintenance payments before 1977 were classified as such even when they were dealt with by social workers of the Ministry of Social Welfare.

The above finding raises a question whether this was the result of a deliberate policy or a result of the difference between the institutional arrangements existing in each of the two types of services. It should be remembered that most of the income maintenance payments are dictated

Figure 2b. Social Expenditure on "Elective" Income Guarantee (Excluding Disability) and Personal Services



Source: See Diagram 2a

by arrangements according to which the basic level of the payment is determined, in most cases, by legislation or by some other indiscretionary method. Thus, in such cases once the number of recipients grows — the overall expenditure on that item will increase accordingly. As seen by supporters of the social services, this demonstrates that the method of emphasizing services in cash is the proper strategy which takes into account all factors including political ones.

From another point of view it would seem that the circumstances that led to this preference have changed. At the beginning of the 1970's, the problems in the area of income maintenance were more serious than they are today. This is not to say that the general picture of equality in the Israeli society improved during this period. On the contrary, the facts reveal a deterioration in the distribution of incomes as expressed in the general inequality index as well as in the relative share of the lower deciles. Nevertheless, the aspect of relative poverty — which is an important issue in social policy — does not reveal the entire picture. In terms of absolute income, it appears that since 1970, the real income of the two lowest deciles went up by 10-20 percent (and it should be emphasized again: in real terms, i.e. in terms of the puchasing power of their income). From this point of view, if income maintenance payments were supposed to reduce social pressures by increasing purchasing power of the poor, the force of the social pressure on this front decreased during these 15 years. On the other hand, the distress of families receiving services has meanwhile increased up to the point of traumatic situations. The problem here is not one of finance but of the availability and standard of the services. Those who are familiar with the problems of the various types of long-term care institutions know that they are most difficult and that even money is not always capable of solving them.

From this point of view, the main social pressure — even if it has not yet found wide public expression — exists, at least potentially, in the sphere of in-kind services and not in that of cash services. Of course, it is possible that there is no institutional substitution between these two groups of services; in other words, if expenditure on income maintenance is reduced, the resources saved will not be directed to in-kind services. In such a case, a mechanism may be devised to create a connection between these two systems.

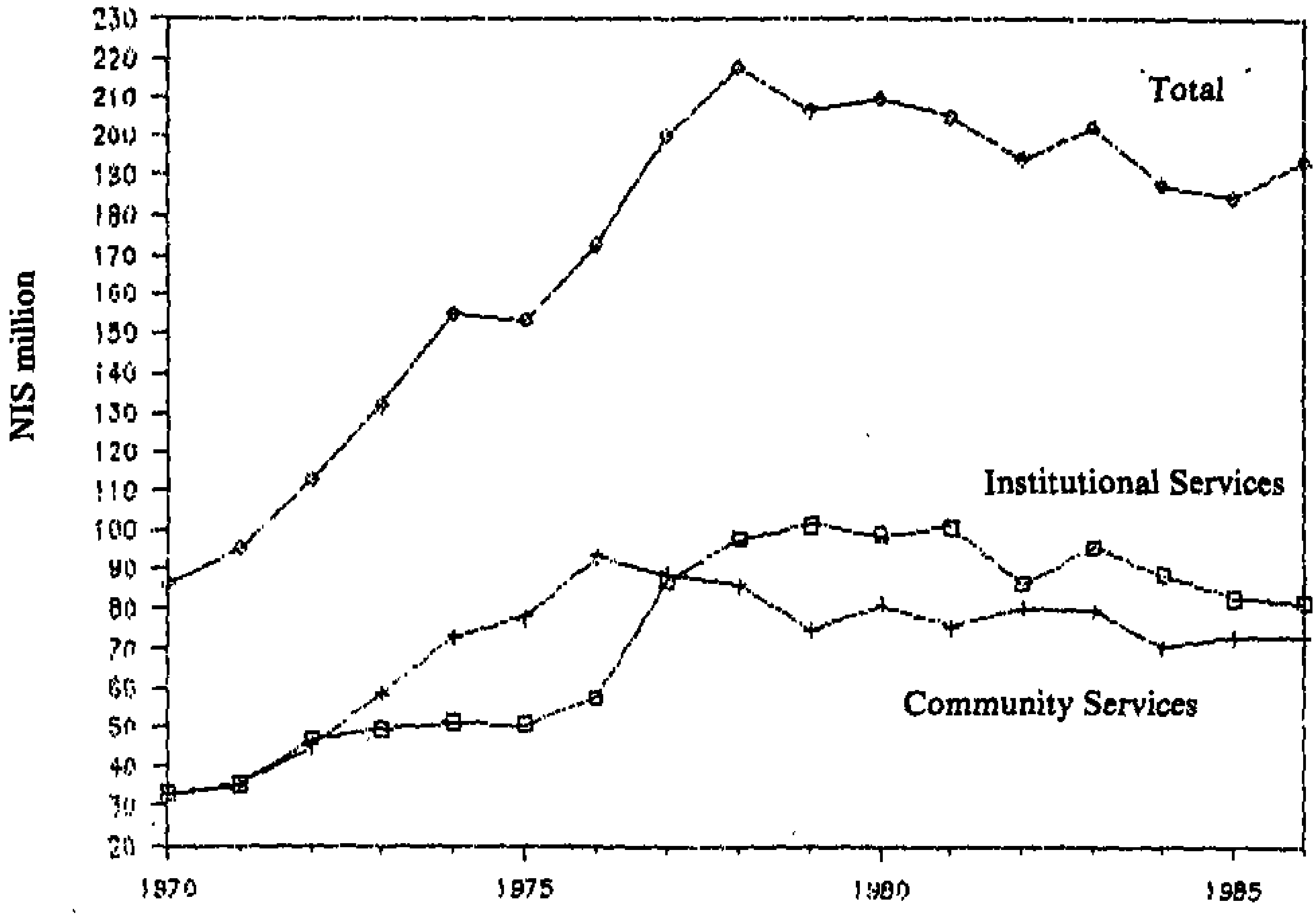
The Development of Community Arrangements Compared with Institutional Arrangements

The subject of substitution among and complementation of various types of services leads to yet another aspect: substitution between institutional and community services. Figure 3 reveals a preference for institutional care throughout the period under discussion. A similar finding was revealed in a previous study[2] in which the matter arose in connection with specific services. Here, the three main services discussed in the past have been combined together with all the other social services.

The figure given here is an emprical one, arising from the measurement of the destinations of the budgetary expenditure. However, it is clear that it does not represent a mere technical classification but rather concerns a matter that occupies quite a prominent place in the literature on personal services. It is widely held that there are important professional reasons for preferring care of the needy in the framework of their families and usual environment rather than in institutional-boarding arrangements; our findings reveal a reality which is the opposite of that considered preferable. The situation here is by no means the result of arbitrariness or inconsistency of thinking and approach but mainly the result of the decision-making

[2] Yaakov Kop (ed.), *Changing Social Policy — Israel 1985-86*, The Center for Social Policy Research in Israel, Jerusalem, April 1986.

Figure 3. Expenditure on Personal Services: Total, Institutional Services, Community Services



Source: See Diagram 2a

process: the maintenance of people in an institution for a certain period requires a given amount of expenditure. Generally it is also not possible to send people away from institutions especially if they are chronically ill. At a time of budgetary limitations, those responsible for the various services are left with a relatively small budget available for operating community services since the institutional budget is more inelastic. It is also possible that this situation arises from the fact that the transition in practice is not as easy as that in theory and in any case it is necessary to develop the requisite organizational tools. Various frameworks of institutional services, which have operated in recent years, have a potential for operating as community services as well, e.g. a boarding institution which allots part of its premises to day care.

It should be emphasized that in this matter, the professional-care consideration corresponds to the economic consideration. Within a given budget it is possible to provide a greater number of consumers with community services than with institutional services. It is claimed that community services are ultimately more expensive since availability of day care institutions and community activities leads to increased use of them. However, this means that there are needs which are not being met in the present system. This is as if we cut expenditure on education by not accepting all pupils; and even if public expenditure on education can be reduced by directing pupils to private institutions, the same cannot be done in social services and there is very little chance that a market of private social services will develop in the future.

Summary

The development of personal social services in 1977-85 indicates a decelaration in the rapid growth that had characterized the preceding period (1970-77) and finally even a certain fall in the level of activity. In the last year (1986), growth began again even though the level that existed at the start of the decade has not yet been attained. In this respect, the personal social services resemble the other direct social services — as distinct from those services based on transfer payments to families.

In this distinction between cash and in-kind services there is a clear preference for cash services (both in the wide and limited areas of social services). It would seem that this process contains, in the sphere of the direct services, a continuation of the emphasis (from the viewpoint of priority of allocation) on institutional-boarding services. Considering the demographic and economic trends relevant to our subject, there is room for a re-examination of existing preferences. It would appear that the trend characterized in the reform of the welfare bureaus is in this direction and it can only be expected to be reinforced.

DEFINITION AND MEASUREMENT OF POVERTY — THE UNSOLVED ISSUE

by Professor Abraham Doron*

Introduction

Every few years Israel witnesses a stormy social and political debate on poverty. Each time the questions come up again: what is poverty; does it exist at the reported scope; are the tools used to define and measure it the proper research techniques? Each time politicians and public figures, from practically across the political spectrum try to deny the very existence of poverty, or to refute the reliability of the reported data. And each time the public as a whole becomes absorbed in the dispute about the extent of poverty and the bitter controversy waged over it.

What are the reasons for this ongoing debate and what is hidden behind it? Is it unique to Israel or does it occur similarly in other countries? In this article an attempt will be made to review the different methods of defining and measuring poverty that have been used in various countries, including Israel, and to examine the relationship between these methods and the continually recurring poverty debates.

Poverty is, of course, not a new social phenomana discovered in the 80's of the present century. The history of poverty is in fact the history of existence of the human race. In every human society known to us, the problems of poverty appeared in one form or another; and, obviously, poverty did not disappear in contemporary society. The question which has concerned developed industrial societies for the past hundred years, and which is also the concern of Israeli society today, is: what constitutes poverty? The problem is not only of understanding the concept of poverty in general, but especially, of the meaning of poverty in contemporary affluent societies. The very existence of poverty in an affluent society points to the fact of a basic contradiction.

The attempts that have thus far been made to deal with this question were to define poverty by establishing a *poverty line*, i.e. by either determining a minimal amount of financial and other resources that should be available to

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a person, or by setting the distance between the individual and a particular reference group. A person or family to whom this amount of resources is not available, or are found at the defined distance, are considered to be poor; i.e. they live in conditions of poverty.

The problem here is that every attempt to establish a poverty line inevitably becomes a focus of public debate and arouses deep differences of opinion, since any such definition is essentially based on a political value judgment. Moreover, as such a definition has important political and social implications, it is very difficult to reach a consensus with regard to it, and it is inevitable that a certain degree of disagreement will arise (Townsend, 1970; Ferman, Kornbluth & Haber, 1968; Fishman, 1966).

To evade this dilemma, many attempts have been made over the years to establish an objective, scientific poverty line, and adopt a definition detached from the personal and political values and preferences of its definer. However, all these attempts to establish an "objective", "scientific" poverty line which would give an unequivocal answer to what is poverty, and which will remain valid at all time and in all places, have not succeeded. In fact, all these attempts were doomed to failure from the start, since they took upon themselves an impossible task. Theirs was a search after a mirage, since science cannot provide an answer to a question which is basically one of social values.

This is indeed what happened. Every time that such a "scientific" poverty line was adopted, there was a public outcry of disapproval when the number of people falling below this poverty line was published. There were always those who would not agree with the adopted definition, or could not reconcile themselves to the fact that the extent of poverty was so high. And the tried path to deny the validity of such findings is by shedding doubt on the scientific method used, and in this case the very measure of poverty was put into question.

It is important to emphasize that the motives for denial of the extent of poverty do not necessarily have to be purely political. They are much more complex. First, as will be shown, the differences of opinion regarding a particular poverty line can certainly be genuine and legitimate. Secondly, it is difficult to disregard the emotional aspects of the debate. Those disputing the adopted poverty line and the scope of poverty revealed by it belong mostly to the affluent middle classes. This social strata cannot become reconciled to the thought that in an affluent society in which they themselves enjoy so much of its abundance, there are also people living in poverty. They cannot accept this seeming contradiction of poverty in an affluent society. And thirdly, the criteria of measuring poverty are certainly not scientific in the full meaning of the term. The objection to the criteria used gives the expression to the seeming desire for pure scientific objectivity. In fact, however, it expresses more the sense of dissatisfaction with the social reality surrounding us as opposed to the image of society most people draw for themselves. The most convenient way of escaping this conflict is by searching for a kind of magic scientific formula, in hope that it will provide the expected answer and will solve the conflict for us.

The fact that there cannot be a purely scientific poverty line does not mean that the scientific methods could not and should not be used in the attempts to adopt such a line and in the measurement of the scope of poverty. The use of up to date scientific methods can assure us that the data obtained has a high degree of reliability and validity. This, however, cannot alter the fact that the poverty line itself is a result of decisions that are not necessarily purely scientific. It is important to maintain this distinction between the notion what is scientific regarding the poverty line, and what is a matter of value and political judgment.

It is in the context of these debates on the meaning and scope of poverty, which have been going on since the end of the 19th century, that the methods that we are using today to establish a poverty line and to measure the scope of poverty were developed. In theory, two main approaches to defining poverty have developed. One approach is the "absolute" approach, and it refers to poverty as a problem of a minimum for subsistence (Rein, 1970; Townsend, 1984). In other words, the poverty line is determined by what is required to meet the basic needs for subsistence. The assumption underlying this approach is that it is possible to establish a fixed and absolute criteria as regards the minimum essentials for subsistence. The inability to obtain these minimum essentials means poverty. This approach expresses chiefly the problem of economic deficiency as a determinant of poverty. What this approach means is that poverty can be easily overcome. All that needs to be done is to provide the minimum income to those who lack it.

The second approach is the "relative" approach, and it related to poverty as a matter of distance and of relative deprivation. It means that poverty is perceived as a condition of deprivation relative to the condition of other groups in society. Persons and families are in poverty, according to this definition, when their circumstances are far inferior to that of most people and families in that particular society or community. The assumption underlying this approach is that poverty cannot be measured by a set of fixed criteria, but by criteria which change with the economic standard of living in society. This approach expresses not only the problem of economic deficiency, as is expressed by the absolute approach, but mainly the problem of economic inequality.

What this approach means is that it is far more difficult to solve the poverty problem, because there will always be individuals and families in circumstances far inferior to those of others, and at a certain distance from them. This, however, must not necessarily be so, since it is possible to change the pattern of income distribution and of the distribution of other resources which leaves many people at a far distance from the circumstances of the majority of the populaltion. The social orientation supported by this approach is indeed the reduction of the existing economic inequalities in our societies and thus, the subsequent prevention of poverty.

It seems important to repeat, that it is impossible to determine scientifically what is poverty according to both these approaches. Both approaches entail, however, a conceptual as well as a political problem. Conceptually, these are apparently two totally different approaches. In actual fact, the difference between them is not as wide as it would seem from their definition. In reality, the approach defined as absolute is to a large degree relative, since it is very difficult in this definition to be removed from the circumstances of time and place in which it is adopted. At the same time, the approach defined as relative is largely influenced by the current conceptions of what constitutes a minimum necessary for subsistence. In reality, there is, therefore, a large degree of convergence between the two approaches.

From the political point of view, both approaches tend to reflect the process of historical development of social welfare policy in industrialized societies in the last hundred years. Until the First World War, and in the period between the two World Wars, the goal of social reformers was limited to assure a minimum of subsistence income. As early as the beginning of the century Sidney and Beatrice Webb raised the idea of "a national minimum" (Drake and Cole, 1948). Until the 1940's the social struggles and the efforts of the many radical movements were directed towards achieving such a minimum. Even in the famous 1942 Beveridge report the proposal set forth was for "an income adequate for subsistence". Subsequently, these ideas were incorporated into the new reform legislation adopted in the immediate post war period. For example, the National Assistance Act passed in Britain in 1948 stated that assistance will be extended to provide the basic needs at a minimum standard of living.

This picture has, however, changed completely in the 1950's and 1960's. What was considered before the Second World War to be a radical demand became in this period a conservative slogan. The reformers of the period, and certainly the radicals among them, rejected the absolute approach, which contents itself with guaranteeing a minimum of subsistence. Their argument was that in modern society it is irrelevant to speak about an absolute minimum. The needs of men are not stable and absolute, but relative and related to the circumstances of the society in a particular period of time. An absolute minimum has, therefore, no meaning in our society. Interestingly, this reasoning was accepted, at least in theory, although doubtful whether in practice, in the British assistance system. A British White Paper, published in 1959 by the Conservative government of the time, agreed to relinquish the minimum approach and to set the assistance rate at a higher level to enable the population in need to have "a share in increasing national prosperity" (Improvements in National Assistance, 1959; Lynes, 1952). Similar attempts to reject minimum based poverty lines occured also in the U.S. in the 1970's, during the War on Poverty period, and as we shall see, also in Israel.

In view of these professed approaches we shall attempt to examine some of the more notable practical attempts to define poverty, and establish poverty lines, which became trend setting patterns in contemporary industrialized societies. At the same time, we shall examine the similar attempts made in Israel. In both instances we shall try to distinguish between the scientific elements included in the definitions adopted and the values and political elements intrinsic to them. In addition, we shall also look into the public reactions that accompanied these attempts, and the extent to which they actually influenced social policy.

Charles Booth — Pioneer of Poverty Research

It is important to understand the background of the first poverty studies. The pioneer in the field was an Englishman, Charles Booth (On him see: Simey, 1960). Booth began his pioneer investigation following a controversy about the reliability of data on the extent of poverty among the working population of London. He was a wealthy man. Born in 1840, he went in his early twenties into the shipping business and by the 1880's he had become extremely rich. His interest in social issues and in the lives of the poor was part of the feeling of guilt and the crisis of conscience that a segment of the middle class was experiencing at the time. In 1885, a popular, somewhat leftist newspaper, *The Pall Mall Gazette*, published the findings of a survey of working class districts taken by the Marxist Social Democratic Federation. The survey showed that one out of four Londoners, that is 25% of the population, lived in abject poverty (Fried & Elman, 1968, Introduction).

Booth, although concerned with the problems of poverty in London, could not reconcile himself to the facts of the survey data. He did not believe that the scope of poverty was that wide and thought that the numbers reported were highly exaggerated (Mackenzie, 1977, p. 130) and inspired by political ideology, rather than by concern for the truth. He decided, thus, to personally conduct a rigorous scientific investigation to refute the published data on the extent of poverty. His investigation covered the entire working population of London. To his surprise he discovered that the data published by the Social Democratic Federation were indeed erroneous, but that they had erred in underestimating the extent of London poverty, and that the scope of poverty was much wider than reported. His findings pointed to a poverty rate of about 35 percent (Fried & Elman, 1968, Introduction).

The importance of Booth's study extends, of course, beyond these findings. In his study he lay the groundwork for the poverty investigation methods still in practice at present. He was the first to use the concept of a poverty line in his measurements. The poverty line he used was rather arbitrary, but the importance of his work lay in the very introduction of the concept. Moreover, in his evidence, he demolished the Victorian middle class myth that poverty resulted from personal failure, vice or improvidence. He found that the causes of poverty in about 85% of the cases were societal in their nature, such as unemployment, low wages, sickness and large families. Only in 15% of the poor could any personal reasons be identified. Despite himself, he imlicitly thus lent support to the socialist argument that poverty was a collective, not an individual responbsibility (Fried & Elman, 1968, Introduction). His vast work was published in 17 volumes in the beginning of the century (Booth, 1902-3).

Rowntree's Inquiry

B. Seebohm Rowntreee was the first researcher who tried to define poverty in terms of a minimum required for subsistence. Like his predecessor, he came from a family of wealthy industrialists, and from an early age became interested in problems of poverty. Although his education and professional training were in the field of chemistry, he became a pioneer in conducting social surveys (Briggs, 1961). His classical work was the study of poverty in the city of York in 1899 (Rowntree, 1941). In this study he decided from the outset that the poverty line was a minimum essential for only a minimum of physical subsistence. The definition he adopted, in his own words, was as follows: "My primary poverty line represented the minimum sum of which physical efficiency could be maintained. It was a standard of bare subsistence rather than living" (Rowntree, 1941, p. 102). Adopting such a definition constituted in itself a clear value choice. In contenting himself with a minimum necessary for physical subsistence only, Rowntree refrained from recognizing other needs beyond the mere physical subsistence. And we all know that man does not live on bread alone.

How, then, did Rowntree construct the poverty line in view of his definition? Rowntree decided to include in his minimum three main components: food, housing rent and household expenditures. With regard to food Rowntree was the first to utilize nutritional knowledge to determine the amounts of food necessary for a person's physical subsistence. The science of nutrition was at that time at its early stages of development, and Rowntree based himself chiefly on the studies of the American nutrition researcher, W.O. Atwater. Rowntree followed Atwaters's findings and on their basis calculated the nutritional needs of an adult male engaged in moderately physical labour: according to Rowntree, such a man required 3,500 calories per day (Rowntree, 1980, pp. 97–98). On this basis he set the caloric requirements for a woman at the level of 80% of that number; youth aged 14 to 18 also require 80%; children at the ages of 6 to 9 require only 50%; and very young children only 30% of the base number.

Having determined the minimum amount of food required for subsistence Rowntree then set down the kinds of food needed and their prices. As to the kinds of food, Rowntree relied on the dietary experience of workhouses in England and Wales. He believed that in this way he could approximate the food consumption patterns of the poor population groups.

With regard to prices, Rowntree checked the prices of the food products he selected in several places and calculated their average. These served as the basis for his final calculations of the minimum.

As for the housing component, Rowntree took the actual sums paid for rent as the necessary minimum of housing expenditures.

In the household expenditures Rowntree included clothing, cleaning aids, lighting and fuel. For clothing he interviewed various people, particularly housewives, to find out what they considered as the absolute minimum required. After he had a list of the various items, he checked their prices and included them in his final calculations of his minimum. He used a similar method for soap, fuel and lighting. Rowntree did not include in his calculations any expenses for travel, or even travel to work, cigarettes, a newspaper or any entertainment.

At the end of this process Rowntree set the minimum required for subsistence for a family, based on the cost per person according to the age and sex of each family member. By this method Rowntree arrived at his poverty line. But he did not content himself with this and he made a further distinction — between "primary poverty" and "secondary poverty".

Primary poverty, in his view, exists in those cases in which the total earnings of families "are insufficient to obtain the minimum necessaries for the maintenance of merely physical efficiency". Secondary poverty existed in those cases of "families whose total earnings would be sufficient for the maintenance of merely physical efficiency were it not that some portion of it is absorbed by other expenditure, either useful or wasteful" (Rowntree, 1980, pp. 86-87). This was a rather artificial distinction, because it is very difficult to require that those families at the bottom of the income ladder should know how to manage their budgets in the most economic and thrifty way.

In trying to assess the poverty line and the criteria used by Rowntree to establish the minimum required for subsistence, one can easily put some question marks on the methods used. Firstly, the "scientific" base of his poverty line. Rowntree indeed made use of scientific nutritional knowledge, but this was, of course, restricted to food only, and did not refer to the other components of the minimum. All the same, this reliance on some scientific data left on Rowntrees's poverty line, and those that later followed his path, the imprint of being scientific. Yet even in determining the categories of food, their amounts and prices, there were more value based choices than scientific decisions.

Secondly, the extent of "absoluteness" in his line. It can easily be discerned that Rowntree's poverty line was not in any sense absolute, but tightly bound to the place and time in which it was set. He concluded in the beginning of our century that the necessary nutritional requirements for a person's physical existence are 3,500 calories per day. Even today, over 80 years later, such a requirement would be considered in India, for example, or in other underdeveloped countries, something of a luxury. People employed in physical work in these countries live on 1,500–2,000 calories a day (Townsend, 1961). In any case, this proves that it is difficult to give a scientific, unequivocal answer even to such a question as what is the nutritional minimum required for subsistence.

Thirdly, Rowntree tried to determine how people living in poverty, or in near poverty, should spend their money. Obviously such a determination is not realistic. It reflected, perhaps, the values of the English middle classes rather than the behavior and consumption patterns of poor families. These patterns are closely related to the social environment in which these families live. Rowntree, apparently, failed to recognize this point (For a new and different assesment of Rowntree's position on this point see: Veit-Wilson, 1986).

Despite the many problems which Rowntree's definition and measurement of poverty have raised, it must be admitted that his work had enormous influence on the poverty studies carried out afterwards. The physiological approach to poverty and the reliance on nutritional knowledge bestowed on Rowntree's approach the mark of being scientific, and in fact, no substitute has been found for it to this day. An additional reason for the remarkable influence of Rowntree's work arises from the fact that he repeated his poverty studies in York two more times, after an interval of 50–60 years. His second investigation was conducted in the mid 1930's (Rowntree, 1941) and his third was carried out with the assistance of another investigator, in the early 1950's (Rowntree & Lavers, 1951). In his repeated studies, Rowntree improved and slightly expanded his poverty line, but at the same time remained faithful to his basic approach.

The Beveridge Report

Most of the social surveys conducted in England until the Second World War that were concerned with the study of poverty adopted Rowntree's measures. They all introduced various minor adjustments to his basic poverty line, and importantly, the poverty line was uprated to the change in prices. However, no adjustments were made with regard to the rapid rise in the population's standard of living as a result of the increase in real incomes during those years. The approach to poverty remained basically static (Lynes, 1961). As in the case of Rowntree, the purpose of most of these surveys conducted up to the Beveridge study was mainly the acqusition of knowledge.

Beveridge's concern with this issue did not arise out of pure intelectual curiosity. While working on his report in the early 1940's, he had a practical purpose to establish the criteria for a minimum required for subsistence. Beveridge's intent was that the minimum social security benefits "be sufficient without further resources to provide the minimum income needed for subsistence in all normal cases". He no longer spoke about a minimum required for physical existence alone, but rather of an income adequate for subsistence (Beveridge, 1942, pp. 121–122). This approach was significantly different from that of Rowntree (In fact, Rowntree himself served as a member of the subcommittee that advised Beveridge in setting the minimum). In practice, however, Beveridge too continues to use Rowntree's criteria while introducing a few changes: he expanded the list of needs to be covered in the minimum essential for subsistence. He took into account five main components: food; clothing; fuel, light and household sundries; rent and a margin for maneuvre for what he called "inefficiency in spending" (pp. 85–87).

To establish the minimum for all these components, Beveridge followed in the steps of Rowntree, even though he had available much wider and more reliable information than had his predecessor. In the area of food he had access to the dietary scales laid down by the Committee on Nutrition of the British Medical Association in 1933 and the Reports of the Technical Commission on Nutrition of the League of Nations from 1936 and 1938. In the area of clothing and other household expenditures he made use of the data available from the Ministry of Labour Family Budget Surveys in 1937–38. In each of these areas, Beveridge had access to the best scientific information available at the time.

The innovative element in his approach was the introduction of the small margins for maneuvre. He understood that it would be incorrect to assume "complete efficiency in expenditure", i.e. that people required to live on a minimal income would be able to use their budgets without some waste, particularly in food purchases, or spend some of the income on things not absolutely necessary. In his opinion, it was necessary to leave some margins of income, albeit very small ones, for this purpose. He thus included in his proposals an allowance for these margins which amounted to about 6% of the subsistence rate of a couple and about 8% for a single person (p. 87).

Beveridge assumed that there is a difference in the minimum requirements of the various age groups and he, thus, set different subsistence rates for each age. For example, he estimated that the food requirements of old people were less than those of persons of working age. He held the same to be true for clothing and suggested that the clothing allowance for a retired person be put at only two thirds of that for a working age adult. On the other hand, the Beveridge report assumed that the requirements of retired persons in fuel, lighting and other household expenditures are higher than those of persons of working age, and set their subsistence rates accordingly. In the same manner differential subsistence rates were set for young people and children.

In evaluating the Beveridge proposals we find, again, that the minimum subsistence level is not absolute, but very closely related to the circumstances of the time, in this case Britain in the 1930's and 1940's. Although he utilized the available scientific data, the minimum he established was essentially value based and politically oriented. Beveridge admitted as much when he said that in the final analysis any estimate of subsistence income is "to some extent a matter of judgment" (p. 77).

The other limitations of this attempt are in the field of method and politics. As regards method, Beveridge continued to base himself mainly on the physiological concept of poverty as adopted by Rowntree, and did not endeavor to deviate from this rather narrow approach. With regard to politics, Beveridge saw before him the conditions of hardship and dire poverty that prevailed throughout the 1930's, as well as the conditions of want and austerity of the war years. His subsistence income was thus very much influenced by these circumstances, and by the desire that the government take upon itself the responsibility for providing a minimum subsistence level for all, something it had not succeeded in doing during the difficult years of the Depression (George, 1968, p. 208).

In practical terms, Beveridge's proposals had an enormous impact on post-war social policies. The principle of a minimum adequate for subsistence was widely accepted and the assistance rates established later in the National Assistance Act of 1948 were broadly based on the Beveridge estimates. His approach continued to influence British social policy in the years to come and the arguments concerning his proposals continue to this very day (Atkinson, 1969; Field, 1981).

The Abel-Smith and Townsend Study

In the 1960's, two British scholars, Brian Abel-Smith and Peter Townsend, conducted a study on the scope of poverty in Britain. Their purpose was to find out the number and the characteristics of persons living at an income that fell below the level necessary for a minimum subsistence. They named their study "The Poor and the Poorest". In planning their inquiry, their first step was to select a measure of low levels of living as indicators of poverty. As in the other studies they had to define a poverty line. The two scholars did not wish to produce new definitions of poverty lines, and they, therefore, chose as a principle measure of poverty, in fact a poverty line, the level of living of recipients of national assistance in each year they studied. With the understanding that in addition to the basic assistance rates the beneficiaries also received suplemental allowances to cover housing expenses and special needs, and that many of them had small incomes and other resources that were disregarded when their benefits were granted, they concluded that the level of living actually guaranteed to the needy population was 140% or 40% or more than the basic assistance scales. They thus adopted this level as their poverty line (Abel-Smith & Townsend, 1965).

The two researchers avoided expressing an opinion about the adequacy of the poverty line they decided to use. In using it, they stated, "we do not intend to imply that we ourselves consider... that this level of living is an appropriate measure". They did, however, justify its use with the claim that "as a publicly approved measure of 'poverty' it has at least the advantage of being in a sense the 'official' operational definition of the minimum level of living at any particular time" (p. 17).

The dilemmas in adopting this kind of poverty line are immense. Such a poverty line, of course, has no claim of being "scientific". Furthermore. although it seems to reflect a minimum income required for subsistence, neither is it absolute. The levels of assistance vary from time to time in line with the social and political considerations of governments. Subsequently, such a poverty line is different at each and every point of time. This is what happened in this particular study. The years that Abel-Smith and Townsend chose to include in their inquiry were 1953/54 and 1960. The basic assistance rates grew between these two periods by about 49%. On the other hand, the average index of prices rose in the same period by only 20%, and the average industrial earnings increased by 52%. It is therefore clear that in the period in question, there was an absolute improvement in this poverty line, and yet it did not catch up with the relative improvement in the general level of living of the populaltion in Britain in the same period (pp. 19–20).

With regards to method, this type of poverty line allows us to examine at any point in time how many people are living at this minimum income level or even below it. It also enables us to study the changes that occurred in the size of the poor population at different periods of time. Abel-Smith and Townsend used thus the findings of their study to emphasize these points. They showed that the percentage of persons having this low level of living was 7.8% in 1953/54 and that this percentage increased to 14.2% in 1960 (p. 57). They could point to the fact that a significant part of the poor population did not even take up the assistance benefits to which they are entitled, in order to supplement their low income which fell below the official poverty line. As a result the study had a strong political impact in the sense that it impelled the government to make efforts to reach out to the needy population groups so as to increase their take up of assistance benefits.

The difficulty of using such a poverty line lies in its political context. Essentially, a poverty line of this type reflects to a large degree a government's generosity in guaranteeing a minimum level of subsistence to the population in need. Paradoxically, the more generous a government is in guaranteeing a minimum level of income to the needy, the larger will be the poor population. The less generous a governmemt will be and the lower the minimum level of income it will guarantee to the needy, the smaller will be the poor population. The dependence of such a poverty line on the political choices of governments makes it a very unreliable criterion for measuring poverty.

The American Experience

The period of the "war on Poverty" in the US during the 1960's was very fruitful in ideas on measuring poverty. The method that received most attention during those years, and that was actually adopted by the US Social Security Administration as an official measure of poverty, was based on the research of Molly Orshansky (1965). The method adopted was basically not different from the other methods described above. Essentially, it defined poverty in terms of nutritional inadequacy, which meant the adaptation of a standard for determining the minimum cost of a nutritionally adequate diet compatible with the food preferences of US families.

In practical terms, the Americans based their estimates on a nutritional standard developed back in the 1930's by the National Research Council. On the basis of this standard, the US Department of Agriculture developed four main family food plans at varying levels of cost to suit the needs of families at different levels of income: a liberal, moderate, low cost and an economy food plan. Each such food plan, and particularly the low cost and the economy food plans were developed with a view to meet the recommended nutritional goals and conform to the food consumption patterns of the target population groups. For the purpose of the minimum necessary for subsistence, or as the poverty line to measure the extent of poverty, the economy food plan was chosen; its cost was about 75% of the basic low cost food plan, which was adopted to the consumption patterns of families in the lowest third of the income distribution ladder.

After the food cost was computed, and in order to obtain the full cost of the total minimum requirements, the food costs were multiplied by a factor of three. This was again based on surveys of the US Department of Agriculture which established that family food expenditures accounted for a third of the income of low income families[1]. This decision was taken on the assumption that if the food consumption patterns of a large population are more of less in accord with the nutritional demands, then it can be assumed that with its remaining income this population can provide itself with the minimum necessary for the other components of the minimum subsistence basket.

The poverty line attained by the above method is certainly open to criticism as were the poverty lines adopted in Britain. Despite the extensive reliance on scientific data, the decisions made in the process were not scientific decisions, but rather reflected the value judgments of their makers, as well as the subtle pressures of the authorities which wanted to assert their influence by means of the criteria selected to count the poor population. The economy food plan was originally suggested, for example, to serve only "temporarily or for emergency use when funds are low". Nevertheless, it was chosen as a permanent criteria (Rein, 1970). Orshansky herself stated "that the standard itself is admittedly arbitrary, but not unreasonable", and that many families would find it difficult to provide themselves with adquate nutrition on this basis.

It is also perfectly clear that this poverty line, by definition, was not intended to be absolute but rather reflected the living conditions in America in the 1960's. The cost of a minimum budget for a family of four in 1963, based on the adopted poverty line, was 3,130 US dollars per annum. An income of this size was certainly considered very high in very many countries of the world.

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[1] In fact, 3 different coefficients were used: a coefficient of 0.27 for a family of two; 0.33 for a family of three and more. For single persons living separately, a special estimate was made amounting to close to 80% of the total of a family of two.

The Katz Committee Report

Having examined the British and American experiences in defining poverty lines, we shall now look at the poverty lines adopted in Israel. The Israeli experience is interesting both from the methodological aspects of establishing a poverty line and because of the sharp controversies they aroused. The first attempt to establish a poverty line was made by the Katz Committee (Bloom & Milo, 1967) The Committee, a public-professional expert group, headed by Dr. Israel Katz (at the time Director of the Paul Baerwald School of Social Work at the Hebrew University of Jerusalem, and a well known social welfare policy expert) was appointed by Dr. Yoseph Burg, the then Minister of Social Welfare, and was charged with the task of determining:

(1) The basket of necessities of a person in need;
(2) A measure for calculating the assistance rates, based on the consumption basket of a needy person.

In the particular circumstances of the early 1960's and the state of knowledge existing at the time in Israel, the Committee faced a complex and difficult task. An additional difficulty had to do with the composition of the Committee itself. Some of its members, particularly the representative of the Treasury, claimed from the beginning that the Committee being composed mostly of experts was lacking the authority to resolve the subject matter of its mandate. In their view, "the decision on the necessities of a person in need is a value or political judgment, and is beyond the authority of the Committee" (All the quotations are from the Report on the Committee's Work. see: Bloom & Milo, 1967). After a prolonged debate the Committee adopted the approach that "a certain model of a family budget, which can provide the minimum necessities in our society, can be established, and our society should be able to provide it to the population in need", and this approach served as guideline to its work. Within this framework the Committee felt able to make value judgments based on "the best knowledge and understanding of its members".

The next issue the Committee had to clarify was the meaning of the task set before it. Despite the fact that this was not expressly stated, the committee was expected to establish "a minimum necessary for subsistence", in fact a kind of poverty line, that could serve as a basis for determining the level of assistance rates. The task had many similarities to those of the Beveridge Committee, which recommended minimum subsistence benefit rates for Britain's social security system. To prepare such a minimum family budget the Committee chose to base its work on a nutritional model, as used by its British and American predecessors. The main components of such a family budget, or the basket of necessities, was thus a nutritional element which included an accepted scientific nutrition standard and the actual consumption pattern of low income population groups.

The Committee's intent was to combine the consumption patterns of low income population groups with the scientifically based nutritional demands. Following is how the Katz Committee managed to integrate these two elements.

The Nutritional Standard. As a basis for the nutritional needs the Committee adopted the standard recommended for the Israeli population by the Nutrition Committee of the Health Council of Israel in 1965. Since this was not a minimum standard, and included wide margins above the levels of malnutrition, the Committee decided to content itself with only 90% of it.

The Consumption Patterns of Low Income Populations. As a reference group regarding the consumption habits of the low income population groups the Committee chose the bottom deciles of the urban employee population. This data was obtained from the 1963/64 expenditure survey of urban employee families, and from these survey data the Committee derived the food basket consumed in practice by the two bottom deciles. Having attained these two elements, the food basket and an accepted nutritional standard, the committee proceeded to examine the food basket actually consumed in light of the accepted nutritional standard. The findings here indicated that the food basket actually consumed, needed slight adjustments in order for it to meet the essential nutritional requirements. The Committee's nutrition experts, thus, corrected the basket and added to it the lacking ingredients of iron, vitamins and calcium (this was achieved by increasing the milk and vegetables items in the food basket). Consequently, a food basket was attained which was very close to the consumption patterns of low income population groups and which also met the nurtitional demands.

The Committee also attempted to establish in a similar manner the other components of the consumption basket of a person in need, but here it met with insurmountable difficulties. While it had been able to make use of a more or less scientific standard in determining the food basket, on the other components, such as clothing, or other household necessities, no such standards could be found. The Committee, therefore, decided to set all the other necessities in the consumption basket, as the Americans have done, according to the ratio between the expenditure on food and the remaining expenditure in the consumption basket of the selected reference group. Since the expenditure on food accounted for 52.5% of the total, it was determined that all remaining necessities would account for 47.5% of the expenditure required.

The decisions on the recommended consumption basket met with opposition both within and outside the Committee. The most vocal opponent within the Committee was the Treasury spokesman. He rejected entirely the Committee's approach and claimed that it wasn't "scientific", but "normative", and that such a normative approach can claim no preference over any other normative proposals which can be set "in accordance with relevant economic criteria for the purpose of making such a decision" within and outside the Committee (Baruch, 1964). The point made by the Treasury man was well taken in the sense that the Committee's recommendations regarding the consumption basket of a person in need were not purely scientific. He ignored, however, the fact that there was not then, nor is there now, any possibility of formulating such recommendations in a scientific manner without involving value judgements as well. No doubt, the concern of the Treasury was not so much with the scientific aspects of the recommendations, but rather with the intents to prevent, insofar as possible, the acceptance of recommendations that would have required the raising of the prevailing levels of assistance, with the resulting effect of a significant increase in public expenditure.

The Treasury representative did not content himself with rejecting the Committee's approach, but also rejected the principle of an absolute approach to determining a minimum necessary for subsistence. As a possible alternative, he proposed the relative approach to setting a poverty line. He argued that "a closer alternative... would be the setting of a ratio between the level of income guaranteed to families lacking a breadwinner, and the prevailing income level of families having a breadwinner". In his view, "the advantage in setting the level of support in line with such a criterion is in that it guarantees the maintaining of a relative standard of living... and of its being to a large extent dynamic in its nature". In summing up his comments, he proposed to "set the level of support of families without income at a level relative to wages in sectors mentioned", as for example, the wages in relief work, agriculture, industry, and of the working population as a whole.

The Ministry of Social Welfare was also dissatisfied with recommendations about to be formulated by the Committee. The Committee, for example, failed to complete its work over a period of more than three years. There were various causes for this, but the Minister of Social Welfare was not prepared, for his own reasons, to accept this lengthy delay in having the Committee's report. The most important cause, however, in the Ministry's dissatisfaction could apparently be found elsewhere. The meaning of the recommendations that were finally formulated was that it would have been necessary to double the level of social assistance rates effective at the time. The facts were that the country was not ready for such a policy change, and the Minister was well aware of this.

Under these circumstances the Minister decided to dissolve the Committee in January 1967, just before it was ready to submit its recommendations. The dissolution of the Committee allowed the Minister to avoid the dilemma of having to act on recommendations in which he was no longer interested, at least not as a public official document. Since the recommendations were already there, the Minister charged two officials who sat on the Committee to prepare for him a report on the Committee's work, and in this way he received all the material prepared by the Committee and the substance of its recommendations.

Assesing the work of the Katz Committee it can be seen that it utilized all the tools made available by modern science to establish a poverty line based on the absolute approach to poverty. It took into account the consumption patterns of the low income population groups in order to determine the food basket and the other components of the necessities of life; it also conformed to an accepted scientific nutritional standard. It can, however, also be seen that in every stage of its work it made significant value judgments as well. Its findings and recommendations did not reflect, therefore, any absolute or pure scientific minimum, but rather a minimum which was largely influenced by the values and preferences of the Committee's members.

The Roter and Shamai Poverty Line

The early 1970's were dominated in Israel by the growing awareness of the problems of poverty and the social gap between the population groups from Moslem countries and those of European origin. The underprivileged population groups increased in these years their pressure on the Government and put forward demands for improvements in their lot. Roter and Shamai, at the time both at the head of the Division of Research of the National Insurance Institute, Israel's national authority responsible for the country's social security system, saw it as part of their responsibility to provide an answer to questions posed by many: Who are the poor in Israel and how many are there of them? To give an answer to these questions there was a need for criteria, again a kind of poverty line, by which the nature and scope of the problem could be examined.

Roter and Shamai were not the first to raise these questions. They were already raised earlier in a paper, "Poverty in Israel", published by this writer in the journal *Amot* (Doron, 1964). The question posed in this paper was, how many people in Israel are living in conditions of economic deprivation or distress and who are these people? The definition of economic distress used was "a condition in which people cannot attain a minimum level of nutrition, health, housing and education required for living in Israel". With the limited resources available to the author he contented himself to counting the number of persons and families that received at the time some form of economic assistance from the institutional welfare system. The fact that they were entitled to such assistance included them, by definition, among those in a distress situation. The population groups included in the count were the recipients of public assistance, those employed in relief works, the needy aged and other persons in need. The scope of this population in distress was carefully estimated at 300 thousand persons, or close to 12% of the total population.

This estimate of the number of the poor aroused some very angry reactions, mostly from those who could not reconcile themselves to the very fact of poverty existing in Israel (for example: Kanev, 1964). Roter and Shamai's intention was, therefore, to provide an answer to questions on the patterns of poverty in Israel that would be based on systematic research. In theory, they chose to adopt a poverty line based on a nutritional standard and on the consumption pattern of families. In practice, however, they decided to use, temporarily, a poverty line defined as a matter of distance, set at a certain point of the distribution of the population by income level. On this basis they chose the model proposed by the American economist Victor Fuchs (1967), which set the poverty line at a level of one half of the median income.

For the purpose of their study Roter and Shamai actually adopted two alternative poverty lines: a "poverty line" which identified the poor families, and a higher "poverty threshold line" including low income families living on the threshold of poverty. Although they chose, in principle, the Fuchs model, in practice they decided to set a lower cut-off point than suggested by Fuchs. They set the cut-off point of the poverty line at the level of 40% of the median disposable income of a family of 4, and the poverty threshold line at the level of one half of this median income. Those poverty lines were adjusted for families of different sizes and compositions in accordance with an equivalence scale for a standard adult. On basis of these poverty lines, they found that in 1969, about 11% of all persons in Israel (253 thousand persons) subsisted on an income level below the poverty line, and about an additional 10.3% of persons lived on the poverty threshold line. Every fifth family, and almost every fourth person in the urban population, lived in circumstances of poverty or near poverty.

Roter and Shamai's poverty line was meant to be only a temporary measure, and to provide an initial orientation on the patterns of poverty in the country. Since the early 1970's it has become, however, the permanent measure of poverty in Israel. Although the two researchers promised to update their findings after completing their full study, no further findings on the subject have been published. The National Insurance Institute began its poverty studies and to measure the changes in the scope of poverty, on a regular basis using these criteria. In the last two decades the Shamai and Roter poverty line has thus become a sort of official poverty line. The consistent use of it by the National Insurance Institute made it possible to follow the changes that took place in the patterns of poverty and in its scope since the late 1960's. The important contribution made by Roter and Shamai was thus in providing an enduring criteria for measuring poverty in Israel.

The continuing use of the Roter and Shamai relative poverty line did not, howeve, lead to any agreement on the validity of this criterion. As could perhaps have been anticipated, no consensus was ever reached as regards the relative nature of poverty it embodies. The debate and the controversies accompanying it have been going on throughout the years, and the shrillness of the tones of the debate were highly related to the current data on the scope of poverty, usually rising with the increase in poverty. A particularly acrimonious debate erupted, for example, in the years 1984/1985. The annual poverty report published by the National Insurance Institute at the time pointed to a very significant rise in the scope of poverty. The debate flowed over into the political arena and even the Prime Minister of the time, Mr. Yitzhak Shamir, took an active part in it. The National Insurance Institute was openly accused of spreading inaccurate information and was denounced for it, although it consistently used the same criteria that it used in previous years (Mann & Cohen, 1984). This debate showed once more the political significance of every definigion and measurement of poverty. In this, no change has taken place since the days of Booth, a century ago.

What was of particular interest in the poverty debates of 1984/1985 was the position taken by the officials of the Treasury. As mentioned earlier, the Treasury representatives on the Katz Committee of the 1960's, rejected in principle, the absolute approach as then adopted, and proposed, as a possible alternative, a relative approach to the measurement of poverty. In 1984, the Treasury people took an opposite view and advocated an absolute approach. They did not ignore the relative dimensions of poverty, but claimed "that the reference to poverty should be examined, first and foremost, in its absolute aspects, i.e. if the household has at its disposal the means to maintain itself in a reasonable, or at least acceptable manner, in accordance with reasonable physiological needs and even beyond these, such as: suitable housing, ability to acquire education, health services, etc." (Ben-Hayim, 1984). This stand would have certainly been appreciated by the Katz Committee at the time, but in the circumstances of the 1980's the position of the Treasury had a logic similar to that of the 1960's. Its spokesmen wanted to refute the data on the scope of poverty, and in this way to influence the budgetary implications which were liable to stem from the National Insurance Institute poverty report.

The Continuing Debate on the Definition of Poverty

For a certain period in the 1970's, it seemed as if there was a suspension in the debate about definitions of poverty and poverty lines. But if there was such a suspension, it was short lived. In recent years, we are witnessing again a revival of the debates in full force. In these debates some new approaches to defining and measuring poverty were brought to the fore; the most prominent among them, being the social consensus approach and the behavioral approach, will be dicussed briefly below. Neither of these approaches pretends to provide an objective, scientific criteria for measuring poverty, but they do try to raise new ideas for an old problem.

The Social Consensus Approach. The main claim made by this approach is that the entire issue should be taken out of the hands of the various experts and the public be allowed to decide what the poverty line should be, or what is a minimum level of living. In fact, this approach is not all that new; already in the 1960's the Gallup Institute in the US tried to use it. Also, one can discern in this approach three variants (Walker, 1987; Piachaud, 1987) of what should the public be allowed to say. One variant deals with the perceived minimum required for subsistence, i.e. what is the perception of the general public of the income required for maintaining a minimum level of living (Gallup, 1963); the other deals with the desired minimum level, i.e. what the public says should be provided at the minimum level (Van Praag et al., 1983); and the third deals with the financeable minimum level, i.e. what the public is prepared to pay for in taxes in order to provide a certain required minimum (Veit-Wilson, 1987).

This approach, although it reflects the new winds of change, also carries with it, however, many problems. For example, one cannot let the public say what the poverty line should be without involving experts to formulate the questions, interpret the answers and give a clear expression of the public's will. Moreover, the question is also whether a consensus can really be reached by the public on a poverty line in any one of the above mentioned variants. From the perspective of the poor population, the question is, whether a poverty line and a minimum income for subsistence prescribed by the public will be any better than that set by experts. It is with these issues that many studies carried out more recently in Europe attempt to deal.

The Behavioral Approach. The staunchest exponent of the behavioral approach is the British social scientist Peter Townsend. In this approach poverty is conceived as a matter of relative deprivation, and Townsend used it in his comprehensive study of poverty in Britain in the late 1970's (Townsend, 1970). *His main argument is that "Poverty can be defined objectively and* applied consistently, only in terms of the concept of relative deprivation" (p. 31). In operational terms the attempt was to define poverty as "a style of living which is generally shared or approved in each society, and find whether there is... a point in the scale of distribution of resources below which, as resources diminish, families find it particularly difficult to share in the customs, activities and diets comprising their society's style of living" (p. 60). Townsend tried "to provide an estimate of objective poverty on the basis of the level of deprivation disproportionate to resources" (p. 249). In other words, there exists some threshold of income or resources, beneath which deprivation rapidly increases and produces conditions of poverty.

The important innovation in this approach is that it tries to include in the definition of poverty a variety of personal and social activities that were not included before in other definitions of poverty. Also, there is no disagreement on the fact that the lower the income, the more severe the deprivation, and that the deprivation increases more rapidly at lower incomes than at higher levels of income. The main agrument, however, against this approach is that it is impossible, in practice, to set an income threshold that will constitute a cut-off point, clearly dividing between the poor and the rest of the population. As early as 1981, Piachaud claimed that "the combination of the two factors — that there is diversity in styles of living, and that poverty is relative — mean that you would not, in fact, expect to find any threshold between the poor and the rest of the population" (Piachaud, 1981 & 1987) and this debate still continues (Townsend, 1987).

Summary

A review of the different methods that have been suggested to define poverty, establish poverty lines, or set minimum levels required for subsistence, reveals clearly that there can be no single meaning, in any objective sense, that these can be attributed to different societies and to different times. Poverty, in all its meanings and various definitions, is a relative concept that changes with the changing circumstances of time and place. Defining who are the poor is essentially describing people in different situations of limited command over material and other resources. There is nothing particularly new in this, yet it is important to clarify it again, due to the simple fact that there is no possibility of defining poverty in any other way.

It is also important to note that the more recent definitions of poverty abandoned Rowntree's simplistic approach, which saw poverty merely as a problem of bare physical subsistence. Rowntree himself relinquished this approach in his lifetime, and most contemporary thinking emphasizes the complexity of the phenomena and the diversity of conditions that may constitute circumstances of poverty. This view has been expressed most notably in the approach of Peter. Townsend, who sees poverty as a matter of relative deprivation.

The present survey may perhaps disappoint those who expected a more clear cut scientific answer to the problems of defining and measuring poverty. Were it possible to get such an answer, this would indeed be desirable. Since this is not within our grasp, we ought not to reject the solutions offered, which may not be perfect, but nevertheless broaden our horizons in the understanding of poverty, and provide us with tools to measure it. The rejection of these solutions amounts to taking the stand of "everything or nothing", which is certainly not helpful. In opposing such a stand, the British economist A.B. Atkinson points to the fact that the proposed solutions are capable of drawing a large measure of public support and are, therefore, valuable (Atkinson, 1985). The decisive issue in all the approaches described is thus the extent of confidence and public support they succeed to obtain.

There is no doubt that the debate on poverty will continue to be with us in the foreseeable future. Already in the Bible it is stated, "And the poor man will not cease from the land" (Deuterenomy XV, 11); and just as the poor, it seems, will not cease among us, so the debate about them will not cease. The issue is not to prevent such debates, which can enrich our ability to comprehend the complexity of the problem, but rather, how to channel them into directions which could benefit all of us and especially the poor themselves.

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OBSTACLES TO CHANGE IN THE STRUCTURE OF THE ISRAELI HEALTH CARE DELIVERY SYSTEM

By Dr. Gerald M. Steinberg*

Introduction

Israel, like many other countries in the industrialized world, is having serious difficulty providing quality medical care to its population. As is the case in Western Europe and North America, the Israeli medical care system is chronically short of funds, and has difficulty in operating hospitals and clinics efficiently and equitably, providing insurance for patients, and for reimbursement of physicians.

What is unique about the Israeli case, however, is the general absence of fundamental institutional change in response to these challenges. In other countries faced with similar problems, the institutions and structure of health care delivery have been transformed significantly, and often more than once. In the UK, Royal Commissions and White Papers have led to basic restructuring of the National Health Service. Professional hospital administrators and other trained managers were brought in to improve efficiency. In the US, over the past twenty years, Health Maintenance Organizations (HMO) have been introduced, government programs to control costs have been adopted, and other steps have been taken to radically alter the institutional structure of health care delivery. While the problems may not have been solved, these systems are dynamic and flexible in seeking to limit the damage and improve the level of service. As the flaws in each new system are revealed, action is taken to remedy the problems.

In Israel, in contrast, the structure of health care delivery has not changed significantly since the founding of the state. Despite many reform proposals and critical reports, over 80% of the primary care is still provided in the clinics of the Histadrut's Kupat Holim Clalit. The system of hospitalization

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is divided, as in the 1950s, between the Kupat Holim Clalit and the Ministry of Health, with a few municipally operated hospitals (in Tel Aviv) and private non-profit hospitals (in Jerusalem). Instead of concrntrating on planning and the regulation of hospitals, doctors, and the system in general, the Ministry of Health is devoting most of its resources to the day-to-day operations of the government hospitals, dealing with frequent budgetary crises, job actions, and other operational problems. These two major systems operate largely independently (despite a 1981 regionalization agreement) often duplicating services in some areas while other areas are neglected. At both the national level and the level of individual hospitals, professional administrators are virtually unknown. While employing the most modern technology and medical techniques, institutionally and organizationally, the system is often perceived as dangerously inefficient and unable to adapt to change (General Controller Report on Beilinson Hospital, 1989).

These problems have been acknowledged widely in the past, and Israel may lead the world in the number of commissions, reports, and plans for reorganization that have been formulated. Various proposals to reform the hospitalization system are currently under discussion, yet implementation continues to be resisted because these institutions have the political and bureaucratic power to resist change.

As part of the ongoing research program on public policy in Israel at the Jerusalem Center of Public Affairs, this study is designed to uncover the nature and impact of institutional variables in the health system, and the factors which have prevented and blocked reorganization and reform. On the basis of general models of institutional change in public policy, and the specific Israeli context, we will discuss the role of government in generating organizational flexibility, and the implementation of organizational and insitutional reforms necessary to restructure the health care system in Israel.

The Importance of Institutions in Policy

In the study of the Israeli medical care system, like other areas in public policy, it is important to distinguish between the *substance* of the policy, and the *structure* and *processes* by which policy is made (or not made), and to examine the interplay between these variables. In past studies of Israeli medical care policy, the emphasis has been on substance, while structure and process have been relatively neglected. Numerous studies and reports have examined the problems in the delivery of health care services, and reforms have been proposed. In some cases, these reform proposals have stressed the failure of the major institutions in the system, the Ministry of Health and Kupat Holim Clalit, to adopt the organizational changes which would be required for reform. However, very few of the reforms proposed for the system have been implemented.

Analysts of public policy have shown that in every issue and political setting, institutions and organizations are very important factors in determining the substance of policy. Talcott Parsons and the "structural functionalist" school have demonstrated that in many cases, the institutional structure by which policy is made and the substance of the policy are closely related (Parsons, 1956, pp. 63–85, 225–239; Parsons, 1960). Other students of organizational theory have focused on such variables as centralization, communication, informal organizations, organizational dynamics, administrative behaviour, and other factors in attempting to understand how policies are made and implemented. Such factors have been shown to play a major role in determining organizational efficiency, and the degree of flexibility or resistance to change.

According to the evidence presented by Blau and Scott, different types of organizations have different goals, which affect their structure and performance. For exampls, the structure and operation of voluntary mutual benefit organizations such as trade unions are quite distinct from private for-profit or government organizations. Health care systems, such as hospitals or clinics, for example, which are operated by a voluntary organization, are expected to be significantly different from health care delivery systems operated by a trade union, a political party, or a state (Blau & Scott, 1962, pp. 27–58).

In his studies of the public policy process in the United States, Wildavsky has demonstrated the restraints which institutional and political institutions and processes impose on policy making. For example, he has shown that the outcome of policy debates is largely determined by the processes and the political "arena" in which the decisions are made. Environmental policies which are made administratively are very different from those which are made by Congress through the enactment of statutes, or through the court system and the legal process. In each case, the different process and structure of policy making has a major impact on the outcome, even if all other variables are held constant. Policies which are resisted administratively might be enacted through the legislative process, and those which are politically untenable for Congress, might be enacted through the courts (Wildavsky, 1979).

Wildavsky and other analysts have shown that the key factor in policy making and change is power; in most cases, changes which limit an institution's *power*, budget, mission or responsibility will be resisted by the affected institution. In this case, the institutions with the greatest power will determine the outcome. For example, the efforts to introduce new budgeting systems (PPSB and ZBB), which would have given external factors a greater role in understanding and determining the distribution of resources, were successfully resisted in the U.S. The administrators who sought to impose these systems did not have sufficient powers over the agencies involved (Wildavsky, 1974; Wildavsky, 1986). While many factors are involved, it is clear that in developing policy prescriptions, the power and process necessary to implement these efforts must be considered carefully.

In Israel, as Akzin and Dror showed more than twenty years ago, ideology and the political structures in the public policy processes were and continue to be very tightly intertwined (Akzin & Dror, 1966; Bilsky, 1980). Policy changes which affect political or bureaucratic interests (and this is the case in most policy areas, from television to sports) must deal with the repsonses of the government and the Knesset, which, in Israel, are basically under the control of the political parties, the Histadrut, and the administrative bureaucracy. It is only when these reactions are considered that the policy making process in any area, including health, can be understood, and on this basis, perhaps even controlled.

The Institutional Structure of the Israeli Health Care System

Like most other institutions in Israel, those which constitute the medical care system originated in the period of the first waves of Zionist immigration (Aliyah) at the beginning of the 20th century. In 1912, the first Jewish sick fund was established by 150 members of the New Yishuv (the Jewish population). Based on mutual insurance, this group later formed the nucleus of the Histadrut General Sick Fund (Kupat Holim Clalit). In 1929, Kupat Holim Clalit also began to establish a network of hospitals to supplement its clinics throughout the area of Jewish settlement. In developing this network, the Kupat Holim Clalit, like other Histadrut institutions, played an important function in the settlement of the land, and the establishment of an infrastructure for the growth of Labour-Zionism. Ideologically, the Histadrut in general, and the Kupat Holim Clalit in particular, stressed the provision of services to all sectors of the population on an equal basis. As a result of these efforts, infant mortality rates dropped dramatically, and diseases such as malaria were largely eliminated (Cohen, 1985, pp. 80-82).

Other institutions and Kupot (sick funds) were established over the years. In 1933, Kupat Holim Leumit was formed by the Revisionist Movement. In 1936, the General Zionists created a sick fund which eventually merged with other groups and became Kupat Holim Meuchedet. Another fund, known as Maccabi, was formed in 1941 by immigrant doctors from Germany to provide themselves with employment (Halevi, 1979). Each of these institutions, as well as other small funds, had a small number of members, but in 1948, about 90% of the population was enrolled in Kupat Holim Clalit.

After the establishment of the State of Israel in 1948, Kupat Holim continued to be the primary source of medical care. The Ministry of Health had nominal responsibility for overseeing the actions of the Kupah and other institutions, but did little to interfere in these areas. The Ministry operated the hospitals that were established by the Mandatory Government, some of the municipal hospitals, as well as those developed for treating the Jewish refugees during and after the war by the JDC and Hadassah. (The hospital and medical school in Jerusalem continues to be operated by Hadassah, and in general, the Jerusalem Hospital system remains largely outside the Kupat Holim Clalit and Ministry of Health networks.)

During the period of massive immigration following the establishment of the State, the Kupat Holim Clalit system played a major role in absorption, and throughout this period, was largely responsible for establishing the standard of medical care in Israel. The Kupat Holim Clalit generally introduced new services and techniques, and continued to develop its network of clinics and hospitals in the Negev, the Galilee, and other areas as the population grew. The administrators of the Kupat Holim Clalit saw, and in many ways still see themselves as the prime source of medical care in the country — from preventive measures to rehabilitation (including the provision of pharmaceuticals). (Protocol of Government Committee, 1988, p. 2626, H. Doron testimony). Most of the achievements of the Israeli medical care system can be attributed to the Kupat Holim Clalit system.

However, the Kupat Holim Clalit was and still is formally a voluntary organization and part of the Histadrut. As the State grew, and State Institutions developed, the relationship between the Kupat Holim Clalit and the government became a source of confusion, and the complexity of the relationship was one of the obstacles to change. In reality, the Kupat Holim Clalit was not the only source of medical care. The role of the other kupot has grown steadily, and the government hospitals are also a major element in the system. Each system is operated essentially independently and as a result, the overall system is inefficient, with major duplications in some areas, and severe lack of services in other areas. Private care and illegal (or "black") medical services have also increased significantly.

Crisis in the System

Despite institutional stagnation, the system functioned relatively well until the mid-1970s. By the 1980s, however, the system began to break down. The main institutions were chronically short of funds, and, as their salaries decreased relative to other groups, physicians, nurses, technicians, and maintenance workers demanded increased compensation. At the same time, the "push to modernize" continued or even accelerated.

Doctors and patients continued to demand the latest in technologies and treatments, and operating funds for these technologies were lacking. Waiting periods for treatment grew continously. At the level of the individual hospital, the Israeli physician-administrators were incapable of coping with the pressures and with the challenges and crises of this period. The system and its institutions stagnated, resisting most efforts to introduce changes, and the result was increasing inefficiency, long waits for surgery and other procedures, sanctions, and strikes.

As of 1988, Israel had 1,800 primary care clinics, and 53 general, geriatric, and psychiatric hospitals with a total of 25,000 beds. The operation of these institutions and the rest of the Israeli health care system cost 4.5 billion NIS in 1988, which is 7.6% of the Israeli GNP and 35% of non-defense spending (excluding debt repayment). Approximately 40% of this total is spent by Kupat Holim Clalit, and over 20% in the operation of the government hospitals (Ministry of the Treasury, 1988, p. 8).

Wages and other benefits account for 75% to 80% of overall health spending. Over 78,000 individuals are employed in these institutions (almost 6% of the Israeli workforce), of which some 10,000 are physicians. With a ratio of 2.9 physicians per thousand, Israel has one of the highest number of doctors per capita in the world (50% above the norm for the wealthier industrial states). (Ministry of Treasury, 1988, p. 27). The workforce in this sector has increased at an average annual rate of 4.5%, while the rate of spending could not keep pace (Ofer, 1987, p. 110). As the salaries of individual physicians and other medical professionals have declined significantly, these groups have engaged in a series of work stoppages and strikes that have plagued the medical system.

Despite the large or even excess number of physicians, medical facilities such as clinics and hospital equipment (including surgical facilities and diagnostic technology) are chronically underutilized. Kupat Holim Clalit hospitals in the Tel Aviv area operate at only 62 to 70% capacity (Ministry of Treasury, 1988, p. 43). Because of budgetary limitations, clinics and other facilities are often only operated a few hours a day.

According to many analysts, the fact that government hospitals are funded on a flat basis dependent only on the number of beds occupied, and with no relation to the cost of particular procedures, is a major source of inefficiency (Rosen & Ellencweig, 1988, p. 4). (As of April 1989, the rate was 345 NIS per bed-day). It is widely acknowledged that this system of funding prevents the development of any incentive to reduce patient hospital stays or increase efficiency. Indeed, hospital administrators have essentially no control over income or expenses and no incentives to increase efficiency or improve service. On the contrary, given the current structure, efforts to reduce occupancy would result in the closure of units or hospitals, and reduction of personnel, and therefore are resisted by the physicians and administrators. Thus, while up to 30% of hospital beds are occupied by patients for procedures which do not require hospitalization, the number of patients waiting for treatments which do require hospitalization is growing daily. According to the report of the Controller General of the Ministry of Health, as of November 1987, over 37,000 patients were waiting for surgery at government hospitals. Waiting periods ranged from six months to two years, and according to Dr. Bruce Rosen of the Brookdale Institute, "Waits were so great that many patients did not even bother to add their names to the waiting lists." (Rosen, 1989, p. 17. also: Protocol of Government Committee, 1988, p. 3936, Shoshana Arbeli-Almoslino testimony).

In May 1989, the State Controller published a detailed report on Beilinson hospital, which is the largest Kupat Holim Clalit facility and in many ways its flagship. The report cited fundamental deficiencies in many areas. For example, it noted long delays in performing critical tests and transmitting results to doctors. Only 15% of biopsy results were available within 10 days, and 33% took up to 60 days. Physical conditions in the hospital were severely criticized. For example, the pediatric x-ray facility is "Less than 9 square meters in area, without windows or ventilation, the room was totally inadequate, and young patients forced to wait in the narrow corridors outside are dangerously exposed to infections". Equipment and facilities are not used efficiently. "In the pediatric ultra-sound unit... even the urgent scans are postponed for as long as five months". Emergency surgery is performed only five days a week in one morning shift. "In most cases, operations don't start before 8 a.m., and if one operation is finished in mid-morning, another is not begun because it would otherwise end beyond the first shift".

As a result, the Controller noted, "Despite long queues for elective surgery and treatments in hospitals around the country, occupancy in many Beilinson departments was way below the norm, and among the lowest in the country... From 1983 to 1987, the occupancy rate in the oncology department ranged from 40—49%, much less than in other hospitals". In contrast, in facilities where costs are low relative to the reimbursement, patient stays were extended. For example, most eye surgery is routinely done on an outpatient basis at other hospitals, but at Beilinson, the controller found that a group of 600 patients awaiting eye surgery accumulated a total of 2,530 hospitalization days (Government Controller Report on Beilinson Hospital, 1989).

Despite the general acknowledgement that current institutions and procedures are a major source of inefficiency, they are maintained, and the reforms that have been proposed have not been adopted. Hospital funding on the basis of a DRG (Diagnostic Related Group) system, and physician reimbursement on the basis of capitation for Kupat Holim Clalit have been suggested repeatedly but none of these proposals have been implemented. Large-scale reorganization of the entire hospitalization system through the establishment of a National Hospital Authority has also been proposed on numerous occasions, but movement in this direction has been effectively blocked.

The reorganization of the Kupat Holim Clalit system has also been studied many times. Various internal reports have been proposed to increase efficiency by decentralizing, granting administrative and budgetary autonomy to the regions, clinics, and hospitals that make up the Kupat Holim Clalit system, and the training of professional health-care administrators (Kupat Holim Clalit, 1984). Despite these recommendations, however, the system remains highly centralized, inflexible, and inefficient.

External Pressures for Change

The particular problems of the health care delivery system, such as funding and reimbursement, and the more general problem of continuing inefficiency, despite widespread recognition of the need for change, are actually symptomatic of a broader condition in Israel. While, as noted, some of the problems faced by the Israeli system are by no means unique, political and sociological conditions and changes have magnified the problems. The two most important factors were the growth of the Israeli middle class and the end of the era of Labour-Histadrut dominance of the state.

A. The Socio-economic Transformation of Israel

During the period following the 1967 Six Day War, the Israeli economy underwent a period of expansion and rapid growth. Israel was transformed from a developing society to a middle-class society with a standard of living, life style and aspirations based on Western European rather than African or Middle Eastern standards. As a result, the expectations regarding medical care and demands on the medical system also increased. Broad public health measures and emergency care were no longer considered sufficient, and Israelis increasingly went to clinics and hospitals for routine matters and elective procedures. Israeli society is generally well-informed about medical advances, new techniques, drugs, and treatments, and demands these services as soon as they became available in other countries. Similarly, Israeli doctors generally seek to oblige them and place a high priority on maintaining the medical care delivey system at the state-of-the-art.

As in other societies, the increasingly middle-class population also sought a different style of medical (and other) service. Many of the standard practices of Kupat Holim clinics, designed to provide the general population with adequate care, were no longer considered sufficient. For example, most patients were (and in many Kupat Holim Clalit clinics, still are) not assigned to specific doctors, but treated by a rotating staff, so that long-term doctor-patient relationships were rare. The system was highly paternalistic, and patients had no ability to choose their doctors. There was also no system by which appointments could be made in advance, so that many hours were wasted. Hospital care was often found to be unsatisfactory and polls and surveys showed growing consumer dissatisfaction (Rosen, 1989, p. 32; Ellencweig, 1983, p. 366).

In addition, the lack of coordination among different aspects of the system meant that there was little follow-up at various stages of the treatment. The Israeli medical system is largely horizontal, meaning that a patient routinely begins treatment or diagnosis at a clinic, and when moved to a hospital, the physicians who began the treatement are no longer involved, and an entirely new physician is responsible, with procedures (tests, records, etc.) starting essentially from the beginning. (Kupat Holim Clalit claims to be organized vertically, but in practice, the system functions horizontally with little or no communication between the clinics and the hospitals. Jerusalem Center for Public Affairs, 1986, p. 15.) Such other issues as patient rights and the need to consult and report to the patient are largely unknown in the Israeli system. While all those factors may have been of secondary importance in the 1950's and 1960's, when Israel was a developing society of pioneers and refugees, in the increasing affluent and middle-class society of the 1970's, these became salient issues, and sources of pressure for institutional change.

B. Political Changes and the End of the Era of the Labour-Histadrut Dominance of the State

Kupat Holim Clalit, which is responsible for over 80% of primary care in Israel through the operation of 1,200 clinics, and for 40% of the acute-care hospitals in the country, is still operated by the Histadrut Labour Union. Members pay a monthly fee (the *Mas Achid*) to the Histadrut which entitles them to services, primarily membership in the Kupat Holim sick fund. The Histadrut, in turn controls the Kupat Holim Clalit, which critics claim means the subordination of the Kupah's interests and objectives to that of the Labour organization's objectives and ideology.

In the 1950's, Ben Gurion sought to shift many Histadrut function to the state, including Kupat Holim. While in most cases he succeeded in his effort, he failed in the case of the Kupat Holim Clalit, which was considered too important an asset for the Histadrut and Mapai (the Labour Party) to relinquish.

Until 1977, the Labour Party dominated and controlled the Israeli government, and in practice, the boundary between state institutions and the Histadrut was often unclear. As noted above, during this period, the Ministry of Health was largely secondary to the Kupat Holim Clalit, providing subsidies and operating the hospitals outside the Kupat Holim Clalit network, but in general not interfering with the policies and practices of the Histadrut's medical system. The government provided subsidies through the Ministry of Health and directly from the Treasury for the construction and operation of Kupat Holim Clalit facilities such as the hospital in Eilat and the Soroka Medical School and hospital in Beer Sheva, but these facilities and the entire Kupat Holim Clalit system of clinics and hospitals were operated independently and outside the control of the Ministry of Health.

Following the 1977 elections, in which the Likud became the dominant coalition partner, the political environment in which the Kupat Holim Clalit and the entire medical system had operated changed radically. Some members of the Likud felt that the State had improperly allowed the Kupat Holim Clalit and the Histadrut to infringe on government and state responsibilities and prerogatives. Furthermore, the government subsidies and other funds provided to the Kupat Holim Clalit were seen as a means of supporting the Labour Party and Histadrut.

These political changes led to a fundamental change in the relationship between the Kupat Holim Clalit and the government (the Treasury and Health Ministries, in particular). The Kupat Holim Clalit could no longer count on the independence it enjoyed in the past, nor on the subsidies and other forms of government support. Yet, as will be discussed below, the Kupat Holim Clalit and the health system which it dominated never adjusted to this change in the nature of the government.

The Kupat Holim Clalit, with the Histadrut, the Labour party, and its allies, were able to resist major reform efforts, such as the creation of a government-operated National Health Insurance system (which would have replaced the Kupat Holim Clalit insurance system) or an independent Hospital Authority (Ellecnweig, 1983, p. 382; Ellencweig et al., 1986). At the same time, however, the Kupat Holim Clalit and Histadrut did not implement any significant institutional or administrative changes, and generally continue to operate as they had been doing for the last 30 years.

This situation led directly to a series of crises in the system. For example, in 1984/5, the government claimed that the Kupat Holim Clalit was not paying its debts to the government hospitals, and the Kupat Holim Clalit counter-claimed that the transfers and subsidies it had been promised from the state were not paid. During the public debate concerning this issue, and the efforts made by each side to put more pressure on the other side, the Kupat Holim Clalit dramatically announced that due to a lack of funds, it could not supply its patients with prescription drugs or its hospitals with equipment (Protocol of Government Committee, 1988, pp. 2630, 2640, 2661, 2684, H. Doron testimony). Such crises exacerbated the problems of the health care system, and contributed to pressures for institutional change in the Israeli medical care delivery system.

Reform Efforts and Institutional Responses: The Failure of Regionalization

These combined pressures should have constituted a major force working for change in the nature and organization of medical care and delivery. However, the institutional and organizational structure of the Israeli health care system has basically remained unchanged for decades. Despite the clear need to establish priorities among health care requirements, to match resources to services, and increase the role of professional administrators, changes have not been implemented.

As noted above, the need for institutional change has been discussed at various levels and many reports and studies have been produced. Many, such as the Mann Commission in 1968, the Zohar Commission in 1978, and the Trainin Commission in 1988, have sought to reorganize the hospitalization system. The establishment of a separate regional network, combining the Kupat Holim Clalit and Ministry of Health systems, would increase efficiency and decrease duplication. A level of regional autonomy, particularly with respect to budgetary allocations and personnel, would also provide for greater flexibility in meeting the particular needs of each region's population.

The Mann Commission report was essentially ignored, but the political changes of the late 1970s led to another effort in this direction. Following the report of the Zohar Commission, the Likud government sought to impose regionalization, and in 1981, the Ministry of Health announced that "several comprehensive regional health service models... and a regional hospital plan" would be implemented (Tulchinsky et al., p. 344). In each region, one facility became the designated regional hospital, while certain more specialized procedures and technologies were reserved for supra-regional hospitals.

Two of the supra-regional hospitals (Beilinson and Soroka) are operated by the Kupat Holim Clalit, two (Rambam and Tel Hashomer) by the Ministry of Health, one is jointly operated by the Ministry of Health and the Tel Aviv municipality, and one (Hadassah, in Jerusalem) is a private non-profit institution. According to the agreement, planning in each region was to be coordinated with the primary as well as secondary facilities, and, in order to increase efficiency, the development of regional resources such as new units was to be centered around the primary regional hospital. Similarly, while the population of each region was free to choose from among local clinics, residents could not go outside the region for procedures and treatments which were offered at the regional hospitals. The agreement specified that the budgetary allocations from the Ministry of Health would also be reformed and based on the demographic profile of the region. In a broader sense, this regionalization agreement was designed to provide vertically integrated medical care, reduce duplications and inefficiencies, increase regional autonomy, and generate incentives to cut costs and improve the quality of service delivery.

In 1982, Dr. Baruch Modan, the Director General of the Ministry of Health, wrote that this regionalization agreement constituted a bold and comprehensive plan to reshape the national health system, including the implementation of a "unified approach" and the "elimination of duplications." (Modan, 1982, p. 343). Had this plan been fully implemented, it would have created a revolution in the medical care delivery system of Israel.

In reality, however, the regionalization program has brought about very little change. The Kupat Holim Clalit and Ministry of Health systems are still administered, operated, and budgeted idependently. Competition for scarce resources has continued, and the high levels of inefficiency and duplication have, if anything, increased. For example, while the Rambam Hostital operated by the Ministry of Health, is the designated supra-regional hospital for the North, and operates an open-heart surgery facility, the Kupat Holim Clalit's Carmel Hospital decided imdependently to open a similar facility (citing increased demand, and ignoring Rambam's plans to expand) and the Ministry of Health was unable to prevent this action (Protocol of Government Committee, 1988, pp. 2675-2677, H. Doron testimony). Joint planning and integration has been negligible.

Furthermore, the budgetary aspects of the reform were never implemented. Funding for regional and supra-regional facilities is still based on hospital-bed occupancy, which means that instead of being given incentives to restrict admission of patients from outside the region, unrestricted admission has been encouraged. The decentralization, flexibility and "inrerplay" of supply and demand which had been promised never materialized. In short, despite the formal agreement, in practice, the degree of organizational and institutional reform was minimal.

The Institutional Sources of Resistance

Israel public policy, in general, and medical care delivery policy, in particular, are basically determined by a combination of three dominant factors:
(1) The interests of the political parties (*Miflagtiyut*):
(2) Ideology;
(3) The all-encompassing role of the state (*Mamlachtiyut*).

Each of these factors is inherently a source of conservatism and resistance to change.

1. Miflagtiyut

The major institutional factor in medical care delivery, the Kupat Holim Clalit, is under the control of the Histadrut, which in turn is linked to the Labour Party. Thus, any changes which the Kupat Holim Clalit leadership might want to introduce must be approved by the Histadrut, and this means Labour Party acceptance. The failure to effect significant institutional changes within the Kupat Holim Clalit is, to a major degree, a result of this structural complexity, and the resistance of the Histadrut and political leaders to changes which would diminish their control over the Kupat Holim Clalit.

As noted, over thirty years ago, Ben Gurion sought to transfer the functions of the Histadrut and other pre-state institutions to the government. Then, as now, any reform proposals which might have infringed on the Kupat Holim Clalit's power were quickly rejected. Changes such as the establishment of an independent hospital system which threaten the core of the Kupat Holim Clalit system with loss of control over operations, budget, and personnel were rejected by the Kupat Holim Clalit, the Histadrut, the Labour Party, and, as long as Labour was in power, the government, and the Ministry of Health.

Ever since 1977, the Histadrut has successfully continued to resist all such proposals. The Histadrut and the Labour Party still see the Kupat Holim Clalit as a major source of members, income, and power. According to Prof. Asher Arian, "A great part of the public belonging to the Histadrut did so only in order to enjoy the health services it provided." (Arian, 1984, p. 50). In the 1950's, only 40% of the membership dues (*Mas Achid*) actually went to the Kupat Holim Clalit — another 40% went the Histadrut itself for administration and the political parties, etc., and 20% went to pensions. In 1957, this was raised to 43%, to 60% in the late 1960s, and is around 70% currently (Protocol of Government Committee, 1988, p. 3961, Shoshana Arbeli-Almoslino testimony).

The Kupat Holim Clalit is also a major source of patronage for the Histadrut. There are over 4,000 administrative employees in the Kupat Holim Clalit system (Government Controller's Report on Kupat Holim, 1985). The annual administrative budget of the Kupat Holim Clalit hospitals is 81 Million NIS, while the administration of the Ministry of Health system, which is 50% larger, costs 14% less (70 million NIS). (Protocol of Government Committee, 1988. p. 2641, H.Doron testimony). This ratio is also reflected in the high budgets of individual Kupat Holim Clalit hospitals such as Beilinson in Tel Aviv, as compared to large Ministry of Health hospitals such as Rambam in Haifa. In this case, the difference is on the order of 30%, even though Rambam, as the Northern Supra-Regional Hospital responsible for treating IDF casualties in the region, can be considered to require a larger administrative capability (Protocol of Government Committee, 1988, pp. 2645-2648, H. Doron testimony).

Thus, proposals for reform in health care policies which affect the Kupat Holim Clalit are seen as attempts to weaken the Histadrut, and consequently the Labour Party, and are resisted. The head of the Histadrut has charged that the official judicial inquiry into the health system was designed to weaken the Kupat Holim Clalit (*Ha-Aretz*, 28.2.89, in Hebrew). The introduction of professional administrators was also resisted as these "experts" are deemed to have primary loyalty to professional standards and peer groups, rather than to the Labour Party or to the Histadrut.

2. *Ideology*

The ideology of the Histadrut and the Labour Party has also been a major obstacle to change. According to many studies and analyses, ideological organizations are inherently even more resistant to change than non-ideological bureaucracies. The Histadrut's ideological attachment to formal all-pervasive equality with regard to wages, fees, and services, has prevented the implementation of a number of innovations designed to increase efficiency. For example, the formal emphasis on a single wage scale has impeded the development of a consistent program of incentives to encourage doctors to practice in those regions and specialties in which there are shortages. Similarly, the Histadrut had repeatedly prevented the imposition of fees to reduce unnecessary visits to physicians and clinics. Attempts to reduce waiting periods for surgical procedures by creating second shifts were blocked when the Histadrut insisted that all medical staff, even those not involved in the second shift, be compensated equally.

This ideology was largely designed and developed in the context of the 1920's through the 1940's, and was generally unchallenged until the 1960's. As Israel became an increasingly middle class society, however, equality of medical care was no longer considered by a large part of the population as the only or, in some cases, the primary or even exclusive goal. In many areas of economic and other behaviour, Israeli society has become market oriented and pluralistic. A significant portion of the population has the resources for additional medical care, and is seeking mechanisms to obtain that care. A number of institutions are seeking to provide such care, but the Kupat Holim Clalit/Histadrut/Labour Party ideology still continues to stress equality.

Ideology also prevents the creation of priorities and choices among competing alternatives. Histadrut/Labour/Kupat Holim Clalit ideology stresses Zionist goals such as building up agricultural areas, the Negev, and the Northern settlements, in addition to "equality of service" for all members. This has led the Kupat Holim Clalit to undertake a number of "national" projects such as the development of the Soroka Medical Center and Medical School in Beersheva. While all analysts agree that there are too many medical schools, given the excess number of doctors in Israel, the Kupat Holim Clalit justifies the Soroka school as necessary for the development of the Negev region (Protocol of Government Committee, 1988, p. 2688, H. Doron testimony).

For many years, as the budget of the Kupat Holim Clalit has been increasingly strained, policy makers, including the Histadrut's leadership, have maintained their commitment to equality and development of the periphery. No priorities have been established. The Soroka complex and medical school continue to be funded, while other hospitals in other parts of the country are starved for operating funds.

One clear sign of the inability to make choices and set priorities is the system of incremental budgeting. Throughout the Kupat Holim Clalit system, as well as the Ministry of Health, annual budgets are almost entirely based on the previous year's allocation, patient loads, and work force, with perhaps some adjustments for inflation. Significant changes in budgets, whether between regions, within a region, or between hospitals and clinics, are entirely absent. Such changes would be an indication of prioritization, but no such evidence is available. As a result, after over a decade of fiscal crisis in the system, instead of setting priorities in order to insure the attainment of the most essential goals, no priorities are set, and the entire system is on the verge of collapse.

The ideology of equality has also been a source of centralization and of fear of allowing local or regional managers to make choices and implement changes. (However, here again, the reality is inconsistent with the professed ideology. Selected regions have received higher per-capita budgetary and manpower allocations, or have received more technological or other equipment, which, in effect, leads to de facto differences in the quality of services. Modan, 1982, pp. 338–339.) As long as the entire health care system is deemed to require a rigid form of equality, regional or even local initiatives (at the level of the individual hospitals and clinics) which might introduce deviations have been rejected. Thus, ideology has been a source of resistence to decentralization in the Kupat Holim Clalit and has blocked local initiative and change at this level as well.

3. *Mamlachtiyut*

Large government and quasi-public bureaucracies such as the Ministry of Health and Kupat Holim Clalit are, in general and in Israel in particular, highly inflexible and resistant to change. They tend to protect their resources and budgets, avoid the risks of innovations, program incrementally, and limit personnel changes. Government institutions tend to be monopolistic in nature, thus preventing the development of market forces, competition, and similar sources of and pressures for innovation and change.

In Israel, the Ministry of Health is responsible for the direct operation of a major portion of the medical care delivery system. The Ministry employs approximately 20,000 people and is responsible for the direct operation of 33 hospitals (Ministry of the Treasury, 1988, p. 81). Promotions of each employee must be approved by the Ministry of Health, and the budget and expenditure of each hospital are also prepared and approved by the Ministry. This operational responsibility had essentially prevented the Ministry of Health from functioning in the planning or regulation of the national health care system.

Yet numerous efforts to reform the Ministry of Health by separating the hospital operations from the planning and regulation functions have been rejected by the Ministry of Health itself. In 1988, the Trainin Commission for Policy and Reorganization of the Health System called for freeing the Ministry of Health "from direct management of personal health services, including hospitals... Only release from direct service provision... will enable the Ministry of Health to concentrate on its principle functions as being responsible for policy making and coordination of the entire health system." (Chinitz, 1988, p. 40). However, government bureaucracies are even more inflexible than the Histadrut, and the Ministry of Health has resisted any reductions in the scope of its responsibility, its budget, and manpower. Ministry officials who currently control a budget of over 1 billion NIS, realize that reform such as the creation of an independent hospital authority, with the ability to set budgetary priorities, wages, employment conditions and fees, or a decentralized system of independent hospitals, would reduce their control and power significantly.

The politicians who have served as Ministers of Health have also brought little change to the Ministry. In general, the ministers have had little power to bring about external changes. The ministers have served for short periods (two to three years) and have been the captives of the Ministry of Health staff, who, as noted, resist change.

Options for Reform: Depolitization and Competition

Despite the crises, Israel still has the resources and the basic elements for the operation of an advanced and effective medical care delivery system. The number and quality of physicians, the infrastructure of hospitals and clinics, and the level of public awareness of health care issues in Israel remain high.

As this analysis has demonstrated, the problems of the Israeli system, and the causes of the inefficiencies and duplications, as well as the strikes and work stoppages which have disrupted medical care delivery are, to a major degree, institutional in nature. The combination of *Miflagtiyut*, ideology, and *Mamlachtiyut* has proven particularly stifling.

In a broad sense, the evidence presented in this analysis suggests two possible approaches to the reform of the Israeli system. One approach would focus on large scale institutional change, such as the implementation of an independent National Hospitalization Authority of independent hospitals competing for patients. The second approach focuses on smaller scale reforms of existing structures, specifically the Kupat Holim Clalit and Ministry of Health. The first approach would require a major and unprecendented change in the nature of the Kupat Holim Clalit and Ministry of Health systems. An effective Authority or system of independent hospitals would deprive these institutions of one of their major missions, sources of employment, and funds, and thus can be expected to be resisted by them. As a result, such reforms have been and will continue to be difficult to implement given the inherent conservatism, inflexibility, and resistance to change in government and quasi-government bureaucracies, as well as the vested interests of the Histadrut in the current system, and the broader Israeli political environment.

It is clear that the implementation of such major institutional changes will require the expenditure of very significant political resources on a scale which, in the past, the political leadership has been unable or unwilling to expend. As noted above, even Ben Gurion, at the height of his power, failed to separate the Kupat Holim Clalit from the Histadrut, while decades of efforts to change the Ministry of Health have also been ineffective. Unless the scale of political and bureaucratic power is recognized and applied to achieve these institutional changes, proposals which are dependent on such changes are doomed to failure. In other words, "the depolitization" of the Israeli medical care system sounds much simpler than it would be in practice.

Alternatively, less ambitious reforms could also be attempted by increasing competition and decentralization within the current institutional framework of the Ministry of Health and Kupat Holim Clalit. Such an approach would allow the Israeli medical care system to build on the foundation and potential of the current structure. To some degree, there have already been some efforts in this direction. The demands resulting from the changing socio-economic environment, and, in particular, the competitive pressures from other kupot and private medical care services, have forced the Kupat Holim Clalit to increase the extent to which patients are allowed to choose their own physicians. The Kupat Holim Clalit has become more open, dynamic, and less bureaucratic, even implementing a system of providing appointments by telephone for some clinics.

In general, the leaders of the Kupat Holim Clalit have acknowledged the increasing impact of competition on the system. The current director-general, Nahum Fassa, has declared that the Kupat Holim Clalit will reduce its staff by 15% in order to reduce overhead and administrative costs (*The Jerusalem Post*, 15.1.89). This is to be accomplished through attrition, rather than direct reductions, and given the failure to execute such declarations in the past, his statement must be treated with some caution. After the Kupat Holim Clalit's main competitor, the Maccabi sick fund, began to offer its members the opportunity to purchase additional insurance to fund treatment abroad (when such treatment is not available in Israel), the Histadrut/Kupat Holim Clalit system followed. Although a relatively small step, this represented a major ideological change for the Histadrut, which had opposed any form of such additional fee-based voluntary insurance as an encroachment on strict equality. Similarly, the challenges of competition, which are particularly intense in the Jerusalem region, have led the Kupat Holim Clalit to experiment with decentralized management in this region .

The extent to which this competition is sustained and fosters continued and more substantial institutional change, particularly within the Kupat Holim Clalit, depends on a number of factors. While ready to a limited degree to accept competition, the Kupat Holim Clalit has also continued to take measures to limit the competition from other kupot. Critics note that the Kupat Holim Clalit dominates the system, and uses its dominance to effectively limit competition. Kupat Holim Clalit hospitals, for example, have sought to limit access of Maccabi members to Kupat Holim Clalit hospital outpatient clinics, even though some of these hospitals are designated regional hospitals, offering exclusive treatments, for which Kupat Holim Clalit receives government funds (Protocol of the Government Committee, 1988, pp. 1302, 1306, R. Roter testimony). Large numbers of Israelis who are employed in Histadrut enterprises are required to pay the membership fee to the Kupat Holim Clalit, and the Kupat Holim Clalit automatically receives the employer contribution (the *Mas Maqbil*) for this group. The Kupat Holim Clalit has also successfully opposed the transfer of responsibility for the collection of the employee contributions to the medical funds (*Mas Achid*) to the National Insurance Inatitute, which would indirectly provide

Histadrut employees with the opportunity to enroll in sick funds other than the Kupat Holim Clalit (Ellencweig et al., 1986, pp. 30–35).

Kupat Holim Clalit has also sought to increase the hospitalization fees charged to non-Kupat Holim Clalit members, and has also attempted to gain a large share of the *Mas Maqbil* collected by the National Insurance Institute, at the expense of the other kupot. Critics have also noted that the 66 million NIS subsidy which the Treasury (under Shimon Peres) granted the Kupat Holim Clalit in early 1989 will reduce the pressures for organizational changes which are deemed necessary to increase efficiency and to improve the quality of care in the system.

Proposals to create a National Hospital Authority which would be operationally independent of the Ministry of Health, have been resisted by the Ministry of Health bureaucracy, which has argued that such independence and decentralization would be inefficient (as if any system could be more inefficient than the current one). The Ministry of Health staff has proposed the creation of a centralized government Hospital Authority in which policy decisions, including fees and expenditures (mainly salary levels) will be set by the Authority and the individual hospital will merely implement these policies (interwiew with Mr. Oren Tokatly, 15.3.89). It is no coincidence that such a system would also preserve the bureaucratic role of the Ministry of Health.

Any reform of the system will also have to develop new systems of physician reimbursement. The Meuchedet and Maccabi sick funds already use capitation and some fee-for-service reimbursement systems. Expansion of such systems to the Kupat Holim Clalit and Ministry of Health nerworks are potentially a means of increasing efficiency while simultaneously increasing the income of physicians in clinics and hospitals. As Chinitz notes, however, the implementation of such a system would also require regulation to avoid abuses (Chinitz, 1988).

Private medicine, both legal and illegal or "black", is also emerging as a major source of competition to the current system. Neither the government nor the Histadrut has encouraged the growth of this alternative, although it has been tolerated, in part because it provides employment for some medical professionals who are unwilling to accept the current low incomes in the Ministry of Health and Kupat Holim Clalit systems, and in part because it provides those with resources and who are willing to pay more with high quality and easily accessible medical care.

As a result of the failures and dissatisfactions with the Kupat Holim Clalit and Ministry of Health systems of clinics and hospitals, and the growing waiting periods for surgery, questions about quality, lack of choice, and deficiencies in the doctor-patient relationships (including follow-up care), many citizens have sought private care. Rosen has noted that between

1982 and 1986, admissions to private hospitals grew at an annual rate of 18.1%, while admissions to Kupat Holim Clalit and Ministry of Health acute-care hospitals grew at a rate of 2.5% per year. The Herzliya Medical Center is perhaps the largest such private enterprise, performing some 5,000 operations per year, including state of the art diagnostic and surgical techniques (*Ha'aretz*, 6.4.88, in Hebrew). Other hospitals, such as the Assuta hospital in Tel Aviv are moving in a similar direction. A number of private insurance funds (such as Shiloah and the new "First Class" insurance), which, in contrast to the four kupot, do not provide any facilities or care, have been created and serve to encourage this trend to some degree. As long as the current system resists the type of major institutional and organizational changes which are necessary to increase efficiency, lower costs, and raise the quality of service, these types of private and even illegal care will grow.

There is also a limited but growing recognition of the important role that professional medical care and hospital administrators could play in the Israeli system. A number of physician-administrators, such as the former director-general of the Kupat Holim Clalit, Dr. Haim Doron, have acknowledged the particular need for developing a training program for such personnel, and in the interval until such a program is developed, to take advantage of the skills of the few people trained in this area that are already in Israel.

Countervailing Power

In the modern welfare state, the state is reponsible for insuring that social services such as medical care are provided for the population at large. In highly centralized, socialist systems, the state provides this care directly, through some form of state operated system of clinics and hospitals. In relatively decentralized, pluralist systems, the role of the state is limited to creating the necessary legal, institutional and economic infrastructure in which a satisfactory level of services can be efficiently provided for the population, given the available resources.

In the United States, the government provides few medical services directly, but both federal and state governments are active indirectly in setting medical care policy. In this case, the institutions of the state, such as the Federal Department of Health and Human Services, act to maintain a balance of power and a form of managed competition among the various competing elements that together set health policy (for a detailed discussion see Chinitz, 1988; for application of this approach see Enthoven, 1978, pp. 650–656, 709–720). According to this theory, the government is responsible for regulating the arena in which policy is made, and for making sure that no single factor or group becomes too powerful. Flexibility and responsiveness in the system is maintained through this balance of power among health providers (private and public hospitals, Health Maintenance Organizations), physicians, insureres, consumer groups, etc. If any single element becomes too powerful, the state steps in to strengthen the weaker elements which are the source of countervailing power (on this theory see Galbraith, 1956; see also Lowi, 1966).

The Israeli system, with the combination of the Kupat Holim Clalit and the Ministry of Health networks, as well as the small kupot, physicians union, and private insurance, is neither exclusively state-controlled nor operatively pluralistic. This system does, however, have many of the characteristics of a monopoly or cartel, controlled largely by the Ministry of Health and Kupat Holim Clalit, with little real competition between them in terms of efficiency and quality of care for patients.

Given the combination of *Mamlachtiyut*, *Miflagtiyut*, and ideology in the system, significant change at any level requires the development of a balance of power among competing actors. Rather than being a major supplier of medical services (and thus a player in the system), the "countervailing power" model of public policy would have the Ministry of Health acting as a "balancer", strengthening weaker actors in the system such as the amaller kupot, independent insurers and consumer groups. This role would also allow the Ministry to act as a regulator, particularly with regard to the Kupat Holim Clalit, which is largely unregulated in the current system.

While a detailed program for the establishment of a system based on countervailing power is beyond the scope of this paper, it is clear that in order to accomplish this transformation, the government would have to end operational control over the hospitals (and thus end the competition in terms of power and resources between the Ministry of Health and Kupat Holim Clalit systems). Further steps would first require a dynamic approach to health care policy, which to date has been entirely absent.

Conclusions

It is clear that to have an impact, any commissions, reports and proposals designed to reform the Israeli medical care delivery system will have to consider the organizational, institutional, and political issues carefully. The keys to reform — competition and flexibility in general, the redesign of the basis for reimbursement, and employment of professional administrators in particular — have already been recognized. The challenge is to translate this recognition into policy and actual reform of the system within the given political, institutional, and organizational context, and to address the problems and pressures which, until now, have not prevented change.

While many of the proposed organizational and institutional changes, including increased competition, and decentralization of the Ministry of Health and Kupat Holim Clalit systems, may have negative effects, the point is that none of these changes have really been attempted or implemented. The highly closed and centralized system which has existed for over forty years has failed; only institutional change can bring improvement. While it may be true such changes are less than perfect and may require continous adjustment and innovation (as in the case of the US and British systems, for example), the alternative is continued inflexibility and inefficiency for which the society, in general, and individual citizens, in particular, must pay.

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IMPACT OF DEMOGRAPHIC AND SOCIOECONOMIC FACTORS ON THE CHANGING NEEDS FOR SERVICES FOR THE VERY OLD*

by Brenda Morginstin**

One of the most acute and visible problems facing the health and social service sectors today is that of meeting the rapidly increasing needs of the elderly. Per capita expenditures for the very old are already larger than for any other age group in most countries. In terms of resources, as the number of very old people increases, proportionally more resources are likely to be used by them than by younger age cohorts.

While that Western industrialized nations are under great pressure to reduce expenditures on income security, health and social welfare programs, the proportion of aged people in the population, especially of the very old, has been growing and is predicted to further increase over the next several decades, with parallel increased pressures on providing care to the vulnerable elderly.

Both developing and developed countries are experiencing population aging. According to data from a 1987 WHO report, in most countries the elderly population is increasing at a faster rate than the population as a whole. The same report predicts that between 1980 and 2020 the total population of the developing world will be increasing by an expected 95%, whereas the aged population will rise by 240%. The period of most rapid growth is expected to be the second and third decades of the next century.

The number of elderly people, which has been growing steadily in this century, represented in 1980 an estimated 5.7% of the world population, and by the year 2025 is expected to have reached 9.5%. In more developed regions the 65 plus age group will reach an average of 17.3% of the total population, and in some Northern and Western European countries such

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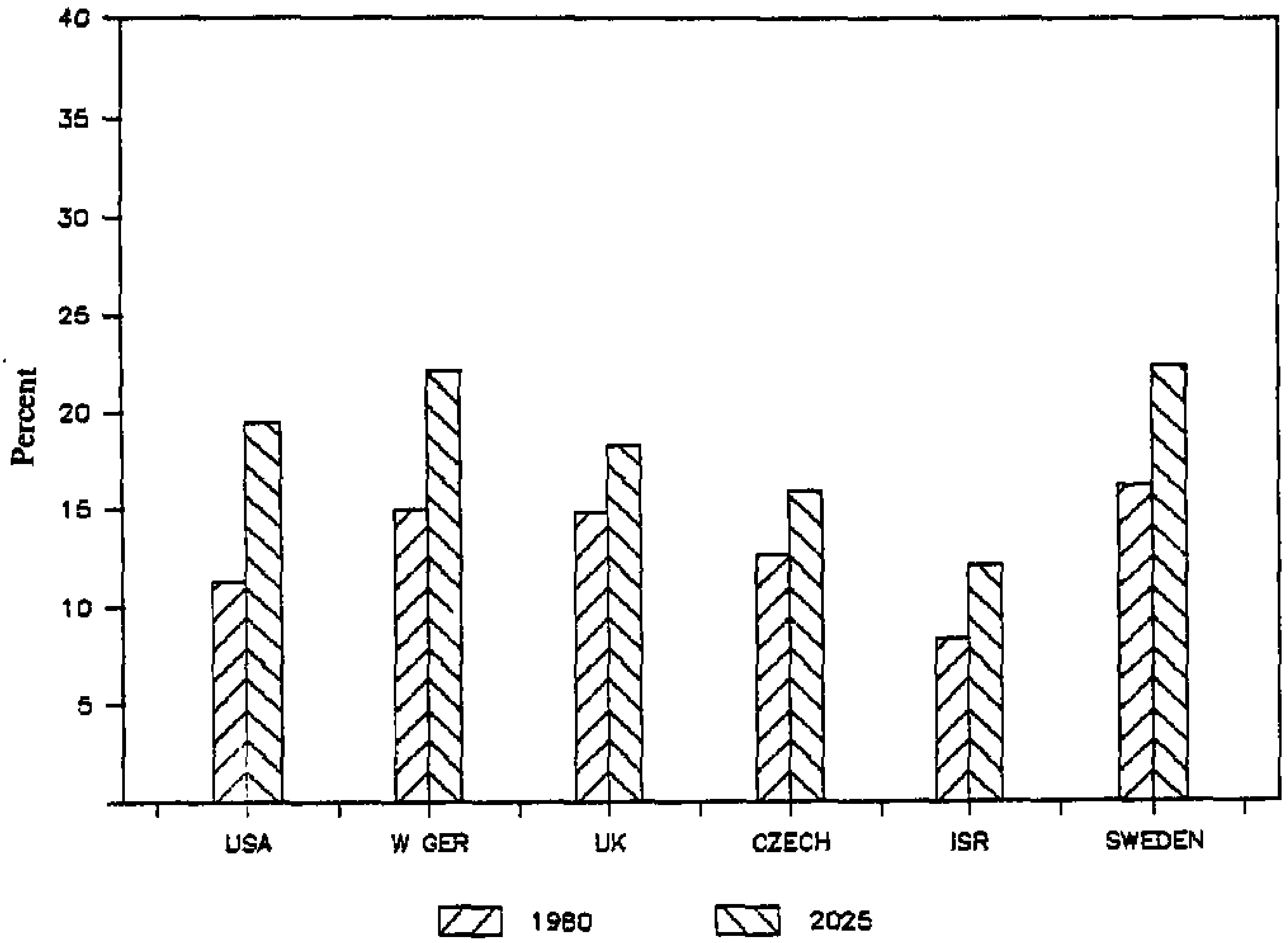
as Denmark, The Netherlands, West Germany and Sweden, it will exceed 22%. Japan, by the way is the most rapidly aging population in the world.

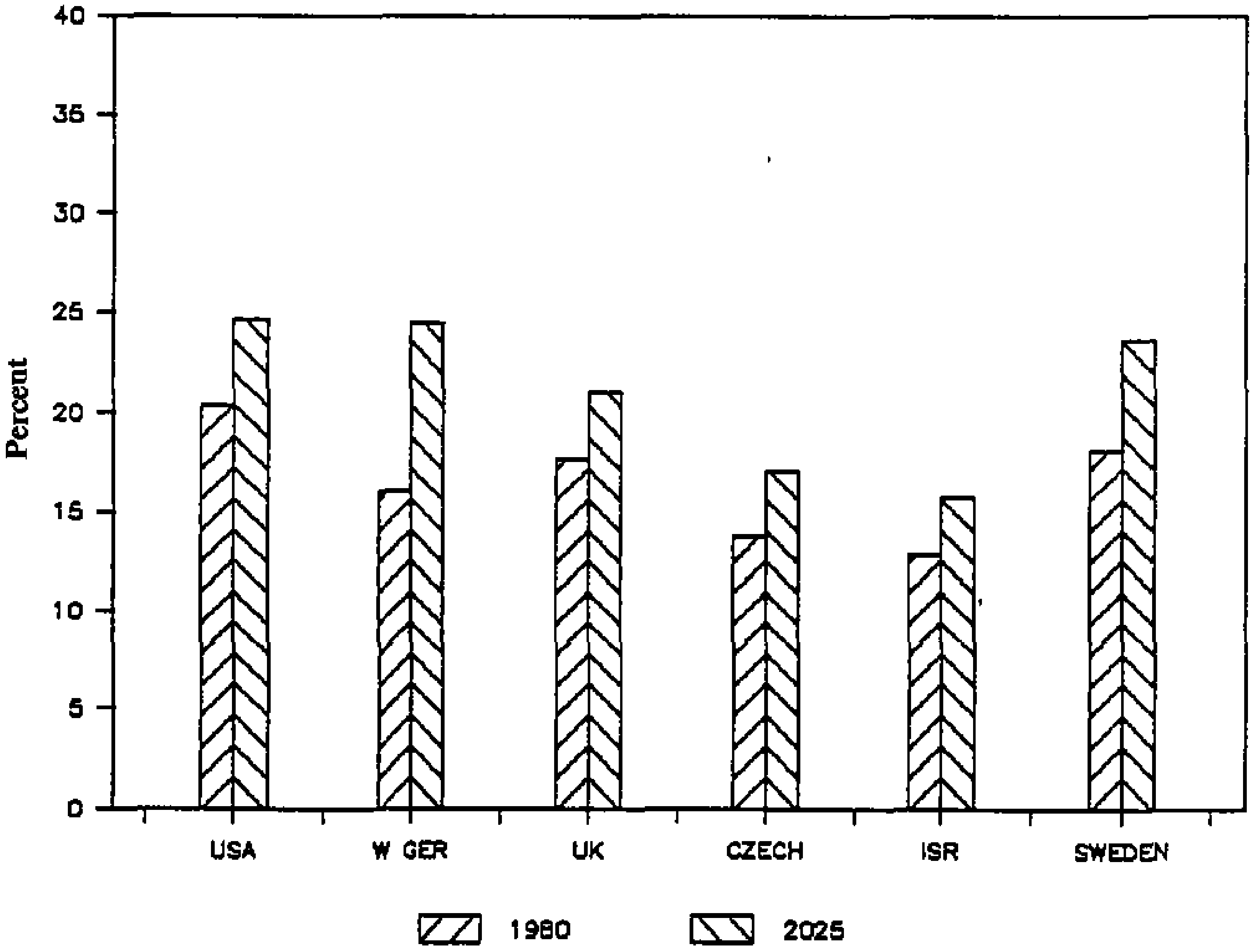
Life expectancy at age 65 is increasing and in the U.S. is expected to be 82 years for men and 87.3 years for women by the year 2035. Literature referring to the oldest old generally include those over 80 or 85. Thus not only is the aged population increasing, but the elderly population is itself getting older as more and more people survive to the highest ages. In fact, most of the growth will occur in the 80 and over group, and in some countries (e.g. Germany, Denmark, Austria, Sweden) will comprise almost one-quarter of the elderly population.

Reductions in mortality due to possible technological and medical advances may have an additional impact on the size of the very old population. If there are further increases in life expectancy due to major breakthrough in treating such diseases as cancer and heart disease, current projections in the growth of the elderly population may in fact be understated, and more and more people will be living into their very old age.

1. Proportion of 65+ in Total Population



2. Proportion of 80+ in Elderly Population



In fact, our health care system is becoming increasingly capable of sustaining the survival of sick people at enormous costs. These costs may not be able to be borne by individuals living on post-retirement income and assets, and are therefore viewed more and more as the responsibility of government. Is this a financially realistic approach? Can governments design policy and plan programs which are predicated primarily on increasing costs without seriously considering alternative options, some of which may undermine previously held principles of social security?

Estimates of per capita public health expenditures for the elderly in 1984 ranged from $975 in the U.K. to over $2,000 in the Scandinavian countries. Public health expenditures for the elderly as a proportion of the GNP varies and is as high as 2.9% in Norway. Total per capita public expenditure for the elderly ranges from 5.4% in Canada to a high 14.5% in Sweden. In the U.S., for example, since 1960 the proportion of the federal budget on programs for the elderly has doubled. The oldest old, who are the subject of this article, have the highest health costs.

Table 1. Total Public Expenditures on the Elderly and as a Percentage of Gross National Product, and Total Public Health Expenditures on the Elderly, and as a Percentage of Gross National Product, Selected Countries

		Total Per Capita Public Expenditure for the Elderly		Public Health Care Expenditures for the Elderly	
Country	Year	Amount	% of GNP	Amount	% of GNP
United States	1981	6,366	5.9	1,212	1.1
Canada	1982	6,096	5.4	1,370	1.2
Denmark	1980	8,499	10.1	2,356	2.8
France	1980	7,993	9.8	1,876	2.3
Netherlands	1982	7,861	8.2	1,534	1.6
Norway	1981	5,005	5.7	2,546	2.9
Sweden	1982	12,293	14.5	N/A	
U.K.	1980	4,416	7.7	975	1.7

Sources: Long-Term Care in Western Europe and Canada: Implications for the United States. Special Committee on Aging, United States Senate, U.S. Government Printing Office, July 1984; as printed in Rabin & Stockton, 1987. Figures are in U.S. dollars.

Therefore, The key policy concerns arising out of current and predicted demographic trends are the following:

a. Whether the aging of populations will automatically lead to a major increase in the cost of public health and social programs, especially for the very old. Are expected growths in public costs direct extrapolations of magnitude of populations increases, of current rates and current patterns in service utilization, or can we meet needs but control costs by policy decisions restricting parameters such as coverage, benefit levels, control of supply of institutional beds, and expanding the role of the private sector?

b. What type of services or programs will be required by which groups of the very old? Will programs be aimed at meeting in-depth service needs of residual groups such as the severely disabled, the cognitively impaird, the poor, and those without family support, or will programs aim at providing a basic level of care to a broader group of the very old?

c. Which of the required services can or should be provided under the umbrella of social security entitlement programs, and which would better remain the responsibility of non-entitlement welfare programs, informal care, or the private market? What is the desired mix of formal and informal, private and public care? What economic and social constraints will affect the optimal balance between these sectors?

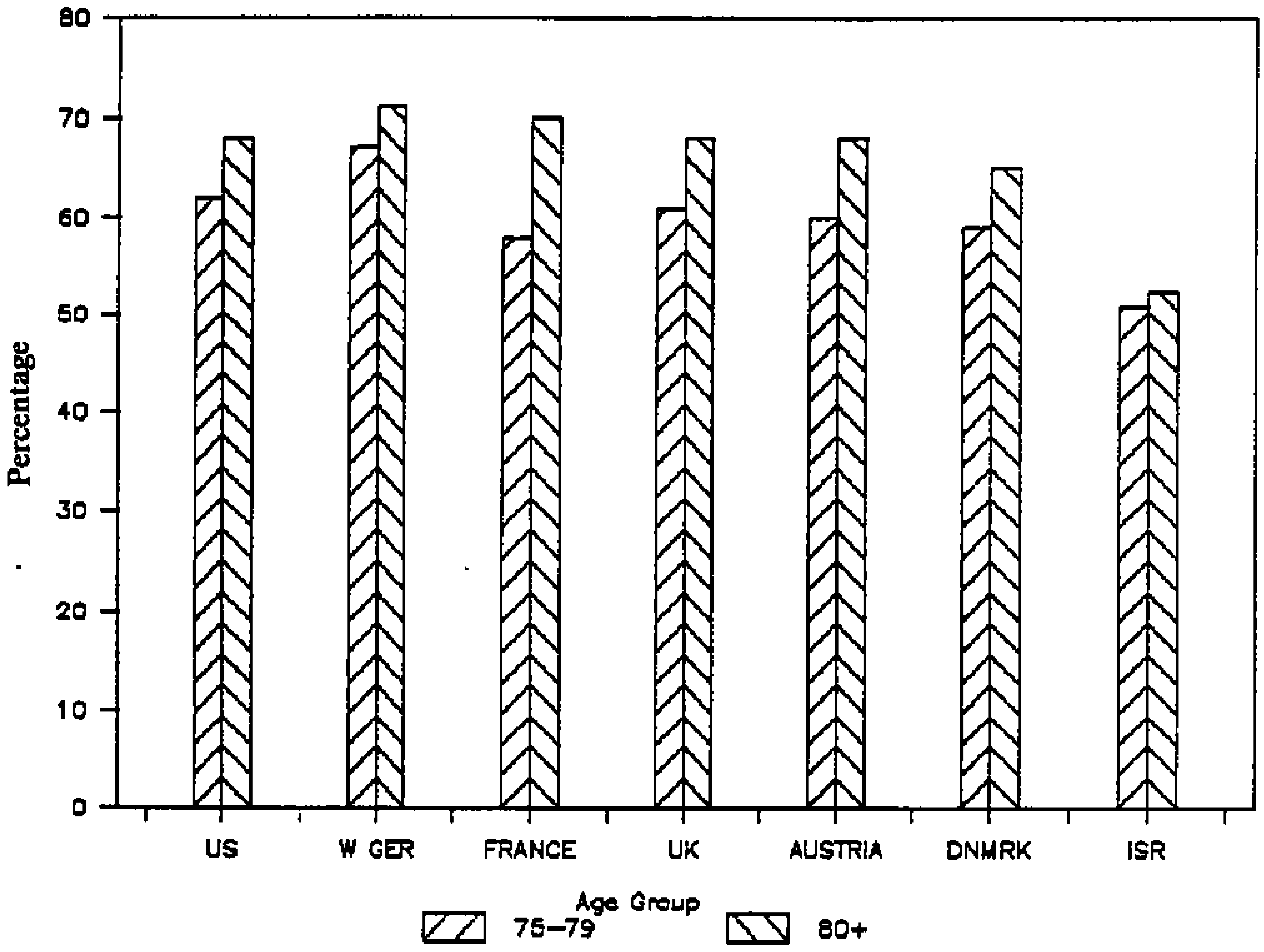
d. Similarly, what is the desired balance between community and institutional care, and how can this balance be achieved through incentives inherent in publicly financed programs?

e. The question which will have to be answered by each country is whether expected increases in health and long-term care expenditures will outstrip real economic growth. Will society, and in particular, the working population, be willing or able to bear the additional financial burden? Which economic policies should be pursued so as to achieve economic growth as well as cost-containment goals?

Today, the oldest old are clearly distinguished from younger elderly in a number of ways. Several of these are:

(a) As expected, there is a higher incidence of morbidity and mortality. Moreover, mortality rates for elderly men are more than 40% higher than for women in countries such as Germany and Japan.

(b) As can be seen from the graph, there exists a unique sex ratio among the oldest old, with a predominance of females as compared to males. Elderly women greatly outnumber elderly men in most countries of the world, with



3. Proportion of Females by Age Group

the percentage of women steadily increasing with each age cohort, especially in urban areas. In developed countries, the proportion of women among the oldest old is as high as 70%. Thus the social, economic and health problems of the over 80's are *largely* those of older women.

(c) As a result, among the oldest old there is a greater probability of widowhood and living alone, resulting in higher incidence of isolation and loneliness.

(d) The levels of educational attainment among the oldest old are considerably lower than among the younger old.

(e) The income levels of the oldest old are lower than those of the younger old.

(f) The oldest old make more extensive use of high-cost services, especially diagnostic medical services, acute hospital and long-term institutional care. For example, the rate of hospital days per 1,000 for those aged 85 and over is twice that of the younger old. The rate of nursing home residents is 11 times higher for men in this age group and 16 times higher for women.

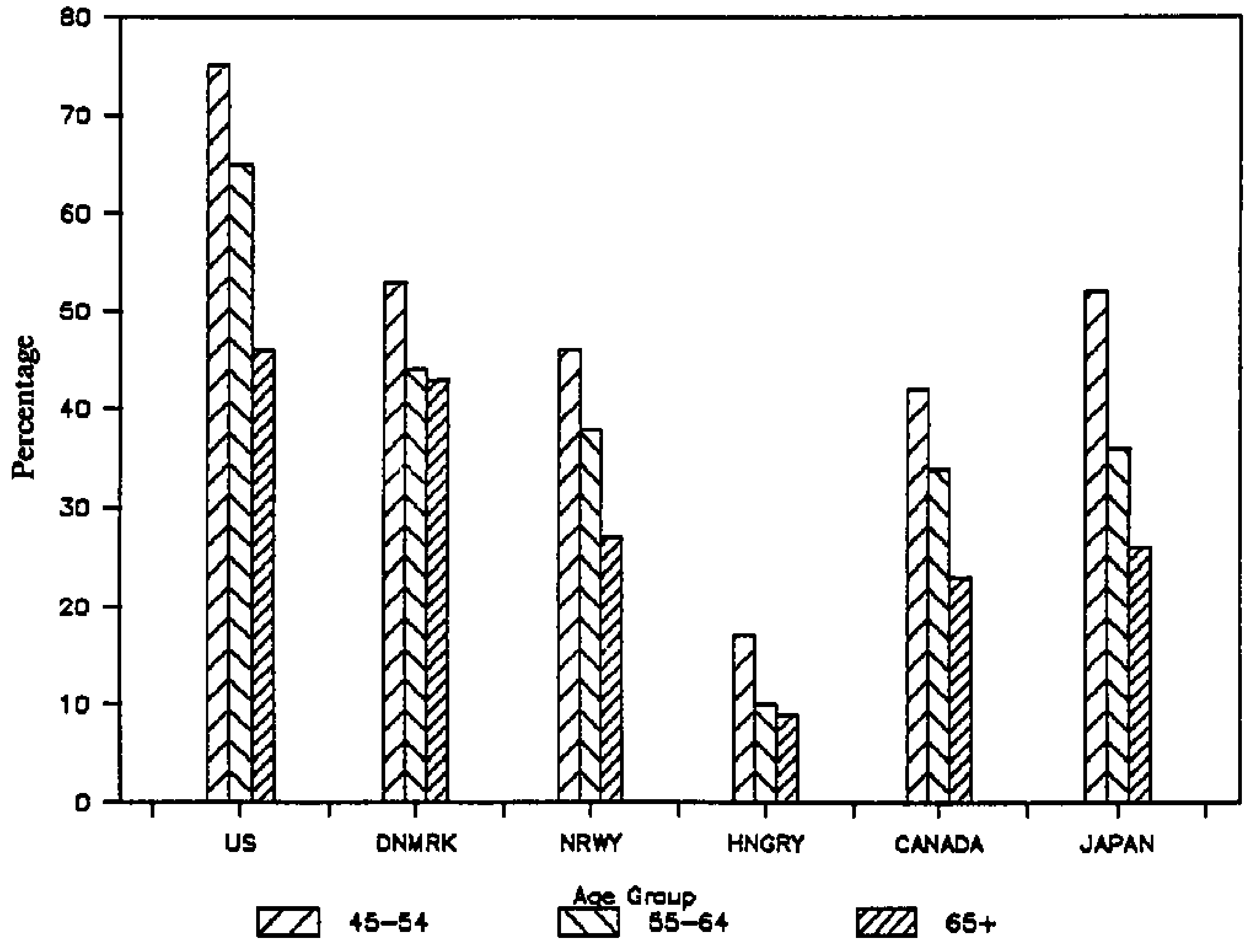
(g) The oldest old are characterized by a higher proportion of dependency in activities of daily living such as mobility, dressing, washing, grooming. Although varying definitions make it difficult to compare, studies in Israel and the US have shown that of the elderly living at home, approximately 7–8% require significant assistance of others in performing such daily activities (ADL). These dependency rates increase sharply with age, reaching about 25% requiring some help in ADL among the 85 and over age group.

(h) The oldest old rely more heavily on the family for providing personal care in the area of daily activities and in homemaking services.

However, in spite of these general characteristics, the fact remains that the group of the very old is far from being homogeneous or static. We have been traditionally studying and providing data for the elderly as a single group spanning some 35 years, whereas in fact there is a great deal of diversity among this group, diversity which should be taken into consideration in planning social security policy.

In addition to the existing heterogeneity within current cohorts of the very old, this population is changing in nature, and in order to make predictions about future groups we should already by looking at younger age cohorts. Thus, for example, future cohorts of over 80's will have achieved higher education levels, as can be seen in graph 4. As we move to younger cohorts, the proportion with secondary level education increases steadily. This is true, by the way, for women as well as for men. Some groups will therefore enjoy higher income levels and good health. Moreover, the interrelated, changing factors of marital status, kinship status and living arrangements are most important determinants of formal and informal care options and utilization of long-term care by the very old, which in turn are affected by longevity,

4. Proportion of Males with Secondary Level Education, by Age Group



changing birth and divorce rates, and increasing participation of women in the labour force.

What other factors are to be considered in defining the needs of the very old and in examining policy options to deal with pressures for greater expenditures based on expanding programs?

It is important to emphasize that operational definitions of needs and subsequent planning for services require different approaches in each society, based on its social and political structures, economic system, tradition of service provision, expectations, division of responsibility among government bodies, funding structures, role of the private sector, desired short and long-term program goals, program constraints, and specific policy objectives (see figure 1).

Traditionally, the literature relating to esimating kinds and scope of needs, or demand for services, for the very old, have focussed primarily on past and projected demographic population data.

Based on a model, which includes additional interrelated factors to be considered in planning for the future, and which in fact were carefully analyzed in Israel during preparation of its Long-Term Care Insurance, a

Figure 1. Factors Affecting Needs and Programs for the Elderly

A. Background Factors

Demographic

-population date
-past and projected age structures age/sex ratios
-geographic distributions
-emigration patterns
-mortality rates, life expectancy for age groups
-fertility rates
-morbidity rates

ADL, IADL dependency rates

Social

-family size
-marital status; divorce rates
-living arrangements (especially % living with spouse and % living alone)
-educational attainment levels
-traditional role of women
-women's labor force participation trends
-*informal care patterns*
-changing expectations for services; preferences retirement age
-number of children, proximity

Economic

-specific economic system
-tax structures
-age dependency ratios
-GNP growth
-inflation rates
-technological advances
-health and social expenditures (by age group)
-economic circumstances of *elderly*
-out of pocket costs incurred in providing care
-labor force participation rates of specific groups: elderly, women

B. Current Patterns of Meeting Needs

a. Type of economic, health and social services and benefits (cash and in-kind transfers).
b. Coverage: rates of institutionalization and home care provision.
c. Adequacy, coverage and maturation of social security and work pension programs.
d. Funding structures and division of responsibility.
e. Role of private sector

C. Policy Concerns

— available resources, public and private.
— economic stability and growth.
— universal coverage versus selective, pluralistic approach.
— concern with quality.
— public/private mix.
— cost/effectiveness considerations of home vs. institutional care.
— funding alternatives such as cost-sharing, restructuring expenditures, selective reductions in benefit levels, changes in retirement age, etc.

D. Program Objectives

Economic Security	Prevention and Health *Promotion*	Curative, Ameliorative Care	Maintenance (long-term care)
labor force productivity earnings, savings social security work pensions housing	public health *personal safety* measures, social supports	primary medical care *acute hospital care* rehabilitation social supports	personal care at home *community adult day*-care, meals, institutional care

number of approaches for planning comprehensive care under social security are suggested;

(a) Adopting a more pluralistic approach in examining the interrelationship between the basic demographic, social and economic variables, rather than using summary data for the elderly. This makes it possible to discern the needs of diverse groups of elderly, not all of whom will require similar levels of publicly funded care. This approach will also facilitate identifying the nature of heterogeneity within the older population as well as target groups with specific acute needs;

(b) Rather than adhering rigidly to existing structures, each society should be examining possibilities for modifying current patterns of meeting needs, such as the balance between institutional and non-institutional care, or the role of the private and informal sectors. The feasibility of change in current patterns will, in each society, be a function of policy objectives reflecting social and political systems, division of responsibility among government bodies, traditions, cultures and priorities, as well as concern with costs, funding structures, and the role of the private market.

(c) It is necessary to begin to examine a variety of options and objectives for funding and program development, some of which may clash with traditions of social security policy development. Options should outline alternatives in at least four basic, interrelated areas that form a continuum of care, rather than focus on saving or spending in one area, without considering trade-offs in another area. These areas include economic and housing security, prevention and health promotion, curative care including rehabilitation, and maintenance or long-term care.

(d) It will be essential to set priorities in resource allocation among these areas of intervention. For social security this especially means finding a balance between income maintenance programs and service delivery programs, as well as drawing boundaries between entitlement and non-entitlement programs.

One variable inevitably determining the size of the population requiring care funded by the public sector, is income. Comparisons show that the risk of poverty is generally higher among those aged 75 and over than for younger groups. Significant differences exist between countries, with Sweden having virtually no poverty in these groups. Studies such as the Luxemburg Income Survey (LIS) which collects data over time, according to uniform definitions, will enable us to monitor changes in the income status of the elderly cross-nationally. As social security and work-related pensions mature, each successive cohort of elderly people may have higher income due to accumulated assets and higher retirement benefits.

We do, however, require better income data for future generations of elderly. In order to project the economic circumstances of people aged 85

Table 2. Poverty Rates* in Several Countries for Persons Aged 65+ and Total Population

Country	Aged 65-74	Aged 75+	Total Population
Canada	11.2	12.1	12.1
W. Germany	12.7	15.2	7.2
Israel	22.6	27.1	14.5
Norway	2.7	7.3	4.8
Sweden	0.0	0.0	5.0
United Kingdom	16.2	22.0	8.8
United States	17.8	25.5	16.9
mean	11.9	15.6	9.9

* Defined as persons belonging to families with an adjustable disposable income below half the median for all families in the specific country.

Sources: Hedstrom & Ringen (1985). Based on Luxemburg Income Study, 1985. Data is for the early 1980's and some changes are expected. In Israel, for example, poverty rates in both age groups were reduced significantly by 1986-7 to approximately 14%.

in 2020, we should be looking at those aged 50 now, examining how they are being affected by improved pension availability, earning histories, changes in women's labour force participation, etc. It is predicted, that in countries such as England and the United States, the financial position of the elderly as reflected by income and assets (primarilly home equity) will improve markedly by the year 2020.

However, this would probably be true about income status only on the eve of retirement. From data based on cross-sectional analysis only, we know little about important income changes and expenditure patterns associated with the aging process itself, and especially about resource depletion over time, which requires longitudinal research. Whereas we do know that there are age-related reductions in major basic acquisitions, we do not know, nor is it easy to predict, the nature of expenditures on health, medical care, etc. From a policy perspective, the question is whether future generations of very old people will have the resources to pay a greater share of their high health costs, or whether they will have depleted their resources by the time they reach advanced age.

Longitudinal data about income depletion over time are therefore of special salience, if we want to look carefully and realistically at cost-sharing and other possible alternatives for providing health and maintenance care for the very old, since cost-sharing programs will be unviable if the resources of those expected to share costs will have already been depleted.

Let us take a quick look at one economic constraint related to population aging and productivity, which affects the way we define needs and our ability to bear the cost of meeting needs: old-age dependency ratios.

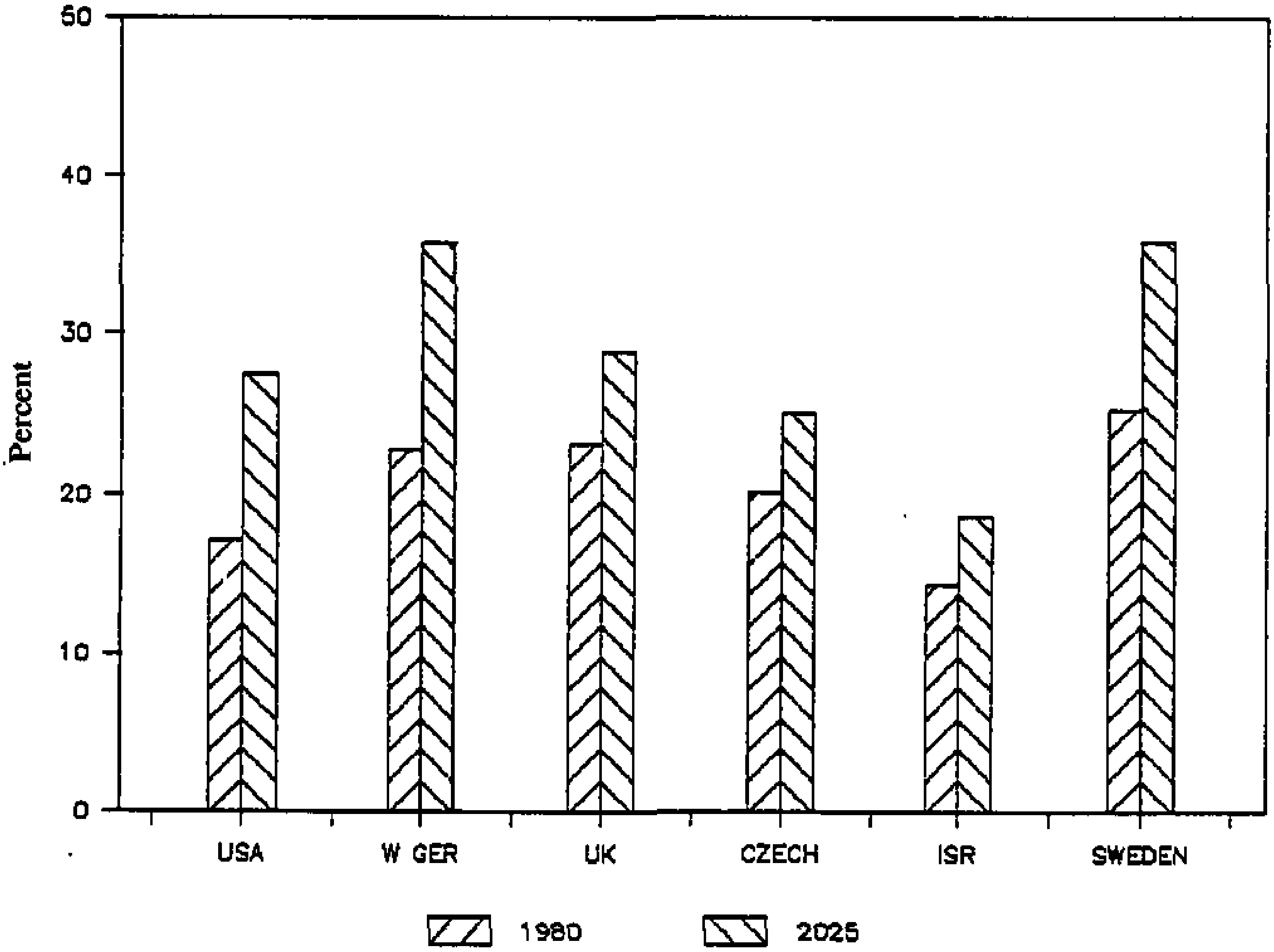
Population aging has important implications for the size and age structure of the working population and the ratio of the population aged 65 and over to the population aged 15–64.

According to a recent OECD report, by the second decade of the next century the numbers of working age people are projected to be falling in almost all industrialized nations.

As can be seen from the graph, which shows only selected countries, the old age dependency ratio is expected to increase in every major region of the world. The most dramatic increases are occuring among the more developed countries (and in East Asia). As people live longer, as mortality decreases, as demands for income support and for a range of social services increase, the difficutlties of supporting comprehensive social security schemes will be felt. Countries will face growing fiscal burdens as expenditures increase and the working age population shrinks.

However, these numbers in and of themselves do not give the complete

5. Old Age Dependency Rations



picture about economic productivity of the two age groups, about the degree to which the economy can support expected costs of care. In fact, these trends may be even more serious if we take into consideration already high levels of unemployment in some countries which are difficult to predict for the future.

On the other hand, we should remember that old age dependency ratios reflect the burden of supporting the care of the non-working, but not necessarily non-productive part of society, since not all productivity can or should be measured in quantitative terms.

The way in which society and individuals deal with the burden of caring is related to other factors than just population and expenditure data, not in the least the way in which society views its elderly people, and the value it attaches to their roles as consumers, contributing family members, volunteers, etc.

Another facet of the burden of providing care to the elderly, not in economic terms or demographic dependency ratios, is the actual immediate burden on the family. In planning the comprehensive care of the elderly, each society will have to decide what will be the continued expected role of the family in providing care, for that proportion of the elderly requiring care, since this type of decision has operative, practical implications for the kinds of programs to be developed.

Several conditions that may affect patterns of informal care, family expectations and service utilization, have been identified in the literature as influencing the types of programs which have evolved in various societies, especially the balance of formal and informal care and community vs. institutional care. These include: differential fertility rates among age cohorts, divorce rates (affecting the availability of children to provide informal care), marital status of the elderly (availability of spouse caregiver, spouses being the silent "unsung" majority bearing the burden of care), and female labour force participation (availability of women to provide informal care at home). To these should be added patterns in living arrangement trends, such as proportions of those living alone, as well as economic status and level of education, all of which would influence not only emerging patterns of formal and informal care but also expectations as to kinds of programs which might be made available, and the ability to pay for services.

In estimating future needs for public services, there remains however the question, whether it is desirable and realistic that the burden of coverage for these groups be largely assumed by the public, at public cost, thus substituting for informal care. At most, the formal sector can only reduce some of the burden associated with caring functions.

In planning programs for the elderly and their families at home, it is necessary to define carefully our concept of social policy in a way that closely reflects actual patterns of informal care, expectations and preferences of the older person and his family, and expected family behaviour in the future as influenced by current programs, and changing social and economic trends among successive age cohorts which will constitute future generations of elderly and their caregivers.

Research as well as experience continue to affirm that the family is and will continue to be the major provider of care for the elderly. Studies have shown that at least 80% of the elderly, dependent in functional activities of daily living, are receiving care from family members. In fact, if we looked at *who* is eligible today for services under Israel's Long-Term Care Insurance program, for example, or receiving care in a program as comprehensive as Manitoba's continuing care program, we would realize that the formal sector is effectively utilized only if some relative in the community is in the picture, responsible for service provision and coordination.

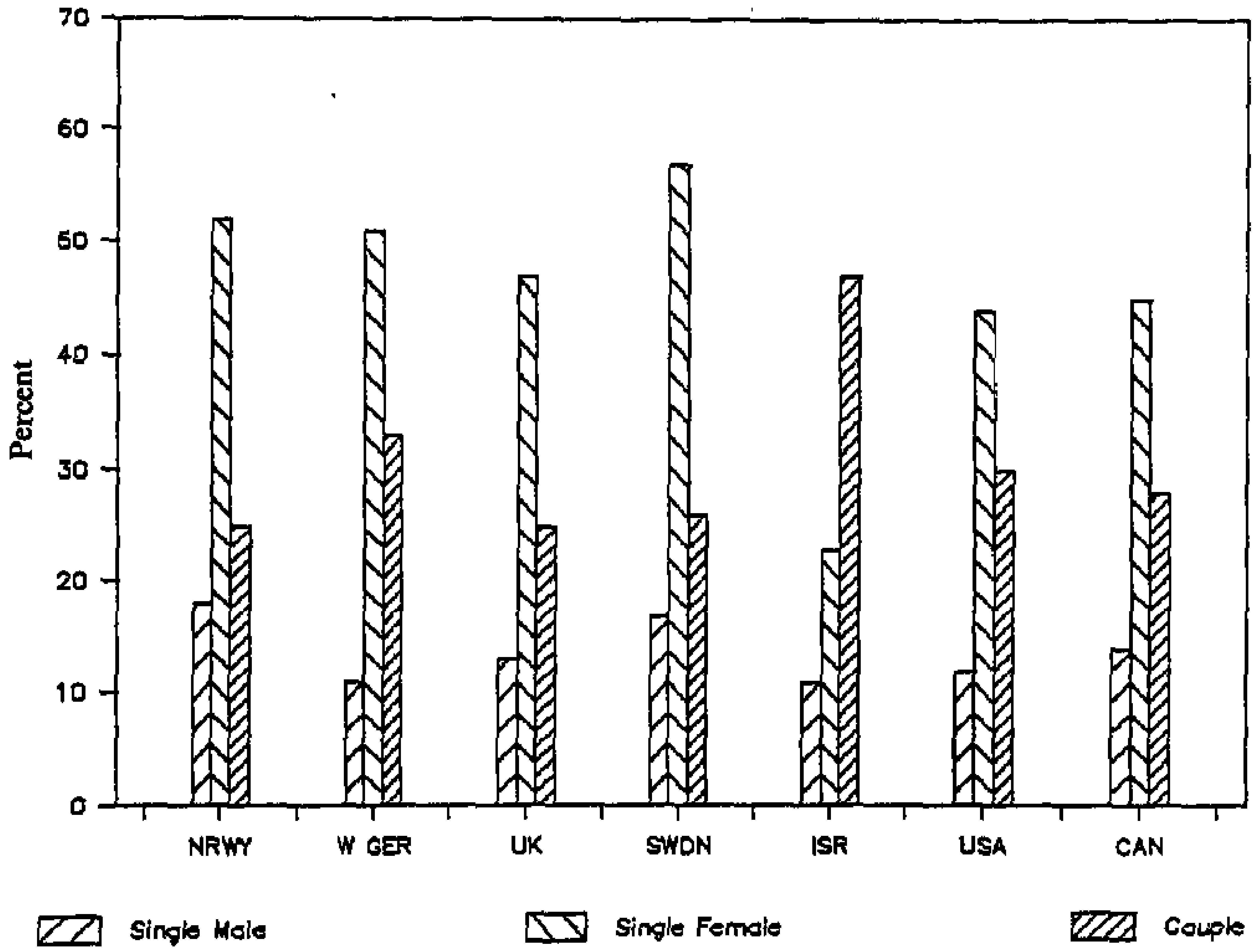
While the family can no longer be considered as a free resource, and Israel has recognized the importance of reducing the burden of care on families in its Long-Term Care Insurance Law, forecasts of the magnitude of public burden and costs must be based on policy decisions in regard to what part of the burden will remain the responsibility of informal as well as private market sectors.

It is clear, however, that given the recognition of the increasing burden on families and the need to provide assistance early enough to prevent crisis, exhaustion, breakdown and inevitable institutionalization, a broadened view of the target population is required, one in which both the dependent elderly and his family are targets of any planned program. This approach has in fact been adopted in Israel's Long-Term Care Insurance Law which is designed to participate in the burden of caring via a joint program of shared responsibility between the elderly and the public.

An expanded view of the target population should be accompanied by a flexible approach in designing the kinds of benefits and services which will be included in a comprehensive program, some of which might be made available to family caregivers themselves. If we are to respond adequately to family needs and expectations, concern with the family should become an integral aspect of planning, as in fact is the case in implementation of Israel's Long Term Care Insurance.

As mentioned, the degree to which relatives are able to provide care is related to a number of factors: demographic, economic and social. For example, caregivers of the very old are primarily the old themselves: spouses and elderly children who are themselves often close to retirement age. Thus the very existence of spouses and children, their age and proximity to the very old will largely determine how feasible it is for the family to fulfill responsibilities in the future.

6. Household Composition of Aged 75+



Household composition of the elderly is thus one important factor and one which may explain cross-national differences in proportions of individuals requiring and receiving care at home and proportions receiving care in institutions. Throughout the developed world, except for Japan, living alone in old age is becoming a social norm. This trend is a result of the high proportion of widowhood among the elderly, especially among women, and the increasing rates of divorce and separation.

Israel is distinguished from European countries by its much lower proportion of people living alone and higher proportion of couples, which may explain its low rate of institutionalization (4.5%), and high rate of family support.

It ought to be pointed out, however, that living alone does not in and of itself constitute a high risk factor for the elderly unless accompanied by other economic, social, health, psychlogical and support risks. In fact, most old people *value* their independence and, far from being a risk factor, living alone would indicate a personal decision and choice on their part. Moreover, although more and more older people are living alone, there seems to be little evidence that they are not receiving support from children and other relatives when this is required.

The changing role of women has been pointed out in several studies as having an effect on informal caring patterns, and the response of the public sector to needs. An increasing proportion of women are entering the labour force and are unable to fill the traditional role of caregiver on a full-time basis. Labour force participation rates are interesting for age groups that are particularly vulnerable as potential caregivers. In the U.S., Israel, Sweden and Canada, for example, the proportion of working women aged 55–64 has increased significantly, as opposed to increasingly early retirement patterns for men, as signified by the steep reduction in labour force participation rates for men (see table 3).

Increased labour force participation rates for women may have a dual effect: while the time available for caring may be reduced, the improved economic situation of women, accrued pension rights, savings, etc., may enhance their position as consumers of services. Data soon to be published from a recent Israeli national survey of the aged suggests that whreas earnings-related pension coverage rates for men may be reaching a saturation point, cohorts of elderly women on the eve of retirement have accrued a greater proportion of pension rights. If it is true that families in which the wife works are more likely to purchase care, the tendency to acquire services from the formal sector may increase as a result of women's increasing participation in the labour force.

In view of studies which revealed, despite predictions to the contrary, that families are not relinquishing their responsibility as caregivers, the implication of this trend is twofold: a greater proportion of families will be expected to exercise greater independence in the way in which they manage care and in their choice of services; and as their earning power increases, women, who are traditionally the managers of care, may be able to purchase more services. Cost-sharing in several forms is in fact becoming a central aspect of some governmental programs for long-term care being sponsored in the U.S.

In fact, part of the alarm raised at growing public expenditures for the care of the elderly are being replaced by willingness to examine cost-sharing and other options in covering the expenses involved in providing care for specifically identified high-risk groups. In addtion to the elderly persons themselves, cost-sharing might more actively include today's younger working population, which is already becoming more cognizant of the importance of investing a part of their current income in protecting themselves against future risks of catastrophic medical treatment and may be willing to insure themselves against the risk of long-term care at home and in institutions.

Table 3. Labor Force Participation Rates in Selected Countries, by Sex and Age Group, 1965 and 1985

	Males						Females					
	55-64			65+			55-64			65+		
Country	1965	1985	Change	1965	1985	Change	1965	1985	Change	1965	1985	Change
United States	82.9	59.7	-23.2	26.6	10.3	-16.3	40.3	41.7	1.4	9.4	6.8	-2.6
Canada	86.4	70.2	-16.2	26.3	12.3	-14.0	27.0	33.8	6.8	6.0	4.2	-1.8
Japan	86.7	83.0	-3.7	56.3	37.0	-19.3	45.3	45.3	0.0	21.6	15.5	-6.1
France	76.0	50.1	-25.9	28.3	5.3	-23.0	36.9	31.0	-5.9	11.5	2.2	-9.3
Germany	84.6	57.5	-27.1	24.0	5.2	-18.8	30.2	23.9	-6.3	7.8	2.5	-5.3
Great Britain	92.7	66.4	-26.3	23.7	7.6	-16.1	35.6	34.1	-1.5	6.5	3.2	-3.3
Italy*	54.8	38.2	-16.6	18.4	8.9	- 9.5	14.3	10.5	-3.8	4.7	2.1	-2.6
Sweden	88.3	76.0	-12.3	37.7	11.0	-26.7	39.2	59.9	20.7	11.6	3.2	-8.4
Israel**	84.6	82.4	-2.2	35.4	27.9	- 7.5	17.9	26.0	8.1	6.1	6.6	0.5
Finland	81.5	57.8	-23.7	18.0	10.6	- 7.4	54.9	52.9	-2.0	3.8	4.8	1.0
Netherlands***	80.3	53.8	-27.0	11.4	4.0	- 7.4	14.9	14.5	-0.4	2.3	0.7	-1.6
Spain	84.2	66.3	-17.9	25.9	5.9	-20.0	22.0	20.0	-2.0	7.7	2.1	-5.6

* 60-64 age group was used for Italy.

** For 1960 and 1980 respectively

*** Netherlands data is for 1970 instead of 1965.

Source. OECD, *Aging Populations — The Social Policy Implications*, 1988.

Additional alternantive policy measures which have been put forth in the literature and should be further discussed include:

- restructuring of social expenditures in response to demographic shifts and changing patterns of need, i.e., a diversion of resources from programs serving the young to those serving the elderly;
- reducing the size of populations eligible for social security benefits (e.g., raising retirement age);
- encouraging growth in productivity of the working population;
- increasing labour force participation for some groups, such as women and the elderly themselves;
- moderation of replacement rates of the benefit while raising real earning levels;
- defining strict eligibility criteria to provide services and benefits only to specifically targeted groups.
- determining a greater role for the private sector in complementing social security schemes in some countries in order to relieve some of the pressures on basic public programs;
- examining possibilities of extending the tax base to include some segments of the elderly population, without harming low-income groups.
- and finally, biases toward high-cost institutional care could be balanced by community-based programs of housing and personal care.

I would like to make a few comments on home care and community care as opposed to institutional care. A cross-national study by ISSA in 1986 pointed out clearly that factors other than extrapolated population data are responsible for institutional rates and should be considered in forecasting the number of required beds. Most industrialized countries perceive their rate of institutionalization as higher than necessary or desirable. Most are currently pursuing deliberate policies to expand home and community-based long-term care services. Whether there is in fact a trade-off between the two sectors, and whether home care is less expensive than institutional care, is still a subject of controversy, although several studies in Israel seem to support this view at least for the less severely dependent. At present, Israel's Brookdale Institute together with the National Insurance Institute is conducting a study examining the effect of our community Long-Term Care program on the rates and patterns of institutionalization. Still, based on the axiom that if there is a bed available, whether in a long-term care ward or an acute hospital bed, it will be filled, it might be argued that reducing institutionalized rates, enabling the deferral of entering a nursing home, is actually a question of policy in controlling the supply of beds, and not only of providing home care.

Only if a decision is made to put severe limits on the number of beds will there be a significant reduction in institutionalization, and for this reason, if the social policy goal is to reduce institutionallzation, long-term planning for building and expanding institutions should not be based on current utilization rates and population growth.

The emphasis might be both on keeping a limit on beds, and at the same time providing an alternative to institutionalization in the community, even for a short period. Long-Term Care Insurance in Israel has at least expanded community options, making it possible to suggest defering institutionalization by offering services at home to those on waiting lists, so that the transition from home to institution is becoming a more flexible one.

Long-Term Care Insurance in Israel should be viewed as a logical continuation and expansion of social policy for the aged under social insurance. Whereas for the past 15–20 years comprehensive measures for income maintenance for the elderly have been developed and refined, this next step in social policy reflects a shift in focus toward a statutory allocation of resources for the functionally dependent elderly, within a social insurance entitlement program.

In effect, the primary aim of the law is to formally define the State's statutory obligation to provide a basic level of long-term care services to the seriously disabled among the elderly, on the basis of personal entitlement and clearly defined eligibility criteria, thus meeting individual needs of the eligible elderly and enhancing the family's role as a primary caregiver.

Long-Term Care Insurance is innovative not because it provides services to the elderly but because it is part of Israel's social security system and operates according to insurance principles, paid for by contributions from the working population. The aim of the law is to enable dependent persons to remain at home for as long as possible, and to support family caregivers by providing services. The emphasis is on providing home and community services, not institutional care. Under the law, an individual is eligible for services only if he or she does not reside in a nursing home. However, it should be emphasized that the role of the law is not to replace family functions and responsibilities. The family continues to have primary responsibility for the care and welfare of the individual, since as alreasy mentioned, the benefit covers only part of the basic costs incurred in caring.

Another basic principle is the continued expansion of the network of available services and manpower, through the benefits themselves, and by allocating special funds for service development in the community and institutions. In fact, one of the important achievements of Long-Term Care Insurance has been the rapid increase in services over the past year, in response to a tripling in the number of elderly persons eligible for and receiving home care.

Israel has developed an interesting mix of centralized and decentralized functions in implementation of Long-Term Care Insurance. There is a clear division between assessment for eligibility on the one hand, and service provision on the other. Service provision and case coordination are decentralized functions, while eligibility determination and regulation based on uniform guidelines and instruments, are centralized responsibilities of the National Insurance Institute, so as to assure maximum equity under law and, it should be emphasized, maximum control over targeting and costs. This measure of centralized control over who will be eligible, the size of the eligible population, and the corresponding cost of the program is an essential, innovative element of Long-Term Care Insurance.

On the other hand, decentralization in service provision is based on the important principle that on the most basic level the family is an active partner, together with local social workers and nurses, in determining what kinds of services the elderly person most requires and when to provide these services, and plays an active role in coordinating services. This in fact reflects an approach not of external intervention in individual choice and prerogative but the development of a model in which family needs and choices are respected and in fact are major determinants in the provision of services.

Following is an elaboration of some of these principles and provisions of Long-Term Care Insurance.

1. Who is eligible under this Law? Men over age 65 and women over age 60 who are severely functionally disabled in their activities of daily living or require constant attendance because they are in danger of harming themselves or their environment, are eligible for services. Eligibility level is defined primarily on the basis of funcional dependency, i.e., the degree to which the individual is dependent on the help of others in basic daily functions including mobility in the home, eating, dressing, washing, continence control, and the need for personal attendance or supervision.

There are two levels of eligibility, according to the degree of dependency, as assessed by a public health nurse from the Ministry of Health, who uses a uniform, objective assessment instrument for measuring ADL. Each person receives a score based on a home visit. Under certain conditions, additional points are awarded to persons living alone and to those requiring constant personal attendance.

2. As mentioned, the benefit is intended for elderly living at home, in the community. Thus, only persons living outside of nursing homes and nursing wards may apply for a benefit. However, persons residing in sheltered

housing or old-age homes that are not publicly financed may also apply. For those elderly receiving a benefit while living at home, once a decision has been reached that they have to enter a nursing home, the benefit will be halted upon institutionalization.

3. Eligibility for benefits is income-tested, based on income of the elderly person and his spouse. The income test is quite liberal. Data for 1988 shows that very few applicants were ineligible due to income levels.

4. As mentioned earlier, benefits provide only a basic level of care. The lower benefit level can be used to provide 11–12 hours per week of personal care and the higher one provides up to 17–18 hours per week. The emphasis is on in-kind services, not cash benefits. Only in specifically-defined instances where services are unavailable, and the eligible person is being cared for by a relative living with him or her, is it possible to receive a cash benefit, until services become available.

5. The kinds of services which can be provided under Long-Term Care Insurance are defined in a proscribed basket of services, and include personal assistance in the home or in organized community facilities (such as day care centers), home help (with basic household chores), personal attendance, laundry, meal preparation and delivery, and supply of absorbent undergarments for the incontinent. Medical, paramedical and social support services, such as home nursing and physiotherapy, are not covered under Long-Term Care Insurance, and continue to remain the sole responsibility of health and welfare bodies.

6. The National Insurance Institute has overall responsibility for the law's operation and its monitoring. However, there is a sharing of reponsibility in implementation between branches of the National Insurance Institute, the Ministry of Health, the Ministry of Social Affairs and the General Sick Fund. Local and professional committees, which are defined by law, have the responsibility for determining care plans, providing services, monitoring changes and reporting.

These local committees are staffed by a senior social worker from the municipal authority welfare department, a nurse from the sick fund and a clerk from the National Insurance Institute.

As mentioned, this arrangement decentralizes the most important professional functions at the level of case management and service provision, recognizing that these are best understood and dealt with at the local professional level by social workers and nurses who represent the responsible welfare and health agencies.

In addition to stipulating which services will be provided, the care plan developed by the local committee indicates which agencies will provide services. The program operates strictly on a sub-contracting basis, raising important requirements of licensing, monitoring, quality assurance and control. Only certified agencies, private and non-profit, having legal status and approved by the Ministry of Labour and Social Affairs can be contracted with to provide services. Benefits cannot be transferred to private persons providing care.

The emphasis, then, is on the words eligibility and services, a combination which does not exist in other countries in the same way as in Israel. That means a combination of a largely universal approach in determining eligibility with a differential approach in service provision according to individual and family requirements.

An important contribution to Long-Term Care Insurance in Israel is that it brought to public debate and resolution, in the form of legislation, many issues that had previously remained solely in the province of professional literature — substitution issues regarding the role of the family in providing care and dangers of over-dependency on public programs; links between informal care provision and formal service structures; public incentives for community versus institutional care; cash versus in-kind benefits; centralization versus decentralization in implementation; roles of private and public agencies in service development and provision; and, in Israel, the drawbacks, benefits and cost considerations of a social insurance-entitlement program, versus existing public programs based on general revenues utilizing selective and discretionary modes of resource allocatiion. Some of these issues have now been resolved in the law; others are still being debated upon.

Long-Term Care Insurance has already had a major impact on the system of Long-Term Care in Israel. To a great extent, the success of Long-Term Care Insurance in meeting social goals and needs depends on the degree of coordination and cooperation between the various agencies and organizations. There are already some indications that benefits do not constitute a separate system but are slowly becoming an intergral part of an improved program, with potential for even greater coordination between Long-Term Care Insurance and other frameworks.

Through the local professional committees we have in fact created a unique opportunity for reducing fragmentation and improving inter-agency cooperation, which it is hoped will enable a more comprehensive approach to the assessment and care of the elderly, in a model of case management, or coordination, we have developed as a result of this law throughout the country including urban and rural areas.

If utilized properly, the local committees have the potential in the future of becoming a single-entry point into the system of care and services for the elderly, which would provide assessment and referral for other required services and, perhaps at some later stage, for initial screening for institutionalization, thereby assuring a continuum of care, more rational resources utilization, as well as reducing the often formidable and insurmountable burden of turning from organization to organization for an already overburdened and exhausted population.

Moreover, the very fact that Long-Term Care Insurance is an insurance based, statutory program, has introduced a large measure of uniformity in tools and procedures for assessment which have become widely accepted by professionals in other related areas, in a greatly expanded network of home visits by social workers and nurses, uniformity in determining treatment plans, in the cerfitication and contracting with private service agencies, and in working within limited periods and deadlines. Because of Long-Term Care Insurance, today dependent elderly who in the past may have had little contact with professionals are being visited at home on a regular basis by local professionals.

A year after its inception, we have already tripled our coverage and almost 5% of the elderly population will be receiving services, when we complete processing all the expected applications. If we add to this the 4.5% of the elderly population in institutions, it is safe to say that Israel is approaching an acceptable level of coverage of long-term care needs, and provides, through Long-Term Care Insurance, a viable option for care in the community.

Of course a program of this type, especially during this period of transition from one system to another, has its problems, and sometimes we have more questions than answers. Because it is a statutory program, covering only a basic level of needs, there are elderly persons who require more hours of care than is provided. The danger of cutbacks in other sources of revenue and essential services for the elderly still exists and must be prevented. Moreover, because of the huge administrative and professional efforts expanded on absorbing and processing the large numbers of applications — about 8% of our potentially eligible elderly populaltion has applied over the past year — there may be a tendency to neglect other necessary services, and other populations of elderly people having different needs. We do not know, for example, what is happening to those who are ineligible for Long-Term Care Insurance but who do require supportive services, or to those who require the immediate response of short-term post-hospital care at home. This has traditionally been and should continue to be the responsibility of our sick funds. It is thus important to make certain that other responsible public organizations do not relinquish their responsibility for providing health, home care, housing, physiotherapy and social support services for the elderly groups on a selective basis, and that they do not cut back their budgets, but rather reallign their programs to complement Long-Term Care Insurance.

One of the law's major achievements, belying much of the scepticism that existed prior to implementation that there would be sufficient services, is that there has been a geometric growth in services and in manpower. Whereas prior to the enactment of the law it was predicted that a sizeable proportion of the elderly populaltion would receive cash benefits due to our inability to provide services, today only 150 out of some 17,000 recipients receive a cash benefit. Services have developed sufficiently to provide care even to the large number of eligible people in our age-concentrated urban areas.

As part of this growth in services, since the inception of Long-Term Care Insurance the number of private, for-profit agencies has mushroomed. It is clear that an immediate major concern for the National Insurance Institute will be that of quality assurance: the development of a program to closely monitor the operation of private as well as non-profit agencies, to assure the quality of care provided, the efficient use of funds for services, in short — to ascertain that agencies are providing services in accordance with the decisions of the local committees, via competent home care attendants, in terms of both hours and quality of care.

The most significant impact of Long-Term Care Insurance is the creation of a basic change in the attention paid to what was until now an overly neglected population. The dependent elderly are being given the weight they deserve and require in terms of social programs, resource allocation and professional involvement, and this is the real implication and benefit of incorporating a program of this type under social insurance.

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THE CONTRUBUTION OF THE LONG-TERM CARE INSURANCE LAW TO THE WELFARE OF THE SEVERELY DEPENDENT ELDERLY

by Bracha Ben-Zvi*

Introduction: The Background to the Long-Term Care Insurance Law

The Long-Term Care Insurance Law did not come to life on virgin soil. For many years, health and welfare institutions in Israel have been providing long-term care services to homebound patients — not by force of legislation, but rather in accordance with administrative directives provided to meet the needs of the homebound, and their families.

The Department of Services for the Aged (DSA) of the Ministry of Labour and Social Affairs, which operates through the Social Services Bureau and which constitutes an address for populations in distress has developed a wide range of services aimed at meeting the needs of the elderly. The fields of intervention and assistance offered are many and varied: counselling and other in-kind services dealing with interpersonal relationships within the family, with problems due to loneliness, due to poverty and due to lack of basic equipment, and counselling in coping with illness and being bedridden.

The DSA also developed community projects, such as day centers, clubs, etc., to solve group problems. In a number of settlements, master plans for services for the elderly were formulated, with special attention devoted to the disabled population. Despite the wide range of professional interventions a relatively small sector of the population received personal care and home help services, since budgetary constraints made the passing of stirct income tests a condition for such assistance. Until April 1986, only 1,315 elderly and their families received long-term care services. One of the striking characteristics of these services is the stigma that was attached to them, namely, that they were services for the poor; thus many persons refrained from applying for them. Furthermore, the provision of services was not

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anchored in legislation, a fact that also deterred, since they thus constituted a kind of "charity", rather than an acquired right. The lack of legislation produced a lack of standardization which increased the discretionary power of each social worker, and a great deal of flexibility was possible in determining eligibility, which services to provide and mode of payment. Some elderly persons acquired long-term care services from Matav, a non-profit organization. Other elderly persons were given money to pay for caregivers, and in many other instances, the local authority transferred payment directly to private caregivers who were recruited by the social workers.

An additional framework through which long-term care services were provided before March 1986, was that of the district Ministry of Health. The focus of this Ministry is long-term institutionalization but they found it impossible to ignore the plight of the homebound elderly or the endless waiting lists for long-term care. Thus the Ministry of Health provided personal care services to 1,000 severely dependent patients at home. Since the Ministry of Health specializes in long-term hospitalization and institutionalization it could be assumed that the personal care services were provided to particularly needy patients where the medical distress would be the dominant one. However, due to budgetary constraints, the assistance that was given was conditional upon passing stringent income tests. Eventually the Ministry of Health decided to transfer the care of this population, including the supply of long-term care services, to the General Sick Fund, while taking upon itself the funding of this service.

The third framework offering long-term care services before March 1986 was the sick funds, particularly the General Sick Fund (Kupat Holim Clalit). This Sick Fund repeatedly emphasized that its regulations do not oblige it to grant long-term care services at home to its insurees, but that it took this task upon itself in face of the rapid aging of the population and the high number of homeridden patients, with the ensuing heavy burden imposed on both family and community. About 2,700 patients received long-term care services from the General Sick Fund, which developed a professional organizational mechanism consisting of a number of Extended Care Units for dealing with this population. These units were supported by a network of health clinics spread throughout the country, which provided and continue to provide home visits of nurses to the homes of patients, making medical acquaintance with them, counselling, follow-up and supervision over their health. The modes of assistance provided by the General Sick Fund to patients were divided into two: first, ordering the needed service from Matav, at its expense; secondly, and more commonly, direct payment to the families for services according to the family's choice, at presentation of receipts.

Long-Term Care Insurance, as a chapter in the National Insurance Law, began in 1980 as a framework law. Since that year, deductions were detracted from the insuree's personal income for long-term care at the rate of 0.2% of their income.

In April 1986, after lengthy debates on professional and other issues, the Long-Term Care Insurance Act was passed in the Knesset, to be implemented in two stages. The first stage was carried out in April 1986, and the second in April 1988. In the first stage, 3 million NIS per year (in March 1986 prices) were set aside for each one of the two Ministries: Labour and Social Affairs, and Health. These sums were to be spent on expanding the scope of assistance customary in those ministries[1]. These resources did indeed expand the scope of the population receiving personal care and home help services, so that by the time of the law's final implementation, on April 1, 1988, 7,300 severely dependent elderly had received services, as follows:

Scope of Recipients of Personal Care and Home Help Before the Law's Implementation

Provider of Services	Until March 1986	Until March 1988
Ministry of Labour and Social Affairs	1,315	2,000
Ministry of Health	1,000	—
General Kupat Holim	2,700	5,300
Total	5,015	7,300
Total Expenses in dollars	$5.5 million	$9.5 million

Guiding Principles in Planning the Implementation of the Long-Term Care Insurance Act[2]

The principles listed below provide the guidlines in planning the law's implementation:

(1) The Long-Term Care Insurance Act has a community orientation. Its aim is to assist elderly persons living with their families within the community, and it does not aim to assist those elderly who reside in nursing homes.

(2) Since its intention was to add financial resources to existing systems of

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[1] Additional sums were allotted from the law's funds to increase the number of persons hospitalized in institutions and to develop services in the community. These aspects will not be dealt with in the present article.

[2] From express stipulations in the law as well as from the intent of the legislator.

assistance for the severely dependent patients in the community, the law sought to integrate with the existing organizational infrastructure and of current services. In other words, the new benefits would be a link in the chain of the already existing infrastructure on behalf of the severely dependent elderly.

(3) The benefit is meant for those elderly who are largely dependent on the help of others for the performance of most everyday tasks, or those who are completely dependent on the help of others. It is not meant for elderly persons who have a mild functional limitation or whose dependence on the help of others is not great.

(4) The long-term care benefit is limited to two levels of assistance, determined according to the severity of the situation and the extent of dependence on others. It is not meant to fully cover expenses arising from the elderly person's need for long-term care services. The principle here is that the law should provide a moderate degree of aid to a larger number of elderly persons, rather than providing comprehensive assistance to a more limited number.

(5) The long-term care benefit is not intended to replace the assistance given the severely dependent elderly by his family. Moreover, the modest rate of the benefit testifies to its reliance on the contribution of primary caregivers of the severely dependent elderly in their homes. The services given by family members to the elderly are accepted as self evident obligations, and there is no payment or other compensation made to the family for these services.

(6) The benefit is meant to help the family in its daily confrontation with difficulties, in order to postpone, or even prevent the breaking point — i.e., the stage at which the family tends to send the elderly person from his home, to a nursing ward or institution.

(7) Since the benefit's purpose is to lighten the burden of care imposed on families, by its very nature it takes on itself some of the family's tasks in the basic, daily, un-professional care of the elderly. The intention is not that the benefit replace professional services — provided by the health and welfare authorities — such as physiotherapy, occupational therapy and psychosocial counselling. Rather, the benefit is meant to partially take over those tasks shouldered by the family in its daily care, such as washing, dressing, feeding, mobility in the home and supervision.

(8) The law determines a preference for in-kind benefits, i.e., the granting of services directly to the elderly person, such as personal care and home help; only when these services are not available in the community may the benefit be exchanged for a cash benefit. The concept behind the principle is that direct assistance to the family in carrying out its difficult tasks guarantees the supply of care services to the elderly person, whereas a cash

benefit is liable to be absorbed in the family budget and would not necessarily be spent on services as intended by the law.

(9) Since the benefit is meant to finance services according to the above principles, it entails an obligation to adapt these services to each family's particular needs: available energies and resources, lifestyle and preferences. Thus a flexible service "package" was determined by the law, which includes personal care, assistance in housework, supervision, day centers offering long-term care services, disposal materials for the incontinent, laundry services and prepared meals. The final treatment program for each individual is formulated from different components of the package tailored to each person after consultation with his family.

(10) As the law is insurance-based, the benefit is guaranteed to all those who are found to be eligible according to uniform rules laid down by law and regulations. The National Insurance Institute is charged with the responsibility of examining eligibility by means of a structured and — as far as possible — an objective dependency test.

(11) According to the law, the local professional committee is responsible for determining the treatment program and making sure it is implemented. The committee is composed of a social worker from the local welfare bureau, a nurse representing the local health services and a claims officer from the local branch of the National Insurance Institute.

(12) Entitlement to long-term care benefit is conditional on passing an income test. The setting of such a condition is not in line with the principles of a social insurance law, and it constitutes a deviation from the National Insurance Institute's usual policy but was necessary due to budgetary restrictions. In practice, few claims were rejected due to high income; Perhapes this is due to the relatively low rate of elderly persons among the high-income population, or perhaps this is due to a broad information campaign conducted by the National Insurance Institute — emphasizing income limitations among other points. For whichever reason, high-income elderly have refrained from applying for the benefit.

(13) An additional principle anchored in the law is the right to appeal one's deferral or to appeal the final treatment "package" offered. The decision on one's eligibility can be appealed to Labour Court, and the client can recieve legal counselling at the National Insurance Institute's expense. As to the content of the care "package" and its implementation, the elderly person or his representative may apply to an appeals committee set up especially for Long-Term Care Insurance. These committees are composed of nurses with professional experience in old-age, health and rehabilitation and senior officials from the National Insurance Institute. Moreover, the elderly client is entitled to appeal the decision of the appeals committee before the Labour Court.

Lessons and Conclusions After the First Year of Implementation

In this chapter I will review the contribution of the Long-Term Care Insurance Law as evident at the close of the first year of its implementation.

(1) Scope of Activity[3]

Number of claimants of long-term care benefit	35,565
Dependency tests in person's home	34,420
Eligible applicants	17,893
Deceased	2,284
Recipeints of in-kind services	14,911
Requests of cash benefit, because of unavailability of services (temporarily)	152
Rejected on basis of dependency tests	12,728
Refusal to receive services	630
Anticipated cost of long-term care allowances	$62.2 million

The number of elderly persons receiving assistance has grown considerably since the passing of the Act. On the basis of, as yet, incomplete data, the impression is that the number of those low-income severely dependent elderly previously unknown and who thus did not "benefit" from services, is very high, and there is no doubt that the application to the National Insurance Institute, which lacks a stigma and grants a legal insurance right, made it easier for them to claim assistance. Moreover, the rate of deferrals due to high income is lower than expected according to the income distributions of the elderly. The connection between income level, functional level and patterns of application for benefit still needs investigation and thorough examination in the course of time.

It seems clear that the large number of persons who have benefited from the program within such a short span of time is an indicator of the stress under which the clients and their families had been living before the implementation of the law. There is thus no doubt as to the immense contribution of the law in filling the gap that previously existed.

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[3] The Law came into effect on April 1, 1988. The data are not yet stable, and they reflect the situation as it was in March 1989. Moreover, the dynamics of the situation should be taken into account, so that at any point of time, there are those in the midst of carrying out dependency tests and those in the process of preparing a care plan.

(2) Standardization of Application Procedures and Service Delivery

(a) Determining Eligibility. Since the implementation of the law, elderly persons and their families, or authorized representatives apply to one address: the National Insurance Institute, by means of its 17 local branches. The Institute has sole responsibility in determining eligibility. On receiving the application the claims officers verify the information, and arrange for home visits by public health nurses, employees of the Ministry of Health who were trained especially to carry out dependency tests in the elderly persons' homes. The results of these tests are sent back to the claims officers, who decide on the basis of the results and in accordance with uniform rules, if the applicants are eligible for assistance.

(b) Uniform Dependency Tests. In keeping with the principle of equality before the law, a dependency test was formulated for examining the applicant's level of functioning. All the agencies which had provided long-term care services prior to the enactment of the law were involved in the formulation of this dependency test. It appeared that every agency had its own methods of diagnosis, creating great variety in the evaluation of the extent of the patients' dependence as well as many professional "languages" among the various agencies caring for severely dependent patients.

After examining all the methods being used prior to the enactemnt of the law, and after reviewing the professional literature on the subject, all the agencies decided to adopt the ADL (activities of daily living) test, which was in use in the General Disability Branch of the National Insurance Institute, and which had proved most reliable. The dependency test according to this method is structured, and based on a system of points for the various daily activities carried out in the home of the elderly person.

Today, a year after the law's implementation, when most of the elderly persons who received long-term care services under previous frameworks passed the dependency test, and many others applied and were found entitled to benefit, one may note a striking achievement of the law: all the elderly persons are tested according to the same criteria. All professionals are speaking in the same language. The definition of the severely disabled patient entitled to long-term care services has become a norm anchored in clear, well-known regulations. The determination of entitlement (or non-entitlement) is carried out in a uniform and equal manner for all and according to the same yardsticks.

All the relevant agencies have adopted the method as the best one existing *at the present stage.*

On the other hand, there is still room for improvement. There is no doubt that the large quantity of dependency tests carried out and the tight timetable dictated by the law detracts somewhat from the quality.

Furthermore, there remains the complex problem of how to ascertain when there is need for constant supervision of the elderly person in order to prevent him from injuring himself or others. It appears that this problem is both complex and complicated, and there are presently no adequate tests concerning the issue of supervision. The test in use now does not fully meet our standards, and we are working to improve it. The National Insurance Institute has commissioned a research study which will hopefully contribute towards a greater understanding in the course of the second year of the law's implementation.

(c) Planning of the Care Package. The care package is formulated by a local professional committee composed of a social worker from the local Social and Community Services Bureau, a regional nurse from the General Sick Fund, and a claims officer from the National Insurance Institute. This local professional committee ensures that all the agencies involved in the care of the severely dependent elderly at the local level work together. The committee sends a social worker or nurse, according to need, to make a home visit, to analyze the family's situation for the purpose of formulating a care plan.

The program is formulated entirely in consultation with the family. The local professional committee orders services from public or private agencies which employ caregivers and which are authorized to provide services after meeting a number of requirements, such as the employment of a social worker or nurse to supervise the actual provision of the services. The service provider issues a report signed by the elderly person and/or his family — on the implementation of the service, and presents it to the local professional committee, which passes it on to the local National Insurance branch for direct payment. This uniform procedure ensures a certain degree of control over service implementation, something which was not possible previously. Two hundred local professional committees are active throughout the country (in every local authority) and they are guided in their work by uniform and equal work regulations.

There are a number of partners to the formulation of the care plan, the division of tasks among them being clearly defined in a pamphlet of guidelines. Among other things, a professional worker is designated for every elderly person and his family to be responsible for them and to follow up on the care provided them. For cases in which the problem is primarily medical, a nurse will be designated as the responsible worker. In other cases, in which the problem is a family one, a social worker will be designated as the responsible worker.

It should be noted that this idea existed before the implementation of the law as well, and interdisciplinary teams, or "junctions" as they were called, worked together in determining procedures of care, but such teams operated in a small number of settlements only, and did not have a uniform composition. The Long-Term Care Insurance Law's express determination of local professional committees, the absolute authority in making decisions regarding the execution of all long-term care services, gave a boost to the "junction" idea and created a uniform, obligatory norm throughout the country of welcome partnership, with its many varied advantages for the elderly person.

Furthermore, the fact that the committee members are employees of the Social Services Bureaus, Sick Fund Clinics and National Insurance Local Branches, ensure that the client will be able to receive a wide range of services in addition to long-term care services. For example: the use of medical services from the clinic; social care, supplies or other assistance from the social services bureau; clarification of other benefits from the National Insurance Institute for which the client is eligible. In this way the elderly homebound population gains access to a wider range of services than that to which it was exposed in the past. It should be further noted that in preparation for the law's implementation, an ambitious two-day training program was carried out for all 600 committee members throughout the country. This training opened an era of unprecedented and continuing cooperation.

(d) Timetable. The law defined a two-month obligatory timetable for the implementation of long-term care services. Any delay beyond this two-month period entitles the family to a temporary cash allowance until the services are provided. One may satisfactorily state that all those involved in the law's implementation — social workers, nurses, and claims officers alike — were very much aware of the importance of their task, and rose to the challenge of making it a success. The large number of recipients of in-kind services, as opposed to those receiving a cash benefit, bear testimony to the great efforts invested and to the establishment of a norm of adherence to deadlines.

(e) The Services "Package". Since the Long-Term Care Insurance Law grants in-kind services, it was clear to the legislators that these services had to be adaptable to a broad spectrum of families' life-styles, customs, living conditions, etc. Together with flexibility, it was necessary to guarantee the specific aims of the benefit as well and to prevent the possibility of using the benefit for purposes — important as they may be — not in line with the obligations of the Ministries concerned. Therefore all the agencies involved prepared a defined basket of services, *not* intended to replace any budgetary deficit in existing para-medical or psychosocial services. It is clear, for example, that physiotherapy, speech therapy and similar services must be funded from the resources of the medical services, and that counselling on problems of interpersonal relationships, poverty and distress must be funded from the resources of the welfare services. Nurses and social workers who are

members of the local professional committee serve as links in the provision of services from health clinics and from social services bureaus, respectively. Thus the operation of the new basket of services constituted an additional volume of auxiliary services directly to the family, at a very impressive scope.

(f) Service Providers — Agencies Employing Caregivers. Prior to the implementation of the law, the Matav organization employed about 1,000 caregivers. In addition, a small number of organizations for the elderly offered local, partial solutions. It was clear to the planners of the law's implementation that these would not suffice for the expected growth in demand for long-term care services. The option of direct employment of caregivers by the National Insurance Insitute or by other state agencies was examined and found to be non-applicable, due to the creation of employer-employee relationships which would have greatly expanded the scope of civil service manpower. Various methods of employing caregivers which had been in use in the social service bureaus and sick funds did not allow for supervision, and were found in the final analysis to obligate employer-employee relationships as well. Direct payments to the families so that they may acquire services were not possible in the framework of the law; would they have been possible, they would have turned the law into one that grants cash benefits rather than in-kind services.

It was thus decided to employ caregivers through companies only, whether non-profit organizations such as Matav, or private companies. Uniform prices were set in order to guarantee an equal scope of services for all and to prevent bargaining and manipulation.

It turned out that the free market met the challenge, and since the day that the law came into effect, forty-one public corporations, recognized as service-providers, have been in operation, in addition to seventy business and profit companies, also recognized as such.

A set procedure was established to ensure the provision of services at a reasonable professional level. According to this procedure, every company is checked by the executive of the Department of Services for the Aged which authorizes its qualification. Equipped with this authorization, the company signs a contract with the National Insurance Institute.

The conditions which the service-providers are expected to meet were formulated by all agencies involved and include: the employment of a social worker or nurse for regular counselling and supervision of the caregivers referred to families, insurance of the caregivers, payment in accordance with the minimum wage law, providing a substitute when the caregiver is on vacation or ill, payment of vacation pay, sick pay and compensation to the caregivers when required by law, ensuring the health of the caregivers and their suitability to the job, non-employment of caregivers having a criminal past, and other such conditions as formulated in the contract.

Every local professional committee is equipped with a list of authorized "service providers", and the committee is responsible for their ongoing supervision. Thus, social workers and nurses have now at their disposal information on a wide variety of organized service-providers, constituting a quickly and easily available address for applications, as well as an unprecedented auxilliary resource of caregivers. Perhaps in certain specific cases the possibility of specialized differential service is diminished, but on the whole one should be aware of the risks inherent in employing thousands of caregivers using many different styles.

In sum, the social workers and nurses were spared the burden of searching for and locating of local caregivers, bargaining with them, and the many complications and risks involved in all kinds of manipulations. Social workers and nurses could divert the energies freed from this burden to their professional tasks — the preparation of a treatment plan and the guidance, counselling and supervision connected with the provision of the services.

(3) The Increased Attention Given to the Severely Dependent Elderly

An additional contribution of the law is the many home visits to the elderly and the resultant attention given them.

Public health nurses employed by the Ministry of Health conduct home visits at the home of every elderly applicant in order to carry out the dependency test, lasting 2-3 hours. In many cases, the nurses identify difficult situations requiring quick intervention, and they of course act accordingly.

Social workers employed by the local welfare bureau and nurses from the Sick Fund visit the elderly person at home in order to examine the forces available in the family, its requests and the adaptation of a care plan; furthermore, they constitute an additional link for the operation of other services from the welfare bureau and clinics. A social worker or nurse, whoever is determined as the worker responsible for the particular family, regularly visits the elderly person at home and watches the changing situation.

The "service providers" — who bring in the caregivers as well as the professional worker, as required, to guide and supervise the caregivers — also visit the elderly person at home.

All these home visits have additional value in that they pay attention to a population of thousands of elderly persons, who for the most part were not granted such attention previously.

(4) The Expansion of the Population Under Care, and Its Influence on Social Workers and on the Social Services Bureaus

From informal talks with social workers, one gains the impression that they feel much satisfaction that this previously unknown population, most of which living in great distress, was discovered. Their satisfaction is even greater since they now have the resources to provide the clients with long-term care services.

It also appears that the social service bureaus have gained in the sense that they now offer a universal service and thus rid themselves to some extent of the stamp of being services for the poor only. Moreover, there is no doubt that thanks to the Long-Term Care Insurance Law, the elderly themselves are granted a higher priority in their social services bureau, which they certainly merit due to their large scope and many needs.

(5) Volunteers

The law stimulated ramified activity among the various volunteers' organizations. At this stage one may note the Counselling for the Aged and Pensioner Service, operating in the framework of the National Insurance Institute, which is one of the largest organizations of its kind in Israel, having close to 3,000 volunteers, all of whom are pensioners and older persons having a special sensitivity to the field of operation of a law such as the one under discussion. In a recent survey of one thousand home visits of severely dependent elderly receiving long-term care services under the law, a first objective survey was recorded. It was found that 800 elderly persons expressed satisfaction with the services, others were less satisfied and a few were found to have certain problems. The volunteers were very active in intervening to improve and to remedy mishaps. Systematic activity is planned in future with volunteers conducting friendly home visits at the homes of severely dependent elderly, and the possibility is being examined of utilizing these visits for purposes of control.

(6) Cooperation between the National Insurance Institute, the Ministry of Labour and Social Affairs, the Ministry of Health and the General Sick Fund

The National Insurance Institute, the Ministry of Labour and Social Affairs, the Ministry of Health and the General Sick Fund joined forces in the process of planning and implementing this law. There are few examples of such successful interagency cooperation as came to the fore in the operation of the Long-Term-Care Insurance Law.

Staff members of the above mentioned Ministries, who worked hard in the preparation of the law and in its implementation, as well as members of the local committees who represent various different sectors, rose and continue to rise above sectoral differences and narrow professional interests, and are imbued with a sense of mission and dedication to the success of the law for the sake of the population in need.

The participating bodies, represented by senior staff members, continue to serve as an accompanying work group. As they incorporate all the professional, health, social and legal bodies, they are in the position of having a comprehensive overview of needs, which contributes to the general development of care in the field, for the benefit of the elderly person and his family. The information and accumulated experience gathered are immediately passed on from one body to the other, are discussed together and translated into uniform guidelines for the local professional committees. At the agreement of all partners, written instructions are transferred to the local professional committees and to the service providers, from a single address: The National Insurance Institute. This procedure prevents varying interpretations, misunderstandings, frictions and contradictions, and allows for a uniform and equal implementation of the law, insofar as possible, throughout the country.

Issues for Thought and Discussion

Long-Term Care Insurance adds an important new tier to the social security structure in Israel, implemented by the National Insurance Institute. There is no doubt that the severely dependent elderly and their families constitute a population in distress, and that the assistance rendered them, modest as it may be, is a sign of distinction for the Israeli society which, despite economic difficulties, has placed them high on the social scale of priorities.

From the perspective of the first year of implementation, it appears that the contribution of the law as described above testifies to impressive achievements in advancing the welfare of severely dependent elderly and their families. At the same time, questions have arisen which should be thoroughly examined, in order to remedy mistakes and improve the continued implementation of the law in the future.

1. The Rapid Growth of Private Long-Term Care Services (Privatization)

In view of the rapid growth of new companies in the private market of long-term care service suppliers, the following question inevitably arises: why is this "business" so worthwhile for entrepreneurs? Who profits most and on whose account are these profits made? What impact does the growth of this market have on the professional establishment — on the social workers in the social service bureaux, on the nurses in the sick funds, and on the National Insurance Institute? What is its impact on state social policy? As mentioned, an accompanying research is being conducted, which will hopefully add to our understanding of the social and economic implications of this development.

2. *The Cost of In-Kind Services*

In-kind services are carried out be caregivers, whose work naturally entails heavy costs. Needless to say, these costs are covered by the benefits aimed at the severely dependent elderly. The discussions which preceded the enactment of the law were accompanied by stormy arguments as to in-kind services as opposed to cash benefits, each side bringing to the discussion strong reasons of its own.

As is known, the final decision was to grant in-kind services, despite the doubts existing at the time as to the availability of services at the required scope. During the course of the law's implementation, the rapid growth and availability of services at the required scope surprised all concerned, yet the administrative cost of supplying these services has been quite heavy. Many questions arise in connection with this cost, and constant examination is required, either to prove the rightness of the course chosen or otherwise. One must take into account the consideration that people tend to prefer cash benefits over in-kind benefits. Yet another consideration comes into play: will recipients of the cash benefits indeed use this money for purposes intended by the law, or will the money be simply absorbed into the family budget? Furthermore: does the standard of living of Israeli residents — particularly the elderly whose habits and life styles were consolidated fifty years ago or more — allow for the acquisition of auxiliary services at home?

An additional cost imposed on the budget of Long-Term Care Insurance stems from the special character of the law: a much greater body of professional manpower is needed to implement the granting of in-kind services. True, one may note with satisfaction that no new service organizations were constructed, and that most of the law's operation has been absorbed by the existing networks of the National Insurance Institute, the social service bureaus, and the General Sick Fund; still, a certain amount of expansion was necessary within these networks, with a small addition of social workers, of Sick Fund nurses and of Ministry of Health nurses.

In calculating the overall cost of this unique law, one should relate both to the cost of labour of the caregivers and to the cost of the bureaucratic and professional networks, as two essential components of a law based on in-kind services.

3. The Loss of the Element of Discretion and the Attitude Towards Exceptions

The law allows for a relatively low level of service benefit for many, while losing the option of a high level of benefit sometimes needed for difficult, exceptional cases. The operation of the law brought with it a drastic reduction in the previously existing options of helping especially in urgent cases. Moreover, due to the standardization and avoidance of setting precedents that could alter the rules, and out of the necessity to treat all equally before the law, the framework of the law does not permit the urgent treatment of exceptional cases. The question therefore arises, must legislation, with its determination on uniform rules and rights, actually put an end to the treatment of exceptional cases? Will future treatment of exceptional cases, not in the framework of the implementation of this law, but due to its influence, also come to a halt?

4. The Care of the Elderly Not Entitled under Long-Term Care Insurance

The success of the law thus far, which has entailed great efforts on the part of social workers and nurses to care for those entitled under law, namely, elderly persons severely dependent on the help of others — raises the question, whether there was not perhaps a "trade-off" of the target population of the social services bureaus and Sick Fund. In other words: does the concentration of care on the disabled elderly lead to neglect of other sectors of the population, also in situations of distress?

From available data we know that out of the 5,700 elderly persons in the care of the Sick Fund prior to the law, only 2,500 were recognized as entitled under law. What happened to the other 3,200 elderly persons who were not integrated into the new framework? Are they being cared for today? The same question can be asked about the wide range of frail, lonely elderly persons, in various situations of great distress who were formerly under the care of the social services bureaus and who are not classified as severely dependent elderly in the rigid terms of the law.

Was there indeed a "trade-off" of the target population under the care of the welfare and health systems? Together with the absorption of severely dependent patients, some of whom had previously received services and others who had not, was there not neglect of other needy elderly?

5. The Quantity of Services as Opposed to Quality

The vast scope of services being supplied today to target populations, which has grown to such large dimensions at such a short period of time; the standardization of administrative and professional processes; the availability of companies and corporations providing caregivers, and the result of relative convenience — should all these not alert us to examine the quality of the services we are providing?

Due to this accelerated growth, both in the scope of the entitled target population and in the scope of services provided, the implementation of a control system is required. The National Insurance Institute intends in the coming months to formulate a wide-scale control model that will focus on two areas: firstly, random checks of elderly people and their families, and the extent of their satisfaction with the services they receive, and secondly, a systematic examination of all service providers to see whether they fulfil the conditions they undertook or not.

This control network should and must necessarily influence the agencies which cooperated in the implementation of the law so that they may draw the required conclusions and pass the information on directly to the individual level for ongoing correction of faults. It should be noted that to the best of our knowledge, no similar model exists in the country for learning and initiating control methods of service suppliers, with such limited manpower resources that are not expected to grow in the near future. We are now facing an important professional challenge.

6. Patronism of the Establishment, and the Discretion of the Individual

Based on the instructions of the law and the procedures stemming from them, the local professional committee was given the authority to determine care packages and implement them. There is no doubt that alongside this intervention, aimed to assist elderly persons and their families, many persons are deprived of the freedom to take their fate in their own hands and decide how to use the money from the National Insurance Institute at their own discretion, for their own benefit. Moreover, many have private caregivers on the basis of independent arrangements; over the years many of these have formed warm positive relationships with their caregivers. The implementation of the law on the basis of egalitarian treatment before the law calls for supplying of services through recognized companies in accordance with set procedures, which reduces the range of other options of care. The fear of breaching these processes with precedents that may create a double standard has ruled out these other options. The solutions that assist somewhat the recipient's freedom of choice are limited to the family's right to refer its own private caregiver to one of the companies, which may then serve as his "employer" and extend to him its system of control and guidance, and insurance payments as obligated by law.

7. Elderly Persons who Refuse Services

During the first year of implementation, 640 out of the 17,893 families entitled to benefit refused to receive the services offered them. According to the law, anyone who refuses to receive services that are available and offered to him — actually forgoes the receiving of benefits.

We are aware of the fact that there are families who do not want strangers, even if they come to help, to enter their homes; perhaps because they feel they have to care for their loved ones themselves. The introduction of uniform norms to all families in Israel undoubtedly forces some families to change their traditional way of care giving.

Despite the fact that the number of those who refuse outside help is relatively small, it is still necessary to make a thorough examination of this population, and of the effects the implementation of the law has on their lives.

8. Services in the Community — As deferring or Preventing an Institutional Arrangement

Finally, we return to the question of the possible trade-off between community and institutional services. The assumption was that the enhancement of the network of community services would bring with it a deferral or even prevention of the institutionalization of the elderly person. There is no doubt that such a trade-off constitutes a humane achievement in itself, in keeping the elderly person in his family and thus perhaps leading to budgetary saving as well. This question contains in itself most of the subjects discussed in this article, and it should be examined in the long run along with the ongoing implementation of the law.

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PSYCHOGERIATRIC CLUBS IN JERUSALEM

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Introduction

During the past decade, there has been a growing recognition of the conditions of elderly suffering from organic brain syndrome, or dementia as it is commonly referred to. There are several reasons for this growing awareness. Firstly, the problem has become more visible due to the growing size of the elderly population. If the incidence of organic brain syndrome from age 65 is 2.1%, from age 75 it increases to 8%, and at age 85 and over it reaches 17.7% (Royal College, 1981). According to a general estimate, about 6% of the individuals aged 65 and over suffer from medium or severe organic brain syndrome (Haber-Shaim, 1985).

The seriousness of the problem results not only from an increase in the number of sick people, but also from the severity of its symptoms. Dementia is characterized by a decrease in cognitive and emotional functioning and sometimes by personality changes (Holden, 1982). These changes have serious implications for the individual's functioning such that he requires extensive assistance from others in many aspects of daily living.

In Spite of progress in the ability to identify causes of dementia, the pharmacological and biochemical treatment of these causes is still in its infancy (Royal College, 1981). It is estimated that 10%–40% suffer from a treatable dementia, but only in very few cases it is possible to considerably improve the condition (Haber-Shaim, 1985), and the primary form of intervention is still one of treating symptoms, by means of social-psychological modification. Specialized methods were developed in recent years (i.e. reality orientation) for treating patients with dementia (Holden, 1982). These methods are applied in community and institutional frameworks. There is an urgent need for improved diagnostic tools and new

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The authors wish to thank the clubs staff members for their initiative in developing this important service and for their collaboration in this research.

methods of treatment in this field. In a survey of treatment methods Haugen (1983) emphasizes that a "realistic" treatment approach for these patients is to diagnose the condition and hope for functioning within reasonable limits. It seems, that in this area the most meaningful improvement following intervention is in the patient's quality of life and in his general satisfaction.

Many of those who suffer from dementia live in the community. It is estimated that 65%–90% of those who suffer from severe organic brain syndrome live in the community. In Israel this proportion is 78%. Of the rest, 17% are hospitalized in institutions, and 5% in pshychiatric hospitals (Haber-Shaim, 1985). In recent years, due to the increase in the number of elderly in the population and resulting larger number of old people with dementia living in the community, the pressure on institutional beds has increased. It is estimated that between 1981-1985 the number of psychogeriatric beds increased by 71%. According to forecasts, in 1985-1995 it will be necessary to increase the number of psychogeriatric beds by 226% (Habib, Factor and Be'er, 1985). It may be that at least part of the pressure on institutions is due to the fact that community services are not sufficiently developed. According to Habib (1985) approximately half of the elderly waiting to enter an institution could remain in the community if suitable community services were available. These data emphasize even more the urgent need to develop services in the comminity.

The family continues to play an important role in caring for the chronically ill patient. Care-givers are primarily the patients' spouses and their children (Treas, 1977). The gerontological literature emphasizes the heavy emotional and economic price paid by family members who take care of the demented patient. Care-givers repeatedly report feelings of depression, loneliness, guilt feelings, reduction in health condition and despair with respect to the future. These findings strengthen the approach that intervening programs for psychogeriatric patients should also include their primary care-givers as a target-group.

The Psycho-Geriatric Clubs

Between 1980–1982 four psychogeriatric clubs were established in Jerusalem, three in community centers and one in a hospital for the chronically ill. Some 10–15 elderly frequent each facility three times weekly for up to four hours per scheduled attendance. They are cared and catered for by appropriately trained, paid professionals as well as volunteers. Each club is serviced by a coordinator, a helper, a physiotherapist, a dance and an art therapist.

The program's major goals are:

1. To take the person out from his home and encourage social intercourse among peers and fellow elderly.
2. To thus increase verbal and non-verbal communication between the clients.
3. Stimulate potential activity.
4. Provide the individual with a sense of identity and of being an essential part of society.
5. Plan and implement a weekly target, towards which the person may look and respond to accordingly.
6. Make it possible for the primary care-givers to enjoy a period of rest and free them to attend to personal affairs.
7. Guarantee transportation to relieve the primary care-giver of the responsibility, emotional and otherwise, involved in making such visits physically possible.

The clubs' activities are varied with particular attention paid to applying the principle of "reality orientation". The range of activities includes discussing current topics, social activities, art, physiotherapy, physical exercise, dance therapy and excursions. In addition the club provides two-way door to door transportation as well as medical supervision. Lastly, joint meetings with spouses are frequently arranged.

Evaluation Study of the Clubs

The present paper is based on an evaluation study which examined the activity of the four clubs operating in Jerusalem[1] (Baich, Morginstin & Carmeli, 1985). The study concerned itself with the following:

1. The extent of burden on the main care-givers.
2. The main difficulties relating to treatment provided by clubs.
3. Scope of help given to care-givers.
4. Relations between care-givers and club staff.
5. Evaluation of the clubs' contribution to clients and care-givers.

The research population included 46 clients and their care-givers. Data collected relates to regular clients who frequented these facilities between November 1983 and February 1984. Lists of the clients were provided by

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[1] The clubs were first established on a voluntary basis aided by contributions from various organizations and financed by the National Insurance Institute's Demonstration Projects' budget. Today the main funding is by ESHEL (about 75%) and Jerusalem's Municipality (about 25%).

the coordinators, whose definition of primary care-giver aptly applies to the person directly involved in caring on a daily basis. However, six such care-givers were not interviewed due to language difficulties or refusal.

Due to the clients' low level of functioning it was decided not to interview them directly and to rely instead on data drawn from main care-givers at home and the clubs' coordinators. The research instruments included a structured interview designed to reveal pertinent details regarding the clients and themselves. The clubs' coordinators were expected to complete a questionnaire for each of the clients, in addition to which they, as well as staff members, filled in personal questionnaires.

Data on Clients of the Clubs

1. Demographic Data

The clients' average age was 73 (age range 55-92). Most of the clients resided in reasonable living conditions, though many received income supplements from the National Insurance Institute. The clients' population was heterogenous with respect to country of origin, professional background and level of education. The numbers of Europeans and Americans were greater than those of Afro/Asian and Israeli extraction. There were marked differences between male and female clients (60% and 40% repsectively), the great majority of the males being married (90%) as against only 31% of the females. This acute imbalance in family status had a considerable impact on the make-up of primary care-givers. Whereas the primary care-givers of 75% of the males were the wives and of another quarter — children and others, the primary care-giver of half the females were children or remote relatives. Data indicate that males attending the clubs had a larger number of children in addition to a wider supportive network than their female counterparts.

According to the data, the clubs are visited by a "special" population (reflecting a distinct pattern). More males attend even though their proportion in the elderly population is lower than that of females. Moreover, married males with a potentially greater supportive network are distinctly in the majority. A considerable number of the females are single or have fewer children. How can this relatively high proportion of males among the clients be accounted for? This difference between males and females visiting the clubs may emanate from a higher rate of female hospitalization, largely of widows, to a lack of care-givers and/or a supportive family. This would account for relatively fewer females without organic injury within the community.

2. *Health Condition; Physical and Cognitive Functioning*

Most of the clients' major health problems were connected to an injury in the central nervous system, e.g. a brain injury (C.V.I.), Parkinson or dementia of the Alzheimer type. Beside these a number suffered from additional chronic diseases, mainly blood vessels and diabetes.

As expected, physical and cognitive functioning of the clients was found to be very low as compared to their peers in the population at large. For example, in the area of daily personal functioning, the highest dependence related to personal hygiene. 74% of the clients were totally dependent, 28% in need of full help for mobility purposes and the majority were incapable of as little as preparing a cup of tea for themselves. It should be noted that in each club, people were functioning on different levels of independence. The data shows that unmarried clients who lived alone, or with children and other relatives, coped better than those who lived with a spouse. This data agrees with the common hypothesis, that a limited old person with a spouse is more likely to stay in the community, whereas the single elderly even when less limited, has a greater chance of being institutionalized (See Table 1).

3. *Cognitive Functioning Ability*

An initial indicator of organic syndrome is invariably an impaired memory as a result of which the capacity to learn new things is limited, whereas

Table 1. Dependence Rates of the Clients, According to Physical Functioning Areas

Functioning Area	Total (N)	Total (%)	Dependence Rate Complete Dependence	Partial Dependence	Completely Independent
Dressing	46	100	35	37	28
Washing faces and hands	46	100	18	17	65
Shaving or taking a bath	46	100	74	4	22
Eating and drinking	46	100	9	19	72
Using toilet	46	100	15	18	67
Going in and out of bed	46	100	11	30	59
Going up and down stairs	46	100	28	18	54
Going out to immediate neighborhood	38*	100	39	18	43
Preparing tea, coffee	45	100	53	14	33
Doing easy cleaning work	38*	100	63	8	29

* Data incomplete

memories from the distant past or old habits remain relatively intact. Progressively the ability to do abstraction, to solve problems and make decisions diminishes. At the third stage severe personality changes become increasingly apparent, not least changes in the individual's ability to take care of himself (even when physically capable of doing so). That this adversly reflects on social behavior goes without saying.

In order to evaluate clients' cognitive functioning, care-givers were asked to report about the clients' ability in this area. Findings thus obtained were subsequently translated into data. No attempt was made to use cognitive tests which are usually administered to evaluate demented populations. The areas examined were:

A. Long-Term Memory
- Does the visitor remember names of family members?
- Does the visitor recall names of friends and old neighbors?

B. Short-Term Memory
- Does the visitor remember names of new people?
- Is he/she capable of describing what occurred the day before?
- Is he/she able to recall to mind items personally placed at home the previous day?

C. Orientation
- Does the visitor remember own address?

D. Behavior
- Does the visitor behave properly in society?

E. Treatment and Being Interested in the Environment
- Is the visitor interested in his home and family?
- Do daily news items provoke attention or response?
- Does the visitor relate to people inside and outside home?

F. Additional Cognitive Functioning Areas
- Capability (physical and cognitive) to make a telephone call unassisted?
- Capability to identify and take medication unaided?

The research data indicate that in the area of cognitive functioning the poorest performance was observed in variables testing short-term memory of involvement with what takes place around. In variables testing long-term memory, e.g. generally remembering names/addresses and demonstrating tolerable social behavior, rates of clients with proper functioning were relatively high (56%–75%). This was also noted where involvement across a broader sperctrum of interest was clearly in evidence (29%). For the sake of comparison it should be mentioned that in research conducted among the entire elderly population in Bnei-Brak (Silberstein, 1985), only 6% of the sample had severe cognitive handicaps.

Another dimension of the damage is a difficulty in establishing contact with the environment. In reply to the question whether the visitor exchanges words in or outside home, the care-givers reported that about one third initiate conversations with people both in and outside the home, 39% respond only when approached, 14% only seldom or not at all. Moreover, about 70% of the elderly are unable to make a telephone call in person due to physical and cognitive limitations. About half do not identify their medications and are unable to take them unaided. From these findings one may rightly deduce that the extent of involvement in the family or general environment is also low.

One of the difficulties in the treatment of this population stems from the fact that a considerable limitation in the cognitive areas is often related to substantial physical limitations. In order to examine this relationship two indices were constructed, dividing the clients according to 3 levels of limitations in each area (See Table 2).

Table 2 indicates that a clear relationship between the two areas exists. There are only very few clients with severe physical limitations and only light cognitive damage. This is clearly apparent in reverse. In attempting to define physical-cognitive functioning, and upon combining these two areas it was found that performance diminishes with advancing age. Where the presence of caring family members relative to the rate of other care-givers is high, the need for support is particularly acute.

4. *Mental Situation*

Organic damage has a direct physical and mental influence both as an integral part of the damage and indirectly. This is reflected in the visitor's mental situation. The examination of the visitor's mental health was important due to its influence on the type and extent of burden of care at home and the necessary help in the club. In assessing moodiness, it was found that clients fell into fairly distinct groups. 37% were of genial disposition much of the time, 20% by and large depressed, morose, low spirited, 22% invariably apathetic and overtly sinking into themselves. A smaller number were restless and suspicious.

Table 2. Physical and Cognitive Functioning (Numbers)

Level of Physical Functioning		Level of Cognitive Functioning		
		Low	Medium	High
Total	44	15	14	15
Low	16	9	5	2
Medium	15	5	5	5
High	13	1	4	8

$x^2 = 10.04$, $P = 0.04$

When relationships between mental situation and physical functioning are examined, one finds as expected, that sound physical functioning ability is characterized by good mood. Physical functioning ability was unrelated to the other mental states. On the other hand, it is important to mention, that among clients with depression there was a high incidence of good cognitive functioning ability. It may by that a depressive reaction is a characteristic in the first stages of cognitive deterioration among those who understand the situation and are aware of it. Subsequently, even though unaware of the severity of the sickness, a typical reaction is apathy or detachment. One should add, that when a person is ill with dementia, it is difficult to distinguish it from depression. Not surprisingly, when functioning is low, care-givers equate the situation with dementia rather than depression.

The Primary Care-Giver Population and Its Problems

The primary care-giver population consisted of 80% females and 20% males. Twenty were wives, 6 husbands, 15 children (of which 13 were female), 5 remote family relatives and one a social worker.

The majority of care-givers were married. Two thirds of the children and half the husbands were working at the time of the interview. Only 20% of the wives worked. The data thus confirms that among care-givers, wives are the most vulnerable group from a health and economic standpoint. It is also they who care for clients with the lowest level of functioning ability.

Among the main difficulties emphasized by the care-givers one may identify 3 areas. The first is the physical one related to the treatment itself. The second area is mental stress and thirdly though by no means least, is the perpetual confinement for hours and days on end. Tension, depression, worry and sheer mental fatigue are part of the course. As a result of full-time care-giving, free time, social intercourse and the ability to attend to one's own affairs are at a premium. While even at best, lack of social mobility gives rise to complaint, predictably care-givers are least troubled or irritated when their charges enjoy a higher level of physical cognitive functioning.

The majority of care-givers claimed they devote some 9 hours daily to their charges, with the rest estimating variously less. The fact that about one third of the clients are unable to stay alone unsupervised relates to the care-giving burden.

In the main care-givers expressed a sense of loneliness when coping with their responsibility and concern over the deterioration of their charges. Yet, in spite of being greatly burdened, half expressed willingness to continue

Table 3. Difficulties in Care-Giving, According to Care-Giver's Reports (percents)

Type of Difficulty*	%
Physical (lifting or washing etc. of the dependent	59
Tension & depression	35
Worrying and helplessness	33
Social isolation	30
Lack of time to attend own affairs	24
Over-dependence	15

* Care-givers were able to mention several difficulties.

Table 4. Care-Givers' Difficulties as per the Client's Physical-Cognitive Functioning Level

		Functioning level				
Type of Difficulty	Total (%)	High	Middle/ High	Middle/ Low	Very Low	P
Total (N)	—	8	9	13	9	
Physical	50	25	67	54	100	0.01
Worry and helplessness	33	0	11	62	44	0.01
Visitor's over dependence	15	0	11	8	56	0.008

* The rates were calculated for the entire population in each functioning group.

performing their functions irrespective of attending tribulations, while more than half opposed institutionalization as a solution to their difficultes.

A clear link between the charge's dependency level, degree of willingness to continue care-giving and the attitude towards institutionalization was established. Only the sense of burden due to the visitor's over dependence had a bearing on whether to continue or not ($p = 0.03$).

The understanding of the care-giving burden revealed an interesting question, namely, which variables are related to the feeling of burden among those caring for demented elderly? One may see in Table 4, that the lower the physical and cognitive functioning, the greater the rates of care-givers stating difficulties in performing their task. Unrelated to the functioning level were the sense of social isolation and lack of free time. The explanation may be, that the difficulties related to social isolation and lack of free time are equally present when the charge is relatively able and independent. A feeling of depression and tension was found to be related only to the level of cognitive functioning. In another research (Zarit & Reever, 1982), no relationship was found between the subjective sense of care-giving burden and the level of physical-cognitive funcntioning.

Behavior Difficulties and Ways of Coping with Care-Giving

Within the framework of this research a primary objective was to describe systematically the difficulties with which the staff is coping in the clubs (Table 5).

According to the coordinantors' evaluation, the most frequent difficulties in clients' behavior relate to passive hehavior (50%) and to detachment from reality during each activity (37%). A symptom of passivity and detachment may be a deterioration in functioning or defensiveness relating to requirements which clients have difficulty coping with. Ultimately such behavior provokes confrontations creating disruptions during activities and causing difficulties for the client.

The coordinators were asked to discuss these problems, expounding the difficulties in coping with same and to specify their solutions. Content analysis of answers revealed the following:

1. Assignment of tasks both familiar to and capable of being carried out by the client.
2. Assign clients to permanent tasks in the club, e.g. reponsibility for setting tables, preparing tea, etc.

Table 5. Behavior Difficulties of Clients in Clubs (%)

Behavioral Difficulty	%*
Aphasia	28
Confusion	33
Passivity	50
Restlessness	24
Language problems	24
Anxiety	15
Unsuitable to group	27
Isolation	37
Hallucinations	15

* The percentages do not add up to 100% (since each coordinator could mention difficulties for each visitor

3. Encourage participation in various classes. Offer clients choice (Painting, copper work or embroidery etc.) and provide ample personal attention.

Group units are one of the most common devices employed to cope with problems of detachment. They are used as follows:

1. To encourage conversation among group members.
2. Motivate the detached clients to integrate.
3. In view of a not uncommon tendency to fall asleep, to stimulate alertness in all manner of ways and encourage self-expression.

Another problem area mentioned by the coordinators relates to mental confusion and forgetfulness (33%).

Coping with these difficulties is usually done by cognitive means, e.g.:

1. Exercises to strengthen recall capability via various memory games, repetitive recitation of names, dates and events and engaging in conversations with particular emphasis upon the person's past.
2. Repetitive attempts to clarify and explain a specific reality, basics such as daily surroundings, time and relationships.
3. Attempts to re-introduce vaguely familiar and all but forgotten skills e.g. cooking, knitting, etc.

Another area of difficulty in care-giving in the clubs is related to the behavior expressed in anxiety, restlessness and hallucinations. These difficulties were less characteristic than passivity or confusion, but still very disturbing. As such, acutely sensitive clients were liable to feel threatened.

The treatment approach applied in such cases was intended to reduce anxiety or restlessness. The staff mentioned the following coping methods:

1. A personal calming approach — physical touch, caressing, holding hands, etc.
2. Diversion of attention from the source of anxiety by shifting verbal or occupational focus elsewhere.
3. Using other calming devices, e.g. music, playing simple undemanding games.
4. Talking about the source or cause of the anxiety.

Another area of difficulty relates to communication problems. This may be due to language limitation or lack of familiarity with the clients' background. The coordinators mentioned the following ways of coping:

1. Employing non-verbal means or translators.
2. Using members of the group as translators and partners in the process of establishing communication.
3. Talking slowly and clearly while observing whether or not the client fully comprehends.

When summarizing the treatment approaches and means employed in the club, one may say that the clients confront the staff with various difficulties either singly or in combinations. The treatment is given on two levels: personal and group, the common points being:

1. A great effort is made to create an atmosphere of acceptance and support in the clubs without subjecting the clients to undue pressure.
2. Every attempt is made to form a recognizable framework, as far as is possible.
3. Care is taken to avoid creating situations of anxiety and uncertainty.
4. The clients participate within the limits of their abilities while subject to a rehabilitative process of engaging in basic repetitive exercises.
5. Much attention is paid to integrating individuals in the group and to utilizing same as a means of helping them to improve.

The Supportive System of the Primary Care-Giver

In order to ascertain the extent and sources received by prime care-givers, the latter were asked to state whether nurses, social workers, volunteers, neighbors or family members assist in care-giving, to what extent and in what capacity. The data demonstrates that the contact with medical or para-medical professions is irregular, taking place only according to need. Involvement of neighbors or volunteers, even of remote family members is smaller and sometimes non-existent. In fact, care-givers receive meaningful help from only 3 sources: home care, domestic help or offspring.

60% of the clients receive help in the form of home care. 25% of the clients are attended for 9 hours or more weekly and a further 35% for some 6 hours or more weekly and a further 35% for some 6 hours or less per week. The role of home care can include supervision or walks with the visitor, and helping with washing and consumption of meals. 43% of the clients did not pay for this help which was financed by the welfare services or Sick Fund. 31% of the care-givers availed themselves of a house helper. Their input added up to 4 hours per week, and were paid for by the primary care-givers.

54% of the care-givers also receive help from family members, mostly offspring. This help is not consistent in scope and is usually given according to need such as social visits, assisting clinic attendances or lending a hand when and wherever else the need arises.

Ten primary care-givers received no help from the above mentioned sources. Home care was more frequent when the individual was depressed, his physical and cognitive functioning low, and clearly in need of supervision. Help from offspring was more frequent where the primary care-giver was a husband or when the usual source of aid suffered ill-health. Similarly to the home care help, the offspring's help is related to the low physical functioning of the elderly. It is important to note that additional assistance does not diminish the care-giver's subjective feeling that after all they basically cope by themselves.

A higher proportion of viably assisted care-givers expressed themselves willing to continue caring for the dependent at home rather that consider the option of an institution. The data therefore indicates that even when the care-giver feels subjectively that he is coping alone, in fact help received from elsewhere encourages readiness to persevere in his role.

Relations with the Club

In the main clients were referred to the clubs by social workers (31%) followed by a large variety of organizations in the community. The care-givers' expectations varied somewhat, most regarding the facility as a social amenity, as providing an alternative to home environment and contact with fellow elderly. A low rate (17%) expected that their charges would receive rehabilitative treatment.

Relations between the club staff and care-givers were quite intensive. Some 70% of the care-givers claimed to have spoken with a coordinator shortly before the interview. In a majority of cases, these talks and contacts were initiated by the coordinators. Such involvement and the interchanging of current information was considered most important.

The Club's Contribution to the Clients

The main contributions to clients according to the primary care-givers, were as specified in Table 6, with social and rehabilitative inputs well ahead. While cognitive improvement was not seen as a main contribution, 9 clients (20%), viewed this contribution as an additional one. The club's coordinators found that the contribution to the clients appeared in areas mentioned by the care-givers in addition to improving self image. In their estimation, the club's activities with opportunities to fulfill roles and produce hand-made presents, make the clients feel more worthy.

The common denominator upon adding up all areas of contribution would rightly be an improved quality of life. Care-Givers reported better daily functioning and more communication etc. However, both primary care-givers and club personnel failed to record changes in mood, motivational level, behavior, etc.

Contributions to the visitors bore a clear relationship to the care-givers' sense of burden. As expected, care-givers who reported fewer difficulties, in the main of a physical character, expressed greater willingness to continue their care-giving role.

Table 6. Contribution to the Clients According to Care-Givers (%)

Type of Contribution	Main Contribution	A Total Contribution
Total (N)	45	45
Total (%)	100	
1. No contribution	9	—
2. Social contribution — meeting people	28	59
3. Quality of life	24	24
4. Emotional situation and mood	13	26
5. Cognitive functioning — memory & orientation	—	20
6. Rehabilitation — physical functioning	26	50

Contribution of Clubs to Primary Care-Givers

The great majority of primary care-givers (84%) looked upon the clubs as making a direct contribution to their own efforts.

The most frequently mentioned contribution was in the area of free time opportunities, enabling primary care-givers to attend to otherwise neglected chores, i.e. shopping, paying bills, etc. (Table 7). The extent of rest breaks and social contacts was influenced to a lesser degree.

The contribution to care-givers in regular employ was most important in the free time and opportunities afforded. On the other hand, care-givers who didn't work mentioned more the possibility to meet with other people.

Table 7. Main and Total Contribution to the Care-Givers

Type of Contribution	Main Contribution	A Contribution
Total (N)	46	46
Total (%)	100	—
1. No contribution	4	—
2. Indirect contribution (clients only)	12	22
3. Mental relief — peace of mind	28	37
4. Additional assistance	17	33
5. Free time opportunities	39	55

Care-Givers Recommendations for Improvements in the Clubs

The main changes recommended by the care-givers related to extending the clubs' activities. Most were keen on seeing an increase in the number of activity days. 52% recommended that the clubs operate daily and an additional 30%, an increase of up to two additional days per week. 45% of the care-givers also expressed a desire to see the present quota boosted by at least 2 hours daily. The provision of a meal service was another recommendation, 37% favoring hot meals. About half of the care-givers indicated an interest in organized activities for families, such as lectures or social encounters. A small number of the care-givers were critical of the staff type of activities as well as the clubs' locations.

The greater the devotion of the care-giver, the keener the interest in increasing the club's activity hours. The recommendation to provide meals and extend activity hours relates to the care-givers' low economic situation and to their being in employ. The client's depression and detachment were also among causes accounting for the recommendation to conduct group meetings for care-givers.

Summary and Recommendation

The data and general impressions recorded during this research indicate the importance of this special service and highlight the efforts and dedication of the clubs' staff to create a treatment framework, as much for the benefit of the elderly frequenting the clubs as for the care-givers at home.

Conducting the research led to a more detailed evaluation of the difficulties in treating a very specific sector of the population and of the areas of contribution extended to those in need. A more detailed understanding of these needs and suitable treatment methods calls for the continuation of research in the development of diagnostic tools aimed at identifying treatment goals and evaluate treatment more specifically.

A. Developing a Diagnostic Instrument

The data of this research was based on the primary care-givers' evaluation in addition to that of the coordinators and instructors of the clubs. There was no direct examination of clients. Neither their situation nor that of their family members was studied. It is important to develop suitable diagnostic tools, by means of which the staff would be able to receive precise information about each client's limitations and the preferred areas of treatment to focus on. Appropriate instruments would make it possible to re-examine the client's situation at several points in time and reveal the extent of changes and development that may have taken place. In other words, it will be possible to conduct a more thorough evaluation of the results obtained and of the clubs' contribution to the client in all areas.

B. Planning the Treatment Setting

Parallel to developing diagnostic instruments there is a case to try and examine the methods applied today by professionals in coping with various situations of people with mental deterioration. The documentation of present treatment programs is imcomplete and does not relate the diagnosis or the client's existing situation to the recommended treatment programs. Therefore, it is of great importance to develop uniformity and systematization in such documentation and to harness the clubs' vast professional experience and so contribute to the creation of similar clubs in other places. This will also facilitate a more systematic follow-up approach of treatment effectiveness in the future.

The research emphasizes that one should neither consider the patient, his mental state or treatment in the clubs as distinct from family members or their approach to care-giving. Monitoring of the latter is therefore advisable from the outset as well as during club attendance for the purpose of ascertaining the total effect upon the client.

C. The Place of Psychogeriatric Clubs in the Wider Framework of Community Services

It is clear that the clubs are known and accepted as a suitable service in the community and that many organizations make a point of referring potential clients to these centers. However, no specifically defined organization in the community is primarily responsible for maintaining contact with the elderly and his family, or to monitor progress. Possibly one organization in the community (the Service for the Aged of the Department for Social Services for Local Authorities or the Ministry of Health, etc.) should be assigned to the task. Professionals treating this population claim that the duty of care for this sector tends to "fall between the chairs" of various authorities.

D. Extending the Consulting Network for Family Members

The data demonstrate a high degree of family members' satisfaction with the clubs and their overall contribution. At the same time, these centers have not proved to be the fountains of information one might have expected them to be. Apparently instruction and consultation relevant to the client's situation and his daily care have been equally lacking, this, in spite of contact with club staff and group meetings for family members. In view of the difficulties involved in caring for these patients and the tremendous burden, both physical and mental, felt by the care-givers, it seems that the service of instruction and counselling needs to be further developed both in groups and on individual levels.

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VOLUNTARY ORGANIZATIONS — A SUBSTITUTE FOR OR A PARTNER TO STATE ACTIVITY IN THE SOCIAL ARENA

by Dr. Joseph Katan*

Introduction

A gradual deterioration in the public status of the welfare state has been evident in most Western Countries since the mid 1970's. The basic principles of the welfare state, such as the value of social solidarity and the state's responsibility to provide adequate solutions to the wide range of its citizen's needs (in the areas of health, education, housing, income support, employment and personal services) — have lost their prestige, and many cracks have appeared in the wide social consensus upon which they were based.

The erosion which occurred in the public support of the principles of the welfare state is evident in governmental circles, among the various political parties, in intellectual and academic circles and in wide population groups (including groups which formerly supported such principles).

A clear indication of the erosion which occurred in the public support of the welfare state can be found, for example, in the results of the elections to the British Parliament which took place in June 1987, and which led to a significant increase in the political power of Margaret Thatcher, who, in her declarations, character and deeds, symbolizes more than any other western statesman the new-liberal ideology of the "new-right", believing in a significant reduction in state intervention in the social arena, and in transferring responsibility for provision of various social and personal services to non-governmental bodies.

At the same time, it should be emphasized that criticism of the welfare state is not confined to rightists alone; it is also raised in various left-wing circles, which complain about the welfare state's misdeeds in achieving the social goals it set for itself. These circles, too, are looking for alternative models of provision of services, which will adequately meet the population's needs and will reduce the gap between the various social sectors.

There are those who claim however — referring to the British case — that

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the attack on the principles and performance of the welfare state has had up to now a greater impact on the ideological and rhetorical level than on the practical level (Mishra, 1984). However, no one denies that the undermining of the basic concept of this state has a number of very concrete expressions in the United States, Britain and other western countries (Le Grand & Robinson, 1984; Walker, 1984; Brown, 1987).

Social Legislation, which constituted an important impetus for advancing and realizing the goals of the welfare state, was limited; real public expenditure in various welfare areas was curtailed; various social programs were cancelled while others were frozen or reduced; and conditions of eligibility for various services were altered with the aim of reducing the number of persons who could benefit from such services.

According to those who oppose the welfare state, extensive state intervention in the social arena should be replaced by three main alternatives: non-profit voluntary organizations, private profit-making organizations and informal social networks (family, friends, neighbors, etc.).

The above bodies played a major role as providers of social services in the days preceding the rise of the welfare state, and continued to function in this role in the era of increased governemntal intervention, but their influence declined. The opposers of the "welfare state" are now trying to restore the "old glory" to these organizations, and to cast them again as lead actors on the social stage.

The opposers agree that the state may continue to play a role in the social arena, but insist that this role be limited to providing assistance mainly to selective population groups and to allocating limited financial aid to non-governmental welfare organizations and to social networks.

Various circles which advocate carrying out changes in the welfare state and its activities tend to recommend, in this context, the idea of privatization, meaning the transfer of responsibility for provision of social services to non-governmental organizations, as well as the ideas of welfare pluralism and mixed economy — two concepts expressing the desire to variegate the agencies dealing with welfare (of which the state is only one) and to increase the consumer's power of free choice (Walker, 1987). There are those who raise the concept of "the welfare triangle", which indicates the need for the involvement of three central components in providing services to the population: governmental-public welfare organizations, the voluntary sector and informal networks (Evers, 1987).

In Israel too, welfare budgets have been curtailed in recent years, and demands to increase the involvement of voluntary organizations and social networks in the provision of services, with a parallel decreased involvement in the share of the state, are beginning to be heard.

This article attempts to discuss the functioning of the voluntary organizations, which, as mentioned, constitute one of the components meant to play a central role in the framework of the alternative arrangements of allocating welfare services, and to examine the manner by which these organizations may fill the vacuum that may be created if indeed state intervention is considerably reduced.

This article has three main sections. The first section reviews arguments against state intervention in the social arena; the second section examines the major advantages attributed to voluntary organizations, with special emphasis on those advantages which supposedly make up for the weaknesses of the governmental-public organizations; and the third section surveys a number of research works which describe patterns of functioning characteristic of voluntary organizations and which identify various vulnerable points which may significantly reduce their ability to provide adequate social services to the population.

The present article does not intend to shed doubt on the large contribution, nor on the necessity, of voluntary organizations. Yet it does aspire to caution against the trend of considering their activity to be a sure recipe for correcting the weaknesses of the welfare state, and a means of releasing the state from its role and responsibility in the social arena.

Factors Influencing Changes in the Welfare State's Status

Various factors which joined together and which had mutual influence on each other led to the weakening of public support for the principles of the welfare state and the reduction of its activities in various countries. Among these factors are the economic changes which occurred in the world since the early 1970's and which diminished the state's ability to allocate resources to welfare; the sense of disappointment from the poor achievements of the welfare state in meeting the objective of reducing economic gaps between various population groups; the loss of confidence in the functioning ability and efficiency of public-government organizations, a main component of the political-organizational web of the welfare state; the weakening of political support for the basic principles of the social policy carried out by welfare states precisely among population groups for whom this policy helped improve their social and economic status; and the undermining of the moral basis of this policy. These changes were accompanied by a new intensive reappearance of classical liberal ideology (although this time in the refreshing form of the "new right"), objecting to state intervention in welfare and calling for a speeding up of the process of releasing the state from responsibilities in this area and their transfer to non-governmental organizations and social networks.

True, attitudes such as these have existed for a long time; however, in the 1950's and 1960's they were pushed to the margins and did not succeed in undermining the wide political consensus regarding the principles of the welfare state. The neo-liberal ideology had its heyday in recent years, and its supporters found in the new social circumstances a congenial and sympathetic background for spreading ideals and concrete influence. The weakening of the welfare state thus resulted from both the unique and combined influence of various economic, social and political factors to which the ideological basis lent legitimacy. These factors have been surveyed rather widely in the literature (Le Grand & Robinson, 1984; Offe, 1984; Walker, 1984, 1987; Doron, 1985; Goldberg, 1987). They therefore will be presented in this article only briefly, as a background to the re-emergence of the private-voluntary organizations as a central factor in the social arena.

A. Economic Changes

The ability of Western Countries to develop as "welfare states" stemmed to a large degree from their economic prosperity, which continued until the early 1970's. This prosperity made available the financial resources needed for the maintenance and development of a vast system of social services in the areas of education, health, employment, housing, income support and personal services. This economic situation also allowed the social services to develop quickly without hurting other objectives, such as economic development and allocation of resources for defense.

The slowing down, freeze and sometimes even regression in economic growth which started appearing in most Western Countries in the early 1970's, changed this situation. These countries no longer had the necessary financial resources for maintaining the system of social services at its present level, let alone for developing it further.

These changes in the economic situation revived the positions of political and economic circles who had for a long time doubted the possibility of co-existence between state intervention and investment in the development and advancement of social services on one hand, and the maintenance of economic stability and growth on the other hand. The above changes also increased public support for the view that clear priorities should be set, according to which economic considerations — such as the real quantity of financial resources available to the state, the vitality of curbing inflation and the need to lower the taxation level of, and encourage investments in the productive sector — and not social considerations, should determine the scope of state activity in the social arena.

This economic viewpoint according to which public social services impose a heavy burden on the productive sector and reduce its ability to function, lent in many Western Countries (some headed by socio-democratic parties) a legitimacy for the state policy aimed at curtailing government allocations to welfare. It also nourished, both deliberately and incidentally, the major ideological arguments of the "new right", opposing state intervention in welfare on both theoretical and practical grounds. Furthermore, the economic changes led to the expansion of awarenesses that the welfare state's development potential had reached its limit, and that there was no escape from looking into alternative, more efficient and cheaper models of providing social services.

B. Sense of Disappointment from the Welfare State's Achievements

While the "new right" is questioning the principles of the welfare state, various leftist circles aim their criticism at the misdeeds of the welfare state in trying to achieve its main social goals. Most of all they point to its failure to achieve the goal of greater economic equality between the various social strata.

This criticism relies, *inter alia,* on many studies which were conducted mainly in Britain and which point to the fact that some of the state's activities in the field of welfare not only did not lead to achieving the goal of social equality, but even widened the gaps between the various groups.

Well known is Le Grand's study (1982) which claims with regard to Britain, that those who benefit from the social services provided by the state (he refers mainly to universal services in the areas of health, education, housing and transporting) are the wealthy groups rather than the weak ones. Townsend and Davidson (1982) join Le Grand in claiming that those who belong to the upper strata benefit from the network of national health services (one of the greatest achievements of this welfare state) more than do those who belong to the low strata. This inequality developed in spite of the explicit obligation of the health services to provide equal services to the entire population. Another British researcher, Taylor-Goobey (1983) pointed to the failure of an additional service to contribute to greater social equality: the transfer payments by means of income support benefits.

The claim that the welfare state failed to achieve some of its goals has been based on various explanations. Leftist circles tend to relate these failures mainly to the inability of the welfare state, functioning in the framework of a capitalistic regime, to drastically change the economic advantages of the wealthy social strata or the balance of power between capital owners and employees. Moreover, radical leftist circles contend that although the social service systems developed in welfare states may have somewhat improved the weak populations' social conditions, at the same time these systems tended to weaken the social status identity among employees and cool their desire to organize in order to bring about radical changes in the social structure. According to this argument these processes helped to stabilize the capitalistic regime, to maintain or even to widen existing social gaps and to perpetuate social injustices inherent in the very essence and character of this regime (Yatsiv, 1986). On the other hand, the "new right" circles stress that the failure of the welfare state is clear testimony to the fact that it is pointless to even try to reduce economic gaps, and they point to the negative results of extensive state intervention.

Whatever the reason for the welfare state's failure to reduce economic gaps, its critics use this as testimony to its failure to achieve the central goals defined by "social reformers" such as Bevan, Krosman and others, who shaped the character of the welfare state after World War II.

C. The Inadequate Functioning of Public-Bureaucratic Organizations

The above-mentioned economic changes, due to which the financial resources available to the state decreased, together with the claim that the welfare state did not achieve its central goals, further strengthened long-existing opinions regarding the inadequate functioning ability of public-state welfare organizations (Walker, 1984; Knapp et al., 1987).

According to their critics, these organizations have many drawbacks: lack of efficiency, waste of resources, unnecessary bureaucracy in the provision of services, high and unjustified costs, over-centralization which causes lack of sensitivity to specific local demands and to various human needs resulting from cultural and social variance, lack of accountability, giving priority (mainly implicitly) to the needs of the organizations and their workers over those of the population receiving services, causing clients to become indifferent and passive, organizational inflexibility leading to lack of creativity and inventiveness and making it difficult to adjust to changing environmental conditions, and a paternalistic approach towards recipients of services as well as lack of adequate co-operation on their part. Habermas, one of the harshest critics of the welfare state, even claims that *state intervention in the social arena leads to a domination of public services* over the citizen's private world (Sipila, 1987).

These drawbacks stem, according to critics, from three main sources: some emphasize mainly the negative results of the bureaucratic structure of these organizations and of their distance from the recipient population. Others refer to the legal basis of public services which forces them to operate on a universal basis and makes it difficult for them to develop particularistic relationships with individuals or specific population groups. Still others put the blame mainly on the public character of the organizations and on their resulting lack of consideration of the market's operating rules. This version, acceptable mainly to followers of the "new right", regards the assumption that public bodies, unlike private ones, work for the public benefit, as a groundless myth. In their opinion, public organizations more than others are exposed to pressure from sectorial groups with narrow interests. Moreover, while private organizations, working under the competitive conditions which characterize the market, are forced to become more efficient and renew themselves in responding to clients' needs and to changing environmental conditions, public organizations, having resources guaranteed beforehand, have in many cases no need to guarantee or justify their existence. They may therefore show tendencies towards inefficiency, awkwardness and lack of consideration of clients' needs.

D. The Difficulty to Determine Human Needs

One of the central goals of the welfare state is to provide suitable solutions to a variety of human needs. Various welfare services indeed put much effort into defining, locating and measuring needs and into developing services and programs which can provide suitable solutions for these needs.

Those who have reservations about the welfare state raise three central arguments with regard to this activity.

Firstly, the needs of people living in any society are diverse and complex, and therefore cannot be subject to any precise measurement which may serve as a basis for providing a suitable solution.

Secondly, due to their great number and variance in type and form, human needs cannot be fully met. However, even when some needs are met and solutions provided for them, this in itself may raise and expose additional needs. In other words, the commitment on principle to provide solutions for various needs and the creation of mechanisms for this purpose tend to raise the public's expectations and throw the state into a vicious circle of commitments and pressures.

Thirdly, due to its very nature and manner of functioning, the welfare state encourages the organization and crystallization of various interest groups which must put pressure on public-governmental bodies in order to please their mambers. The groups which are most successful are not necessarily those who represent weak or needy populations (quite frequently these groups do not have adequate representation) but rather those who represent populations with political power, on whom the public bodies are most dependent.

E. Doubts about the Moral Basis of the Welfare State

The new right's criticism of the "welfare state" is not based only on economic considerations, but also on moral ones. The main representatives of this approach are Hayek (1940) and Friedman (1962, 1980), who totally reject the government's right on principle to direct or regulate market processes or to intervene in its citizen's functioning: Friedman agrees, at most, to public intervention in very limited areas in which government assistance is unavoidable. State intervention in welfare goes beyond the desirable scope of the state's activities, which according to their thinking must have very narrow boundaries. State intervention unnecessarily strenghens the power of state mechanisms, seriously damages the individual's liberty and freedom of choice and fetters his freedom of initiative and creative ability. Moreover, state intervention in welfare increases the citizens' indifference and releases them from responsibility for their condition. According to this view, not only does state intervention *not* solve the basic social problems which it purports to solve; it even aggravates them. Solution to society's problems can be found only in its free functioning with no fetters imposed on it by the market.

Thus, critics and opposers of the welfare state raise various agruments, most of which are not based on empirical studies, against the extensive intervention of public-governmental bodies in the social arena. In their opinion, this intervention is contradictory to the state's economic needs, harms basic human rights and is detrimental, non-realistic and purposeless.

It is worthy of note, that supporters of the welfare state did not sit by idly, but rather came to its defense, while firmly refuting the arguments raised by its opponents (Le Grand & Robinson, 1984; Walker, 1984; Doron, 1985; Wilding, 1986; O'Higgins, 1987).

A full presentation of the reactions of the welfare state's supporters to its opponents is beyond the scope of this article. We will therefore limit ourselves to the three major arguments they raise.

Their first argument is that even if the welfare state did not succeed in reducing economic gaps, there is no doubt that it contributed to the advancement of weak population strata and to their escape from economic distress.

The second argument is that had it not been for the activities of the welfare state, the gaps between the strong and weak population groups would undoubtedly have been much wider in many countries.

The third and final argument is that there is so far no solid proof for the claim that alternative organizations, supposedly a substitute for state bodies, are indeed superior (this point will be discussed further below).

Although supporters of the welfare state firmly defend the principles on which it is based, they do not ignore its many weaknesses nor do they deny the need to make changes in its patterns of functioning. One of the main changes proposed by opposers of the welfare state as part of their aspiration for "privatization" — a change in part supported even by some of its adherents — *is the need to give greater responsibility for dealing with* welfare matters to voluntary organizations. But while the opposers see in the voluntary organizations and other bodies such as the social service networks, a full substitute for public-governmental organizations, adherents of the welfare state emphasize the necessity to have cooperation between the public-governmental sector, on the one hand, which must continue to be considerably involved in welfare, and the voluntary sector and networks of social support, on the other. The sources of this support in the voluntary sector will be described in the following section.

Advantages of Voluntary Organizations

The category of voluntary organizations involved in welfare (called in many reports "The third sector" or "The independent sector") is not a uniform one. It includes a large variety of organizations different from one another in their social composition, the share of volunteers in their institutions and activities, their goals, the kinds of services they provide, their geographical location and their relationships with other organizations.

All the same, those who wish to regard these organizations as a substitute — even if only a partial one — for the activity of state organizations in welfare, point to several characteristics which they consider to be typical, and which enable such organizations to function without the many drawbacks ascribed to public-state organizations.

The empirical study examining the functioning of voluntary organizations and comparing them to other organizations provides sofar only primary and partial data on the extent to which these characteristics are indeed unique to them (the data will be described below).

Let us briefly describe the positive characteristics as presented in the literature (Report of the Wolfenden Committee, 1978; Scott, 1982; Salamon, 1986; Le Grand & Robinson, 1984; Walker, 1984, 1986; Ostrander, 1985; Knapp et al, 1987; Anheier, 1987).

A. Saving Public Expenditure on Welfare

The operating cost of voluntary organizations in various social areas is lower than that of public-state organizations operating in the same areas. This lower cost is due to five main factors:

1. The ability of voluntary organizations to rely on work of volunteers who carry out the tasks of salaried employees. True, one may contend that state organizations are also capable of recruiting and using volunteers. It is assumed however, that due to their nature, location and organizational culture, these voluntary organizations have a greater capacity to attract, retain and use volunteers in various fields of activity. In state organizations, the employment of volunteers may encounter severe opposition from salaried employees who worry about their jobs in the face of competition from workers who are active in these organizations not for the sake of payment.
2. The costs of wages and level of working conditions in public-state

organizations are usually higher than those offered to salaried employees working in voluntary organizations. In most of the latter organizations the workers are not organized in trade unions, and therefore their salary and working conditions are not determined by collective agreements between workers' unions and management. The situation is different in public-state organizations, where both salaries and working conditions are determined in binding agreements. This argument is heard mainly in Britain (Knapp et al., 1987), but there are grounds to assume that it is relevant in other countries as well.

3. Due to their size, structure and organizational culture, voluntary organizations may content themselves with a smaller clerical-administrative component than the relative size of this component in public-state organizations.

4. Unlike public-state organizations, voluntary organizations may request payment, even if only a partial one, for their services without encountering public objection to such a step; such payments may increase their private revenues.

5. Voluntary organizations are able to recruit financial resources in the local and state levels from voluntary funds and private contributors. They can thus finance various welfare activities without imposing any additional burden on public budgets.

In sum, those in favor of "the third sector", who support the increased intervention of voluntary organizations in welfare, claim that the operation of such organizations for the provision of services today provided by state, public-financed organizations may lead to condisderable savings. Moreover, the possibility of achieving such financial savings makes the voluntary organizations the most suitable organ for involvement in new or undeveloped service areas.

B. Greater Suitability to the Client's Needs and Wishes

Due to their size, composition and location, voluntary organizations are capable of planning activities and providing services which are more in line with the different tastes of various client populations. This advantage is particularly (if not exclusively) characteristic of ethnic and occupational organizations, which are based on and equipped for providing services to specific populations with unique requests.

Moreover, in cases where several voluntary organizations work in identical areas, the client has the option to choose between them. This possibility may grant him a higher degree of influence on the level and quality of the services offered to him.

The assumption underlying this claim is that voluntary organizations' activities are characterized by greater correspondence between claimants' needs and the solutions offered to meet these needs than are public-state organizations, which, due to their nature and connection to the statutory system, tend to emphasize components of a standard and universal uniformity in their policy and activities.

C. Specialization in Exclusive Service Areas

There are many examples of extensive intervention of voluntary organizations in the development and provision of services intended for populations with special needs not met by the public or state organizations. In various countries, such as Britain, the United States and Israel, voluntary organizations were those who took upon themselves the responsibility of establishing services to meet needs of casualty populations, such as paraplegics, the blind, the deaf, alcoholics, autistic children, battered wives, former prisoners, former mental patients, and the homeless. The involvement of voluntary organizations with such populations may be explained in several ways.

1. At least some of these organizations were established at the initiative of those suffering directly or indirectly from the problems, who therefore took steps in order to cope with them.
2. Due to their centralistic character, state organizations have difficulty in developing tools for coping with the unique problems which characterize specific low-salient populations. Moreover, due to various reasons, such as lack of resources, governments in some welfare states prefer to leave the responsibility for providing services to some populations in the hands of voluntary organizations.
3. Due to their size, location and organizational structure, voluntary organizations have a greater ability to show a pioneering and innovative approach both in locating specific needs and developing services for meeting these needs.

D. Flexibility and Innovation

As opposed to public-state organizations, usually characterized by bureaucratic traits which determine a strict mould for their activites and force them to follow working procedures established ahead of time, voluntary organizations are free of such binding ties and are thus able to show innovation, initiative and great flexibility.

These advantages are expressed in their ability to adapt their goals, programs and activities to changing environmental conditions, an ability reflected, inter alia, in the abolishment of existing programs which do not provide adequate solutions to needs of populations and in the development of new programs and in structural and personal changes within the organization. It is assumed that the ability of voluntary organizations to show great flexibility and innovation improves the level and quality of the services they provide and leads to greater correspondence between these services and the needs of populations.

E. Public Participation

One of the main advantages attributed to voluntary organizations is their contribution to increasing public involvement in shaping the face of the society in which they live. This contribution is made, inter alia, by means of opening opportunities for people to participate actively in organizations having different tasks such as providing services to populations, coping with personal problems (mainly in the framework of self-help groups) and putting pressure on local and state bodies which determine policy in various areas. Voluntary organizations also offer people the possibility to contribute various resources, such as money and know-how, to developing various services which may improve their quality of life.

The voluntary organizations' capacity to enable public participation derives, according to their supporters, from several of their main characteristics, for example: their small size, structural flexibility, localism and involvement in unique problems which characterize specific populations. These characteristics enable voluntary organizations — more than state bodies — to attract and retain workers, and to open before them opportunities for social activism.

Public participation in voluntary organizations has several main advantages both for the organizations and the participants themselves and for society at large. To mention some of them: firstly, the establishment of service networks more sensitive to populations' needs; secondly, construction of active two-way communication channels among the citizens themselves and between them and government authorities, in the local, regional and state levels; thirdly, assistance in recruiting various resources for serving people (know-how, money, time, etc.); fourthly, education toward greater social awareness and involvement, and to the strenghening of public recognition of their own power to influence the shaping of the environment in which they live; and finally, strengthening the connection between the inhabitants and the community in which they live.

F. Advocate for Distress Populations

One of the central and unique occupations of many voluntary organizations is to serve as advocates of populations with various needs. These organizations act as "pressure groups" representing distress populations, criticizing activities of public and state organizations and raising before them demands aimed at achieving goals such as: changing policies and activity patterns, developing new services and enacting new legislation.

Public-state organizations, too, developed specific mechanisms for mediation and control (such as the state comptroller and the ombudsman), but one cannot expect these to be equal to those of independent voluntary organizations, which represent specific citizens' groups.

G. *Voluntary Organizations' Independence of Political Parties*

Contrary to state organizations, influenced by political party changes (such as state and local election results) which may lead (when a new political factor attains control) to changes both in policy and in executive compostion, voluntary organizations are immune to such changes and may thus plan their actions in a more stable and organized manner. Supporters of voluntary organizations claim further that their activities and policies — contrary to those of state organizations — are not motivated by political considerations.

In their opinion, their political immunity is what enables them to serve the needs of the populations they represent honestly and objectively and to criticise state organizations without any constraints. (This argument is of course relevant mostly to countries where a strong tradition of a non-political government administration has not yet developed, and to voluntary organizations with no political affiliation.)

The voluntary organizations have, then, many advantages according to their supporters: efficiency, economy of resources, sensitivity to varied needs of populations, increasing clients' options, mobilization and full use of resources, specialization in dealing with specific unmet needs, flexibility, innovation and creativity, adequate representation of distress populations, loyalty to the population and its needs, immunity to party and political considerations, active involvement of citizens, mediation between people and distant authorities, ability to consolidate community life and heightened civilian responsibility.

These positive contributions are presented against the background of the negative qualities of public-state organizations, described above: lack of efficiency, structural inflexibility, remoteness from the population and lack of adequate sensitivity to its needs, high cost and dominance of political considerations.

The assumption is that extensive involvement of voluntary organizations in welfare, inter alia, by taking responsibility for tasks carried out by state organizations, may help correct drawbacks in the functioining of social systems governed by these organizations and thereby improve considerably the quality of the services provided.

There is therefore no cause for surprise that voluntary organizations are considered by those who object to the werlfare state to be one of the main tools by which to bring about considerable reduction of state intervention in the social arena, and thus to undermine one of the basic principles of the welfare state.

Questions to be examined in this context are: Are the advantages mentioned really characteristic of voluntary organizations? Are voluntary organizations indeed capable of improving the level and quality of services provided to the population or perhaps they too have drawbacks which inhibit their ability to play a significant role in the social arena and to serve as a suitable substitute for state organizations in major service areas? These issues will be discussed in the following section.

Voluntary Organizations — Problems and Difficulties in Functioning

Several researchers who examined the functioning of voluntary organizations in the social arena, while aware of some of the many advantages of these organizations, also pointed to several of their characteristics which may hinder their ability to serve as a suitable substitute for state organizations. These characteristics are discussed below.

A. Dependence of Voluntary Organizations on External Resources

Quite a few voluntary organizations are permanently faced with the need to mobilize financial resources from organizations and people around them in order to guarantee their existence and proper functioning.

These resources are mobilized from four main sources: state organizations, private persons and organizations, other voluntary organizations and payments by those benefitting from the services. The aid recieved from these sources and the significance of dependence on them is discussed below.

a. Government Allocations

In several countries government allocations serve as an important, sometimes, primary basis, for financing activities of many voluntary organizations. In Israel the government assists many and varied organizations, and in some cases (for instance, organizations of women who operate day-care centers in development areas and neighborhoods) also finances a considerable part of their budget. In the United States, the aid budget for voluntary organizations was cut down considerably in recent years; however, before these cutbacks the federal government financed over 50% of the total expenditure of other voluntary welfare and communal development organizations. The government covered, for example, two thirds of expenditure on operation of day-care centers and two fifths of the expenditure on operation of family-planning services (Ostrander, 1985). In Britain voluntary organizations have become a valuable tool in carrying out the conservative government's policy aimed at reducing its direct intervention in the social arena. This policy is expressed, inter alia, by the transfer of responsibility for providing various services to these organizations and by allocating government aid for this purpose. Between 1975/76 and 1980/81 government allocations to all voluntary organizations grew by 50% (in real terms). These allocations counted in 1980/81 to about 8% of the total financial sources of these organizations. Moreover, government aid to these organizations and its share in their total revenues are constantly rising (Knapp et al., 1987). Walker (1987) mentions in this context that about an eighth of the budgets of the local welfare bureaus in Britain is transferred to voluntary organizations to finance their activities. In Holland as well, the state finances a considerable portion of the budget of voluntary organizations, which carry the greatest burden of providing welfare services to the population in this country (Kramer, 1983). Granting extensive government aid to voluntary organizations characterizes additional countries, such as Canada, Australia and South Africa.

State assistance to voluntary organizations active in the social arena is granted in different ways. The main way is by charging these organizations with the responsibility for carrying out various programs, in which the government is interested, while the government itself covers most or all expenses. This arrangement is referred to in the literature as "contracting out". The development and maintenance of day-care centers in development areas and poor neighborhoods in Israel are a clear example of this type of aid.

Government assistance usually compels the voluntary organizations (particularly when it is government activities that are being financed through them) to act according to criteria determined by the relevant government ministries and to be subject to their control.

In many countries, such as the United States, the curtailing of state assistance to voluntary organizations severely hurt their activity (Leat, 1986; Salamon, 1986).

b. Contributions from Private Persons and Bodies and from Other Voluntary Organizations

The extent to which voluntary organizations are indeed assisted by contributions from private persons or bodies differs from one organization to another; however, most private organizations invest a great deal of effort into recruiting contributions from these sources, thereby increasing the share of this component in their total revenues. These efforts are intended, inter alia, to extend and diversify their sources of assistance, to diminish their dependence on state organizations and to preserve their voluntary character. In 1980/81, over 12% of the revenues of the voluntary organizations in Britain came from this source (Knapp et al., 1987).

c. Clients' Participation in Financing Services Provided to Them

A major income source of some voluntary organizations is clients' payments for the services they receive. The inclination to lean on this source is increasing in recent years, due partly to the curtailments on governmental aid (Ostrander, 1986). In Britain, for instance, income from this source amounted in 1980/81 to about 66% of the voluntary organizations' total revenues. Moreover, real receipts from this source grew between 1975/76 and 1980/81 by 167%. This was a higher rate of growth than that of any other income source (Knapp et al., 1987). Clients' payments are made either directly or through a third party (various insurance companies, etc).

What are the possible implications of the dependence on external income sources on the goals and functioning of voluntary organizations? How can their financial dependence affect their ability to achieve their wide range of goals in countries where state intervention in the social arena is diminishing? Studies which have explored these questions (Kramer, 1983; Ostrander, 1985, Knapp et al., 1987; Kramer & Grossman, 1987) point to several possible effects.

d. The Influence of Financial Dependence on the Policy, Programs and Concrete Activities of Voluntary Organizations

Many organizations invest a great deal of energy in mobilizing external resources: salaried employees and volunteers work on recruiting contributions; directors spend a great deal of time in establishing contacts and in carrying out negotiations with external financiers and private donors; workers dedicate much time to searching for potential sources of aid and to preparing programs for which aid may be received. While preparing the programs the organizations must make sure that these programs suit the specific requests of the financiers. After the aid is received and during the implementation of the programs, they must prepare proper reports so as to please the financiers, and, when the need arises, to be able to mobilize additional resources. Some studies mention too that the commitment to organizational activity in accordance with rules and regulations demanded by external bodies (mainly governmental ones) increases bureaucratic tendencies in the voluntary organizations, and thereby changes their very character (Knapp et al., 1987).

The intensive occupation with mobilizing resources therefore puts its stamp on the voluntary organizations' policy and specific programs of activity (they prefer to deal with areas for which it is possible to mobilize resources, even if this involves neglecting an unattractive, though important field with which they dealt in the past), on their organizational structure and on the work of both directors and workers who are forced to channel a considerable part of their time and authority to carriying out various activities deriving from the organization's need to mobilize resources.

This picture of voluntary organizations constantly searching for resource-oriented programs in order to assure their existence is very different from their usual image as organizations which invest most of their energy in providing high-quality services to meet clients' needs.

Another possible implication of the dependence on external resources is mentioned in several studies which examined those voluntary organizations which rely mainly on financial resources provided by very wealthy private donors or by other voluntary organizations, which have many wealthy members. These studies indicate, among other things, the possibility that such organizations will take on issues, initiate policy steps and operate programs in accordance with the expectations and beliefs of the financing bodies. This possibility becomes even stronger when one adds the inclination of voluntary organizations to include among their policy makers, people having a high economic, social and political standing (Wilensky & Lebeaux, 1958; Neugeborn, 1977; Ostrander, 1985).

Ostrander (1985), for example, who examines this possibility on the basis of various studies carried out on voluntary organizations in the United States, such as the organization for family services (FSAA), as well as on the basis of her own in-depth study on several organizations, contends that the public benefitting from these organizations' services is not necessarily the poor population.

Sossin (1984), who studied the involvement of various voluntary organizations in emergency aid programs in 240 counties in the United States, points to the fact that in regions with a low poverty rate there exists a ramified network of voluntary organizations active in the social arena. In other words, in regions having a higher poverty rate, the pressure of such organizations is smaller. He attributes these findings to the fact that communities which are well-established financially are better able to offer financial aid to voluntary organizations, and therefore the latter's presence and activity in these communities are greater.

Beyond its supporting the claim of the bias in voluntary organizations' activity in the direction of the stronger populations, Sossin's study points to an additional aspect having to do with the privatization tendency: the inequality which may develop between various regions with respect to the level and quality of services provided to the population by voluntary organizations.

These studies, then, point to the sources of finance of voluntary organizations as capable of channelling their activities in the direction of well-established populations while reducing their involvement with distress populations.

Several studies examining the implications of voluntary organizations' reliance on clients' payments — as one of the main sources of financing their activities — on their work patterns, point to tendencies similar to those described above. Ostrander (1985) mentions in this context the inclination prevalent in volutary organizations in the United States to serve clients who are capable of paying for services while detaching themselves from clients lacking such means. This phenomenon of private voluntary organizations' detachment from low-income populations had already been indicated by Cloward and Epstein (1967). A similar development is mentioned by Walker (1984, 1987), who sums up various studies pointing to a "residualization" process of public services following the increased intervention of private organizations: clients capable of paying for social services buy them in the private market, while public services provide solutions for low-income populations. This process leads, in Walker's opinion, to social differentiation, to a stigmatization of the poor population, to a decrease in the level of services provided this population and to an increase in inequality. This situation confirms Titmus's claim (1968) that separate services for poor people, operating in the framework of strong private organizations, will turn out to be poor services.

As was mentioned in the beginning of this article, the welfare state has been subject to harsh criticism due to its inability to reduce gaps between different groups of society.

The above-mentioned studies indicate that giving greater responsibility for welfare services to voluntary organizations may make this problem even more severe.

The uncertainty characterizing the relationship between the voluntary organizations and their environment, together with their concentration on attempts to guarantee a permanent flow of resources, may have several additional implications. They may imbue these organizations with a sense of temporariness which may lower the morale of both volunteers and salaried workers' and erode their organizational commitment. This unstability may even grow due to the permanent necessity of these organizations to adapt themselves to the changing moods prevalent in their environment and therefore change their goals and activity patterns according to need.

Although adherents of voluntary organizations may see in these circumstances a source of creativity and innovation, one should not ignore their possible negative influence on the organization's perseverance and ability to plan its activities in the long run.

The dependence on external resources therefore has four main types of influence:

1. It provides clear evidence of the inability of many voluntary organizations to manage and function properly without external aid, including substantial

government aid. The assumption that by speeding up the process of releasing the state from responsibilities in various welfare areas it will be possible to reduce public expenditure without hurting the level of services requires thorough examination, which should include testimony from different countries such as the United States and Britain, in which such organizations meet up with difficulties in mobilizing resources and were seriously hurt by the reduction of government aid.

2. It leads to the channelling of a considerable part of the organizational energy to activities related to mobilizing resources, at the expense of inputs which could be dedicated to services for needy populations.
3. It causes organizations to prefer well-established populations and well-developed regions, thus increasing inequality.
4. It accelerates the bureaucratization of voluntary organizations, thus undermining some of the advantages attributed to them by their supporters (the organizations' bureaucratic structure will be discussed more fully below).

B. The Degree of the Voluntary Organizations' Uniqueness

Regarding the second question — are voluntary organizations indeed different from public-state organizations? — those who support the extension of the responsibilities and activities of voluntary organizations often praised their structural advantages, such as organizational flexibility, creativity and innovation, sensitivity to the population's needs and social-cultural background and willingness to cooperate with this population, and immunity to political pressures. These advantages were attributed mainly to the manner in which the organizations were established, their non-bureaucratic structure, independence of state bodies, local character and size.

This argument raises three central questions which were examined in various studies:

1. Are these advantages really characteristic of voluntary organizations?
2. Are they indeed different in this respect from public organizations?
3. Can these special characteristics of voluntary organizations have negative implications in addition to their positive ones?

Several studies which examined the first two questions do not give an unequivocal answer. These studies referred to a number of traits described as unique for these organizations.

Level of Bureaucratization

The argument that voluntary organizations do not have bureaucratic traits was not definitely proven in several studies. Over 30 years ago there were already researchers who pointed to processes of bureaucratization which took place in this very type of organization (Tsouderos, 1955;

Chapin & Tsouderos, 1956). A similar picture appears from research papers published in the last decade. Kramer (1983), for instance, mentions in his comparative study concerning voluntary organizations in Britain, the United States, Holland and Israel, that in their early years voluntary organizations were indeed characterized by lack of bureaucratic traits; however, their ability to stabilize and preserve these traits gradually diminished over the years, and most of them underwent bureaucratization processes which are reflected, inter alia, in formalization, role definition, division of labour and crystallization of hierarchic patterns of authority. Similar testimonies to bureaucratization processes in voluntary organizations are presented in additional studies (Ostrander, 1985; Anheier, 1987; Knapp, et al., 1987; Walker, 1987).

These developments are due to various factors, such as the increase in the scope of government aid which, as mentioned, compels voluntary organizations to introduce mechanisms of control and reporting which strengthen their bureaucratic traits, which in turn may undermine — even if only partially — the advantages attributed to their non-bureaucratic character.

Innovation and Sensitivity to the Population's Needs

Knapp et al. (1987), who summarized various studies (conducted mainly in Britain) regarding two of the central advantages attributed to voluntary organizations capcity for innovation and sensitivity to the needs of weak populations, state that public-state organizations are not necessarily less innovative or sensitive than voluntary organizations.

Moreover, several studies contend that the innovative ability of public-state organizations surpasses that of voluntary organizations. Schorr, cited by Knapp et al. (1987), mentions in this context, that the main innovative experiments in the social arena carried out in the United States in the 1960's were initiated by the government. Wilensky (1983) and Kramer (1983) agree with him in this. At the same time, it should be noted that some of the innovations initiated by state organizations were actually carried out be voluntary ones. These organizations serve in many cases as a kind of executive agency which implements innovative programs (Knapp et al., 1987). Anheier (1987), who sums up various studies concerning the functioning of voluntary organizations in developing countries, sheds doubts on the contention that voluntary organizations, unlike state bodies, are characterized by such traits as sensitivity to the social-cultural background of the population and immunity to political pressures.

Efficiency

Several studies, summed up by Le Grand and Robinson (1984) and Walker (1984) do not support the argument used by those who favor privatization, according to which state organizations are inferior to voluntary organizations in all that concerns efficient and quality of services provided. Some of these studies state that there is no difference whatsoever; others point to small differences; while still others, such as that of Titmus (1970) on the supply of blood in several countries, indicate the advantage of public organizations. The studies comparing voluntary and state organizations are relatively few; however, the picture arising from the studies which do exist sheds doubts on the uniqueness of voluntary organizations.

The third question raised above concerns the possibility that together with their positive aspects, some of the characteristics attributed to voluntary organizations, which are especially striking in those who retained their nonbureaucratic nature (e.g. limited size, low structural level, occupation with specific issues) have negative aspects as well. We shall refer to two of them:

1. Small organizations specializing in specific subjects have limited capacity to develop activity areas which may be essential to their proper and regular functioning. Some such areas were identified, for example, by Ostrander (1985), who pointed to several striking characteristics of the voluntary organizations she studied, such as absence of systematic data collection regarding needs of populations served by them, absence of planning and lack of evaluation of results. Knapp et al. (1987) mention additional drawbacks, such as inconsistency, absence of reporting and digression from standards.
2. The existence of a number of voluntary organizations in the community, closed up in their own exclusive framework and governed by a management often consisting of people whose personal prestige is attached to the organization and who attempt to retain their identity focussing on specific subjects while competing with other organizations on mobilizing the same resources, may lead to extreme fragmentations, duplicity, waste of resources and lack of coordination in the provision of services to the population. The population, in turn, may find itself facing an organizational labyrinth. Furthermore, the fragmentation may complicate any joint interorganizational planning of comprehensive, integrative programs intended to deal with the community's problems while combining various resources.

The first part of this article discussed the positive aspects of the existence of a variety of voluntary organizations, limited in size and offering social services to the population. In this second part we described the other side of the coin — shortcomings which may result from such a situation.

Summary

In recent years there has been a growing tendency in many countries to diminish state intervention in the social arena and increase that of voluntary organizations. This tendency is accompanied by sharp criticism on the state's poor performance in the area, on one hand, and an exposition of the advantages of voluntary organizations, on the other.

In this article the positive characteristics attributed to voluntary organizations were described as were several studies which criticize their activity and doubt their ability to serve as a suitable substitute for state activity in the social arena.

Most of these studies do not object to the voluntary organizations' functioning, but they request cooperation between the state, the voluntary organizations and additional bodies in the social arena, with the state continuing to play a central role in lelgislation, policy determination, central planning, allocation of resources and provision of specific services, both directly and indirectly through voluntary organizations and other frameworks, such as family and social networks (Ostrander, 1985; Salamon, 1986). Research in this area, however, is still at an early stage. Only additional research which systematically compares the functioning of the various organizations may shed more light on the problematic issues raised in this article.

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THE MEDIAN ROLE OF THE ELDERLY VOLUNTEERS IN THE SERVICES FOR THE ELDERLY AND PENSIONERS, THE NATIONAL INSURANCE INSTITUTE, ISRAEL

by Zvi Givoli*, Batya Berkman** and Baruch Oberlander***

Introduction

A bureaucratic system, in the view of some theoreticians, is an organized hierarchic framework which operates rationally in order to achieve administrative aims (Coser & Rosenberg, 1965; Merton, 1965; Weber, 1965). This concept stresses that a bureaucratic organization operates and functions according to clear, unified and rational procedures, not according to some arbitrary approach. In this article, we shall use, alternatively, such concepts as establishment, service systems and welfare services but in every case we mean a bureaucratic system.

The basic orientation of most service systems is to attain a high level of rational procedures in order to achieve the aims and assignments confronting it, in the most efficient way. This basic approach has a number of effects, both positive and negative, on the connection and interaction between the citizen and the bureaucracy, on the way the service is provided and received as well as on the system itself. We shall refer only to the main ones as a background to our description of the mediation role played by scores of counsellors — elderly volunteers — in the framework of the National Insurance Institute's Counselling Services for the Elderly and the Pensioners.

Background

In our society, most services, including welfare services, have led to the creation and operation of bureaucratic systems by means of which they ensure the population of the services or materialization of rights. Every

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welfare system expects and demands the service supplier to be faithful and bound to the fixed and rational procedures of the establishment and that he operate in accordance with them alone. Basing itself on rational procedures obliges the service system to transform aims or assignments into administrative and rational categories, suited to the organizational and professional framework of the system itself. Generally, it may be stated that these characteristics and not they alone, are supposed to ensure that every citizen receives equal and efficient service.

It may be assumed that most welfare service systems reach a high standard of efficiency and equality. However, the more a bureaucratic system aspired to bind itself to the characteristics mentioned above, the more distant, estranged and indifferent it becomes with regard to the citizen. The more faithfully a service operates according to procedures, the less it can afford personal involvement. The establishment expects and actually forces it to be objective and rational. The citizen who wants to materialize his rights or benefit from services to which he is entitled is regarded by the official as an anonymous object with specific data according to which alone the services or rights will be granted, Lack of data and mistakes in the filling-up of a form may delay and sometimes cancel the provision of a service or the materialization of a right, just in the time of hardship. The computer, for example, has undoubtedly raised the standard of the rational procedures of a considerable number of welfare systems. Nevertheless, at the same time, many citizens, especially those elderly living in hardship or undergoing a sudden crisis, feel that the conputer has increased the personal estrangement. This development has had a number of negative effects on the quality of life of the needy elederly which will be discussed below. One conclusion to be drawn is that the permanent attachment to rational procedures may perhaps streamline the service supplier's work but at the same time the service recipient, the citizen, becomes a mere object with data instead of a person in need of assistance.

Welfare and service systems have a natural tendency to divide up into specified sub-systems suited to the organizational and professional character of the system. However, human problems are not delimited by defined aspects or spheres. A person's life, especially that of an old person, is not divided into special categories but is integrated into one system. For example, a retired person who comes to arrange his old-age pension at a national insurance branch suffers sometimes not only from economic difficulties but also from ill health or personal and family problems as well as from problems related to his environment as a result of his retirement. The national insurance claims official will, in this case, deal only with old-age pension. If the elderly person is interested in receiving services for his other needs or in solving his other problems he must apply to other systems.

Each system will carry out a thorough examination of his case in order to decide whether he is entitled to its services. The fragmentation of welfare systems into special sub-systems thus increases the interaction between the needy citizen and the service supplier. This development not only reinforces the above-mentioned estrangement between the citizen and the bureaucrat but makes it even more difficult for the citizen, especially the elderly one, to receive a service or materialize his rights.

In addition to the conclusions presented above — regarding attachment and loyalty to rational procedures — an interaction of a special character develops between the citizen and the establishment. On the one hand, the service supplier who operates from a rational viewpoint, fixes procedures such as hours of reception, forms to be filled or obligations to present documents. On the other hand, the citizen who wishes to materialize his rights must conform to those procedures fixed by the official. However, as opposed to the rational benefactor of the service supplier which has been put down in written procedures, the citizen must use a number of skills and know-how without which he will not manage to exploit his lawful rights. The citizen has to be tolerant and patient, to possess a minimum amount of information on his rights, to keep to a timetable, to be able to ask questions, to receive information and to know how to use it. He must be equiped with basic knowledge, to be able to maintain good relations, to be familiar with the labyrinth of forms and to know how to read and write Hebrew. Apart from these requirements he would do well to have some diplomatic capability, to reveal a certain amount of firmness (and some people believe that even a little aggressiveness can only help him...); moreover, he will need — even the smallest amount — of ability to negotiate, of a sense of humour as well as a reasonable amount of physical health (in order to queue up or run from one official to another), optimism and, above all, he must win the official's confidence. Thus a considerable number of skills and a substantial amount of knowledge are involved. A pensioner, old person or any other citizen who lacks the ability or the knowledge how to use these skills or a large part of them will find it difficult, in many cases, to receive the service he needs or to materialize his rights.

Moreover, lack of ability on the part of the citizen to use the skills we have mentioned impairs the rational interaction that the service supplier tries to create in order to fulfil his task efficiently. The official will send the elderly person or needy citizen back and forth until all the conditions are fulfilled: the form is filled in exactly, the right documents or certificates are presented, the applicant appears at the correct time etc. — and only then will he allow himself to deal with the applicant's request or make a decision. In most cases the elderly person will indeed receive the service he requires but this will not prevent a feeling of estrangement and in many cases he will develop a lack of confidence and some suspicion towards the service supplier. Quite a number of elderly persons have despaired after several unsuccessful attempts to receive a service and having reached the conclusion that the process is too tiring, thus foregoing their rights, preferring to bear their hardship silently.

In our estimation, most bureaucratic systems, especially welfare systems, are aware of the absence of the human dimension between the citizen and the supplier as described above. They therefore make continual efforts to improve the services they provide. But in most cases the tendency is to continue concentrating on the search for rational procedures because the officials are trapped in the snare of the establishment concept and then, naturally, nothing changes. On the contrary, the general feeling is that the anomaly and the estrangement between the citizen — especially the elderly one — and the service system are on the increase. There may be no way out of the trap which has been created; in spite of many complaints by citizens, the establishment has not developed mediation services between the citizen and the service supplier (Schwartz & Zalba, 1971). We shall later go into details of the intermediary's role and its impact on the citizen and the official. Here we shall only mention that in the interaction between the service supplier and the citizen, a non- bureaucratic link is missing whose task is on the one hand to work in favor of the simple citizen, who is not equipped with the experience, information and know-how to exploit services or materialize rights and, on the other hand, to help the service systems to achieve their aim. This is not the place to give the reasons why bureaucratic systems refrain from developing extensive and institutionalized mediation services. We will only bring as an example a welfare service which institutionalized and developed (non-bureaucratic) services for the elderly and whose aim was, among other things, to mediate between the weakest and oldest population and the National Insurance Institute and other welfare services.

The Counselling Services for the Elderly and Pensioners in the National Insurance Institute

In 1972, the National Insurance Institute developed a Counselling Service for the Elderly and the Pensioner within its own organization. In addition, a group of friendly home visitors was organized to visit old people who were unable to come themselves to the branch service stations in order to receive aid and advice. The aim of the service was to improve the services supplied to the elderly by the Institute and not to limit itself to the granting of monetary pensions only (Arad & Blumensohn, 1982). The challenge facing the Institute was to recognize the need to place an informal system of advice and mediation not connected with bureaucratic procedures at the disposal of the elderly and pensioners in order to ensure efficient exploitation of the pensioners' rights in the Institute and use of the wellfare services in the community. The founders of the service were faced with a bureaucratic system which regarded the service as an "unnatural" body in a system based on law and rational procedures. Despite everything, and by virtue of the few who believed in the service, the project developed and proved itself.

The service operates today in sixteen of the National Insurance Institute's branches. Its specialty is the fact that it is based on approximately 2,900 volunteers, themselves old people who are operated and guided by thirty professional workers, most of them social workers. Most of the service stations are located in the Institute's branches in spacious and comfortably furnished rooms which give the elderly who come to receive advice a feeling of welcome and understanding in a relaxing atmosphere, without bureaucratic procedures. The eldetly person can apply to a counsellor to whom he feels close without having to fill in a form or even introduce himself. Hundreds of volunteers who make friendly home visits bring, among other things, their service to the homes of thousands of old people who for various reasons are unable to come to the service stations in the branches in order to receive aid and advice.

A counselling service for the elderly is based on the assumption that their problems are not limited to the economic field with which national insurance or other pension funds are supposed to deal. Many old people lack the ability and skill to cope with daily life and the difficulties arising from their loss of status in the business world and sometimes a deterioration in their health which leads to a chain of losses, family, social and environmental loneliness and above all lack of ability to benefit from the welfare services existing in the community. In most cases, these old people need immediate and direct help, not involving bureaucratic procedures, in order to continue to live their lives satisfactorily and independently of others. Accordingly, the task of the counsellor, both at the station and during the home visit is not only to give good advice, to listen and create a continuous and meaningful contact but to be at the dispoal of the elderly and extend active assistance to enable them to exploit their rights in the Institute or their community welfare system (Arad & Blumensohn, 1982). In these cases, the counsellor or home visitor functions as a mediator or advocate (Givoli, 1979). We shall present bellow a number of cases in which the volunteer counsellor acted as a mediator and helped both the elderly and the service system. We shall now discuss mediation in a more specific way.

Presentation of Cases

The following accounts of mediation were given, at our request, by volunteers at a number of counselling service stations for the elderly and pensioners. Names and other identifying features have been erased in order to prevent identification of the clients.

Mr. S., a home-visiting volunteer, was asked to deal with a 70-year-old bachelor living alone. The latter had limited mobility and was unable to leave his home in order to tend to his affairs. He also had difficulties in establishing contacts with others due to his poor command of Hebrew. Mr. S. was asked to make frienfly home-visits and help the old man to maintain contact with various community services.

On his first visit, the volunteer discovered that the old man had been living since his immigration (twenty years earlier) in a dilapidated and leaking hut without proper bathroom facilities. Everybody agreed that he was living in sub-human conditions but nothing was done about it in practice. The old man himself made a number of attempts to improve his situation, failed, despaired and gave up all hope that anybody would be willing to help him to change matters. Mr. S., the volunteer, found an embittered person who did not do much for himself and decided to deal first with his accomodation.

He operated on two levels: on the first, he tried to help the old man to be more active regarding exploitaion of his rights. Following his second visit, he contacted the Ministry of Housing and Amidar Company and got them to work towards solving the accomodation problem. The running-around, the many delays and the difficulties did not deter Mr. S., who continued to represent the old man. After seven months of effort, he succeeded in transferring the old man to a new and spacious apartment to the latter's full satisfaction. In recognition of his efforts, the volunteer received a letter of commendation from the social worker who was supposed to deal with the old man's affairs.

In this case, the volunteer mediated between a handicapped old man and a system whose task was to ensure proper accomodation for the homeless. The volunteer succeeded in getting the system to help the old man, and in getting the old man to help himself. In the second case which will be presented here, a volunteer managed to get two systems to act on the behalf of an old woman.

In the framework of a joint operation of the Ministry of Defence's Rehabilitation Department and the National Insurance Institute's Counselling Service for the Elderly and the Pensioners, a volunteer went to D., a 62-year old bereaved mother and widow receiving a pension from the Ministry of Defence. She lived together with her old mother and her soldier son. D. complained that she could hardly live and that she had not the means to buy the basic products. The house looked poor and neglected and the furniture were mostly old and broken. The volunteer was amazed at the family's condition and asked D. if she received a survivor's pension (since she was a widow) from national insurance. The answer was negative, despite the fact that she had been a widow for fourteen years. The woman did not know what her rights were even though she had brought up five children.

At first the volunteer did not believe her, and clarified the matter with the branch claims offical. It turned out that D. had not submitted a claim for a survivor's pension and the volunteer began to deal with it immediately. He helped D. to obtain a death certificate and other documents and within a short time she began to receive a regular monthly pension. The volunteer applied to the Ministry of Defence and with the help of a rehablitation worker managed to obtain new furniture for D.

Did D.'s plight arise from ignorance of her rights or because the Ministry of Defence's rehabilitation worker did not know what her rights were under the National Insurance Law? It appears to us that her plight arose first and foremost from lack of specific and singular attention on the part of various welfare services.

The next case is that of an old woman, M., who did know her rights but was not entitled to receive a pension because she was not able to obtain the necessary documents. M. told the counsellor at the National Insurance branch that she had been in the country for over two years and had not received a pension despite the fact that she had claimed one. The counsellor discovered that the claims official had sent M. a number of letters but since she had not replied, the matter was closed. The counsellor requested that the file be reopened and discovered that in order to continue to deal with it, M. had to produce a number of documents but was unable to do so. The counsellor applied to the Ministry of the Interior, the Ministry of Immigration Absorption and to the local Council and soon obtained all the necessary documents to complete the file. The claims official acted quickly and M. began to receive an old-age pension. In this case the old woman lacked the capability and dexterity to cope with various bureaucratic systems in order to obtain the documents demanded by the service.

At times, the elderly persons encounter arbitrariness, indifference and estrangement on the part of service systems and only the help of a volunteer acting as an advocate and mediator enables all sides to disentangle themselves. For example: K. lived for a long time in a caravan trailer. He then mananged to rent an apartment from a public company but before he moved in, it was broken in and badly demaged. K. was afraid to live in the neighbourhood and submitted a request to move to another area. The company which owned the apartment demanded that K. pay for the damage before giving him another apartment. This condition was made uncompromising and a charge was brought against K. Penniless and helpless, K. turned for assistance to the counsellor who explained the matter to the company's director-general. The latter asked for various documents and confirmation of the sum of K.'s old-age pension and promised to see to it personally that the charges against K. be dropped. Shortly after presenting the documents, the matter was closed and K. was given another apartment to his full satisfaction.

There are old people living in isolation and hardship who are unable to materialize their rights and whose suffering increases because they cannot find somebody willing or able to lend them a helping hand.

L., an old woman living with her husband, was asked to appear before a committee after submitting a claim for a special old-age pension — an accepted process in a number of National Insurance branches. In the course of the conversation, the counsellor learned that L.'s husband had undergone open-heart surgery and in addition was suffering from other illnesses. The elderly couple was in severe financial difficulty and unable to mobilize any help. The case was brought for consultation before the branch director and it was decided that the husband should submit a claim for a general disability pension. The claim was submitted to a medical committee which granted him a permanent medical disability rate of 100%. As a result the man was entitled to a monthly pension which ensured a regular income for the family enabling it to maintain a proper standard of living.

As in the case of the widowed bereaved mother, the claims official in this case too dealt only with the applicant's problem within the sphere of his authority and not with his general condition of hardship.

The Nature and Scope of the Mediation

Mediation means, according to Webster's dictionary, "intervention between conflicting parties to promote reconciliation, settlement or compromise". Therefore, a mediator should be regarded as a person who looks for compromise or brings about mutual understanding between two parties who, without him, would not be able to maintain the necessary contact for their mutual benefit. Schwarz describes the role of a mediator as an active agent who activates the applicant and the system (Schwartz & Zalba, 1971). The mediator's main task. on the one hand, is to create conditions in which the applicant (or citizen) can materialize his rights or benefit from the services which he needs and to which he is entitled; on the other hand, the system that provides the service fulfills its role in accordance with the law and its aims (Schwartz & Zalba, 1971, pp. 10–12). In the National Insurance Institute's Counselling Service for the Elderly and the Pensioners, the mediator's task, as defined, includes various functions and aspects in accordance with the condition and ability of the old person in need. Sometimes, the mediator acts as a bridge and link, creating contacts and connections between the elderly and the community's welfare systems; at other times, he acts as an advocate or champion of the elderly's rights. In all the cases presented here these functions of the mediator can be clearly seen.

In order to fulfill the various mediating functions, the mediator does not identify completely with his client, the elderly person, against the other party, the service supplier. To succeed in fulfilling his role, the mediator must try to identify with both sides, seeing himself as obligated to both at the same time. However, the counsellor in his role of mediator acts in ways which are suited to the needs — in this case the needs of the elderly — free from the ties of the establishment and its formality. His activity and behaviour differ from those of the professional who is an employee and is often bound by the formalities and procedures of the profession. For example, in the case of the new immigrant, the counsellor acted in the belief that the claims official would do his job faithfully and according to procedures following the presentation of all the necessary documents. In such a case the counsellor uses his skill, known-how, understanding, pressure and good offices — which the applicant does not possess — vis-a-vis the service system so that it will act in accordance with the law and procedures and not against them. The counsellor's strength and efficiency lie in his ability *to reveal the human side of the problem to the service supplier and show him* the plight in which the needy client finds himself. Mediation, or bridging, as part of the counsellors's work, are, as Gotlieb (1980) pointed out, intended to create the contact between the elderly and the service system. In all the cases presented the counsellor acted as an active mediator where the old or the needy person was unable or incapable to obtain on their own the services they were entitled to or to materialize their rights. This activity of the counsellor reduced estrangement, anonymity and lack of confidence in the interaction between the elderly and the bureaucracy. We estimate that both sides gain from it. However, the process has another side to it which we shall discuss in general terms.

As already mentioned, modern society has placed the formal responsibility for supplying welfare services on bureaucratic systems manned by paid employees who generally do not regard the integration of volunteers in their work as having top priority. In order to ensure that such integration take place in a welfare service system, active and accepted cooperation is needed between the wage earners and the volunteers. Schwartz (1977) pointed out that certain myths are attributed to volunteers. For example, a volunteer necessarily has less qualifications then a paid worker; work done for free is worthless; volunteers expect external benefits for their efforts. When paid workers believe in such myths it is difficult to absorb volunteers into the service. Levitas states that paid professional workers tend to be suspicious from the start about the volunteers' good intentions (Levitas, 1977). The officials and professionals in the system regard anybody who claims to want to save the world or improve it by good deeds, with suspicion.

The volunteer who acts as a mediator or advocate, as described above, does not necessarily help the officials to cooperate, change their view or reduce their suspicions of him. On the contrary, experience shows that the volunteer, due to his systematic and energetic activity on behalf of his client often creates tension, conflicts and misunderstanding which strengthen existing myths and suspicions.The volunteer who usually deals with one case aspires to attain immediate results. He appears before the official when it is convenient for him and does not always consider the burden of work on the official or the procedures to which the latter must conform. Moreover, he expects that the service supplier will show understanding, a human approach and willingness to agree. Therefore the volunteer is often regarded as a nuisance and disturbance who upsets the regular work process, makes proposals that contradict the law and procedures and assumes authority which he has not been granted. Nevertheless, despite this image, a certain amount of cooperation is ultimately achieved. This is an interesting phenomenon which merits more study. Only a partial description will be presented here.

It may be assumed that there exists some ideological coordination between the professional official and the volunteer. Both of them, each one from a different point of view, aspire to raise the standard of the human service provided by the welfare systems to the citizen in need or in hardship. The wage earners, such as the claims officials of the National Insurance Institute or the social workers in the welfare system, regard themselves as professionals and aspire to attain sole control of their field of activity and the know-how in their possession. For this reason, as Levitas (1977) has mentioned, professional workers feel they have to reject the possiblity that a non-professional can provide a service of any worth within their professional field. On the other hand, the volunteer who acts as a mediator is familiar with the conditions and procedures which ensure materialization of rights or supply of welfare services but does not have to act in accordance with the laws and procedures of any establishment. The volunteer's motivation stems, among other things, from the desire to do a good and responsible deed on behalf of his "client" and therefore the motivation is unique and urges the volunteer to struggle for his "client".

It may be assumed that this unique motivation receives its strength and the will to contimue, to defend and mediate on behalf of the old person from the volunteer's identification with his client whom he regards as a person in need. The more the volunteer's mediation succeeds, the stronger this identification becomes and so does the volunteer's impetus to act as a mediator. The professional official cannot participate in such a process; on the contrary, he feels threatened by it. It may be assumed that the volunteer is regarded by the official as an outsider, not bound by any procedures or subject to the supervision of the bureaucratic system (Levitas, 1977).

The volunteer is also regarded as someone who can afford to disagree with the service supplier regarding manner and approach and even try to "educate" him at times. These concepts undoubtedly lead to a sense of threat to the latter's status and capability. Hence, it can be assumed that despite the fact that ideological agreement may exist between the official and the volunteer concerning the nature of the service to be supplied to the citizen, in reality considerable complications, conflicts and lack of cooperation arise in the course of the mutual relationships between the official and the volunteer.

In view of the conclusion drawn above, the question arises as to how the volunteer nevertheless succeeds in his bridgework and contact making. The volunteer, as he has been described, struggles on behalf of his client until he attains his aim. In our estimation, there is another reason for the success of his mediation activity. Schwartz (1977) distinguishes between two types of wage-earner in the welfare system. The first is the one with the "professional approach"; the second is the one with the "bureaucratic approach". The former regard their work as a mission; their approach to work is dictated by the needs of society and the service recipients and not only by the formal definition of their task. They do not work routinely or claim exclusiveness in their treatment; and above all, they are not afraid of participating with other people when working with an applicant if they think the latter may benefit from it. Those with the "bureaucratic approach", on the other hand, identify with the organizational framework in which they work and not with the needs of the service recipients. Their way of treating the latter is limited to the formal definition of their task only. Their style of treatment is routine due to the emphasis they place on the system's work procedures and their strong identification with them. They are afraid of cooperating and consulting with others and claim exclusiveness in their treatment of the service recipient.

According to this division the "bureaucratic approach" advocates cannot absorb volunteers or cooperate with them and tend to regard them as a threat to their status. On the other hand, the "professional approach" advocates regard the volunteer as an important participant in the service. They will absorb the volunteer and accept him because they regard him as a person who can help them in various spheres within the system (Schwartz, 1977). There is no doubt that the "professionals" not only absorb and lovingly accept the volunteer (mediator) but strengthen him and help him in his task.

The volunteer has no way of knowing beforehand whether the official he approaches is a "professional" or a "bureaucrat" but it may be assumed that in the course of time he learns which official is ready to cooperate with him and help him. We have no evidence to prove it but it may be assumed that the success of the volunteer in performing his mediation role is made possible mainly because he works together with "professional" officials. It may also be assumed that to a certain extent their prolonged and continuous work with the service systems exert a positive influence even on those officials whose approach can be described as "bureaucratic".

The mediator-counsellor is not regarded as an agent of change in the Counselling Service for the Elderly and the Pensioners despite the fact that his work sometimes leads to personal and environmental changes as in the case of K. The volunteer-counsellor regards his work as an important and worthwhile mission resulting mainly from his sense of obligation and concern towards his client and the system, all this without renumeration. Langerman, referring to the integration of volunteers in welfare services, says: "By its nature, volunteering focuses on man's internal duty towards his fellowman as well as the community and society in which he lives. The significance of this obligation is expressed in the individual's assumption of responsiblity for what is happening in society and in his active participation in what is happening in his presence in his own circle. This concept demands not only consciousness and readiness to respond but private initiative to take actions, with deeds — whether few or many — constituting the main foundation" (Langerman, 1980).

Involvement and obligation on the part of the counsellor as in his role of mediator brings prestige, status and appreciation not only to the volunteer himself but also to the welfare system which is prepared to support him and use his services. Moreover, the volunteer's involvement as part of the welfare system ensures that for the weakest population group, i.e. the elderly and society as a whole, a direct and non-bureaucratic system, in addition to the formal service system, will be at its disposal at a time of crisis and hardship. This approach is strongly and clearly supported by the National Insurance Institute and the cases quoted above testify to the efficiency of the volunteer-counsellor's service within the bureaucratic welfare system. Our experience shows that the elderly, like other people, do not want to be helpless and dependent; they are not built to be passive; they have wishes of their own in times of crisis too.

On the other hand, experience teaches that the service supplier or the director in the National Insurance Institute and other welfare systems is interested in fulfilling his tasks faithfully in accordance with the law and procedures. The volunteer-counsellor takes both wishes into account and forges a link between them. We believe that this activity of the volunteer is the most fitting interpretation of the humanization of the welfare services. This humanization is almost the only way to work against estrangement, anonymity and the lack of confidence which exists and is growing between the elderly and the establishment.

Summary

In this article we have attempted to present the mediation role as part of the counsellor's work in the National Insurance Institute's Counselling Service for the Elderly and the Pensioners. We have tried to show that welfare services continue to be faithful and tied to rational procedures and, consequently, the mutual activity between the citizen, particularly the elderly, and the service supplier, is becoming more complex and complicated. We presented a number of cases in which we attempted to show that an old man or elderly widow living in hardship and lacking the ability, dexterity and know-how to act in accordance with bureaucratic procedures, is entirely exposed to his hopeless plight. The only way to assist this weak group is to provide a volunteer counsellor who acts as part of the establishment welfare system and whose task is to mediate between the needy elderly and the system that is supposed to supply welfare services.

The volunteer mediator, as we have described him, belongs to the system that supports and operates him but is not bound to that system's formal procedures. The mediator acts as a link in order to create the conditions that will ensure that the system supplies the elderly with the service or materialize the rights to which they are entitled. In this process the mediator creates and ensures the humanization of bureaucratic welfare systems.

As a final conclusion it should be stressed that we do not expect that the bureaucratization of the welfare services will ever come to an end; therefore, the existence of volunteer counsellors (part of whose task is to mediate) within welfare services ensures that the weak and poor population has a single address to which they can turn for help in time of need.

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DEVELOPMENT OF APPLICANTS' INDEPENDENCE, RESPONSIBILITY AND COOPERATION IN THE TREATMENT PROCESS

by Gur Haran*, Sara Ofir**, and Rachel Naftali***

Introduction

The Rehabilitation Department of the National Insurance Institute is responsible, by law, for the rehabilitation treatment of various groups of disabled and widows. The traditional rehabilitation process includes location, assessment, processing and implementation of vocational rehabilitation (training) programs, assistance in job placement and follow-up of the rehabilitee's integration into work. The goals of the Department's treatment as summarized in "Developing the Rehabilitation Department's Activity by Goals and Objectives" (June, 1982, p. 15), stress vocational rehabilitation (preparation for work, sheltered employment and assistance in placement). The rehabilitation officials being responsible, by law, for the rehabilitation program beginning with the decision regarding the applicant's entitlement to rehabilitation, through approval of the program and ending with the follow-up of the integration of the disabled person into employment.

Among applicants to the Rehabilitation Department there are severely disabled people with extremely limited independence in daily life amongst whom a connection is not always to be found between the severity of their disability and their ability to integrate into employment and community life. Therefore the staff of the Rehabilitation Department sought other methods in addition to the traditional ones in order to achieve its goals of absorption in employment and integration into community life.

According to the accepted approach of social workers, the diabled person is a full partner in the rehabilitation process. Nevertheless, we found that in many cases, the rehabilitee develops a dependency on the rehabilitation

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specialist who in turn shows signs of patronage towards the client, which stem partly at least from the legal and professional authority possessed by the rehabilitation official. The tendency towards patronage is at times expressed in the attempt of rehabilitation workers to force their opinions, to supervise, dominate or direct the behaviour of their clients even if they are not always aware of this tendency. This situation urged the Rehabilitation Department's staff to put their efforts into developing ways of treatment aimed at bringing about greater independence of the disabled person and to make him accept a greater degree of responsibility for his life through the course of the rehabilitation process. This approach of transferring more independence and responsibility to the client himself has been adopted some years ago in several countries.

In the United States, the trend of increasing disabled persons's independence started about twenty years ago. The program for disabled students at the University of Illinois was one of those aimed at integration of people with serious physical disability. In 1982, severely disabled students were moved from distant and isolated dwellings in which they had nursing supervision to a house adapted to their needs in the center of the campus. Since then, the program for severely disabled students has developed as a meaningful effort of self-help and has resulted in this university becoming one of the most accessible institutions from an architectural point of view (Crewe & Zola, 1983, p. 8). However, the main impetus to the Independent Living Movement came from the establishment of the independent Living Center for the Disabled at Berkeley University California, in the early 1970's (Vash, 1981, p. 211). A number of severely disabled graduates of Berkeley discovered that their academic diploma was not sufficient to enable them to settle in work and live independently. As a result, they established the Center with the purpose of enabling them to live independently in the community and not return to boarding institutions or be dependent on their parents again after completing their academic studies. The phenomenon apread and according to Vash (Vash, 1981) independent living centers for disabled persons were established in many places at that time. Other states such as Texas, Ohio, Massachusetts etc., began to develop centers or programs for disabled persons' independent living.

According to Rubin and Roessler (Rubin & Roessler, 1983, p. 205) the idea of independent living for disabled persons was rooted in the first Rehabilitation Law passed in the United States in 1902. This law stated that training for home employment was to be considered a suitable training program and legitimate employment target. Despite the fact that as early as the 1960's attempts were made to pass laws to make independent living for disabled persons possible, this goal became a realistic one only in the 1970's.

The significance of increasing disabled persons' independece differs from society to society and the nature of the problems involved are different in each place. Due to differnces in historical development, legal systems, values, social norms and the like, the situation of disabled people and the approach to their problems differ from one society to another (Tate & Chadderdon, 1982, p. 161). Efforts to grant greater independence to disabled persons are made in environments composed of complicated variables of an economic, social, cultural and political nature.

Definitions of independnt living for disabled persons can be found in the professional literature - from two viewpoints:

The first viewpoint is that of the consumers and stresses the ability to participate actively in community life. Rice & Clark, for example, define independence for disabled persons as the ability of the severely disabled to play an active role in society, to work, to possess property (mainly a home), to bring up a family and generally to participate as much as possible in normal daily activities (Rice & Clark, 1980, p. 6). Wright (Wright, 1980, p. 733) writes that disabled persons independent living means the ability of a disabled person to control his life and reduce his dependence on others to a minimum so that he can make decisions independently concerning his own daily life. Rubin and Roessler $1983, p. 206) quote definitions of various writers who stress different aspects of disabled persons independent living. Cole and his colleagues (Cole et al., 1979) emphasize the need to achieve adults' rights and privileges. Stoddard-Pflueger (Stoddard-Pflueger, 1977) mentions the need to play an active role in society. Cassat-Dunn (Cassat-Dunn, 1979) writes about the need to choose and maintain a life-style based on the personal aspirations, means and expectations of the disabled persons.

The other viewpoint is that of the service suppliers — the rehabilitation specialist who regards the Independent Living Movement as additional — more comprehensive — services to disabled persons, i.e. rehablitation services beyond those given traditionally by professional rehabilitation services aimed at improving quality of life or, in other words, supply of rehabilitation services in broader areas of life such as housing, mobility, leisure time etc.

One of the aims of the Independent Living Movement which grew in the United States against the background of previous social movements such as the Civil Rights Movement, the consumer movement and the like, was to anchor the rights of disabled people in the law. Rubin and Roessler (1983, p. 217) stress that the concept of independent living reflects a development of the recognition that people with severe disability can achieve greater control over their lives by means of supportive services and removal of environmental obstacles. De-Jung claims that beyond the goal of ensuring disabled persons' rights, the Independent Living Movement represents an attempt to change attitudes towards disability and disabled people and to promote new methods of intervention (see Crewe & Zola, 1983, pp. 11–20). The encouragement of the establishment of self-help groups, peer counselling and the like, constitute the basis of many disabled independence projects being undertaken according to three models which are accepted in the United States. Those described by Rice and Clark (1980, pp. 14–15) and Rubin & Roessler (1983, p. 210) include the community model, the boarding model and the transition model.

In Vash's view (1981, p. 52), the development of the Independent Living Movement as a consumer movement of the disabled is perhaps the most dramatic event in the history of rehabilitation. After centuries of isolation, estrangement, control and supervision by others, the people with the problems finally arose and proclaimed that they "prefer to act themselves". They added: "Till now, you gave us your money, now give us our rights". These were significant and deep expressions of the new direction whose principle was that the disabled people are interested in accepting responsiblity for their own lives and making an effort to normalize their way of life.

The development in the direction of greater independence for disabled people was emphasized more, as stated, in the United States in the last two decades. However, in other countries too, which developed rehabilitation services, much effort is being made to increase disabled people independence as described by Tate and Lay (see Crewe & Zola, 1983, pp. 88–112; 1982). The goal of the struggle for disabled people independence according to Vash (Vash, 1981, p. 48) is to lead a more or less normal life in more or less normal surroundings whilst breaking out of the circle of poverty and limitations, leaving institutions and entering the mainstream in all levels of life, starting with education, through employment, social and community life and ending up with family life. In other words, the goal of the Independent Living Movement is normalization of the disabled person's life.

The concepts and techniques developed in various countries as well as the social and economic developments that took place in Israel have led the Rehabilitation Department of the National Insurance Institute to undertake new activities and develop new trends of treatment. These trends are meant to reinforce independence and assumption of responsibility by the Department's clients as well as choice — and acceptance of responsiblity for the choice made by the client — at key points of the vocational rehabilitation process. These trends were expressed in programs based on a less patronizing approach and increased independence of the disabled persons and the responsibility that they assume. In addition, ways were sought to reduce dropping-out from the rehabilitation treatment process and to develop a deeper awareness on the part of the applicant of his own needs. At first we defined clear goals and located clear and efficient rehabilitation techniques derived from these goals. In other words, our starting point differed from that in the Unites States but the trend towards greater independence, responsibility and participation of the applicant in the treatment process, the goal and the techniques to achieve them are quite similar to those in other countries.

Nevertheless, it should be remembered that these programs are not suitable for every type of population group treated by the Rehabilitation Department. Some applicants do not integrate into work with a group while others require a greater degree of initiative on the part of the rehabilitation official. Some disabled people do not have the required strength to accept responsibility for independent living in the community, yet they are entitled to the services of the Rehabilitation Department. Therefore, there is no intention to cancel the traditional treatment methods conducted by the Department and the programs described below are supplementary to those techniques that have been used in the Department.

Orientation Workshops for Applicants

The orientation workshops were adapted to a large group of applicants in the initial stages of the rehabilitation process. The participants in these workshops are undependent in terms of sex, type of disability, occupational background, education, etc. The purposes of the workshops are to provide information about the Department and the rehabilitation process, to enable the applicant to participate and to take responsibility in choosing a rehabilitation alternative, to stimulate his motivation by clarifying his expectations and attitudes regarding the rehabilitation process as well as his ability to integrate, and utilise these systems to his benefit, to provide support and encouragement in order to develop his faith in his ability to manage his own affairs and ultimately to enable him to begin his relationship with the rehabilitation officials from a better starting point, with a better understanding of the essence of the rehabilitation process. In this way, he will be able to make better choices and undertake more personal responsibility and commitment to invest in the rehabilitation process.

The workshops last three to five days, sometimes running consecutively, and sometimes spread over two weeks. The program includes familiarisation, providing information by means of lectures and such aides as slides, clarification of the term "rehabilitation", discussion on problem solving and decision making processes, discussion on expectations and separation, all of which is done with the aid of simulation, group dynamics, games and other means of demonstration. There are very few lectures or frontal presentation in the workshops. On the other hand, the participants are enabled to define what rehabilitation means for them. Following this, they are shown that their goals, expectations and desires are not different from those of the rehabilitation officials.

There is very little group dynamics in the workshops and more emphasis on tasks with mutual assistance and less dependency on the instructions, but more on the group. The approach is more cognitive and behavioristic and the techniques too are basically cognitive and behaviorist. The situations in the group create an atmosphere of acceptance of personal responsibility towards rehabilitation. The issues in the group (not the dynamics) enable the participants to see the range of rehabilitation opportunities and enables them to choose. It is a sort of "supermarket" which has something suitable for every rehabilitee and therefore it is worthwhile for each one to choose the way most suitable to him. The decision-making leads to a sense of commitment on the part of the rehabilitee together with a feeling that it is wortwhile and important for him to put effort into it. The atmosphere of acceptance in the workshop also enables the rehabilitee to break the chain of withdrawl and abstention (Givoli et al., 1986, pp. 5–6).

After conducting several orientation workshops at various National Insurance branches it seems to us that, in addition to attaining the stated goals that were set at the begining, a number of other results have been achieved:

1. Anxiety was reduced through a "softer" entry into a better "known" system.
2. The group process itself produces commitment and progress in the rehabilitation process within a short time.
3. The group influenced each of its members to see his strong and healthy side as opposed to the one to one relationships in which emphasis is placed on the difficulties and limitations arising from a disability.
4. The group promoted identification and strengthened the sense of self-confidence amongst the participants.
5. The removal of formal bureaucratic barriers between the rehabilitation staff and clients, leads to a better cooperation between them.

Coming to Terms with Disability through Group Dynamics

After the applicant's entry into the rehabilitation process, the next stage in which the disabled person is liable to develop dependency or refrain from developing a sense of responsibility is his coming to terms with disability. At this stage difficulties in adapting to the disability and the loss arising from it appear. The disability and loss are followed by a process of mourning which includes pain, sorrow and longing for the former situation and finally, adaptation and reorganization. In order to reduce dependency and increase the independence and responsibility of the rehabilitee, he should become involved at this stage in planning his rehabilitation process. Disability itself is an objective situation, but its consequences are very subjective and personal. Disability has a different significance for each person and each person has his own way of coping with it.

Wright (1983) presents two possibilities for the disabled person: to submit to the disability or to accept it. A disabled person who submits stresses his loss and seeks "solutions" in medicine and frequent visits to his doctor; he reduces his family and social activity and in the course of time his limitation spreads to all areas of his life. On the other hand, a disabled person who is reconciled to his disability must undergo a process consisting of four stages:

1. Preventing the limitation from spreading to other spheres of life.
2. Directing the focus of the system of values from physical values to other values.
3. Avoiding comparison of the present situation with that in the past and with that of others.
4. Recognition of his skills and developing this asset.

Rehabilitation is a process by which a disabled person can be helped to learn to see his ability and exploit it to build an infrastructure for the future. Thus reducing the scope of his disability and expanding the possibilities of his activity in society, work and family. A direct result of this is the creation of satisfaction for the disabled person and for those who come in contact with him.

The Rehabilitation Department deals with this subject in a number of ways. Most of the work is concentrated on individual treatment but there are rehabilitation units which have started to develop workshops or group activity to process disability at this stage. These groups are delimited in the time and focus mainly on a change in the disabled person's concept of himself as a person with capability who is able to assume responsibility, take initiative and develop a rehabilitation process for himself.

Various techniques and aides were used in these groups such as: discussion, drawing, writing and role playing in order to help the clients to see where they stand after recognising their ability: in the family circle, the social circle and the employment cycle. The groups dealt with the following questions: "How do I really look upon myself and my limitations? Do I regard myself as a sick person, a disabled person or a person with limitations? How much do I brood over my loss? The purpose was to create an atmosphere of ability and responsibility and to stress that whatever the disabled person could do is an asset. There were even groups which produced a motto: "I recognise my limitation but I am still worth something and can do many things that will cause me and others satisfaction".

Self-help Groups

Another aspect of the acquisition of independence and responsibility by the applicant in the framework of the rehabilitation process is the self-help group. The background to the establishment of these groups was social movements such as De-institutionalization, Civil Rights, etc, and the model to their organization was Alcoholics Anonymous. As stated, such groups began to become part of the establishment in the United States already some twenty years ago. In Israel, the background from an historical, social, economic and value point of view was different from that in the United States (see Tate & Chadderdon, 1982; Tate & Lay in Crewe & Zola, 1983). Therefore the self-help groups which developed in Israel differ from those which developed in the United States. Those groups also arose to solve problems of rehabilitees in sensitive social and psychological spheres or to meet other needs of rehabilitees but they differ from the American groups insofar as the initiative for their organization came from the professional workers representing the bureaucracy. This initiative is expressed by the fact that the rehabilitation officials guide the groups in their first meetings. According to their instruction, the group must define its aim and it will become a self-help group after the instructors cease to guide it. Already in the first stages of organization, the instructors enable the group to decide on its goal and they help only in organization. After about ten meetings they stop the active instruction of the group but continue to accompany it as advisers.

The groups are characterized by: personal participation, the determination of goals and ways of actions, mutual relationships among the applicants, transition from a condition of weakness to one of mutual support and reinforcement by the group's members. The instructors who are involved in the groups' organization attach importance to the fact that it is the people with the problems who are the ones likely to know how to cope with them because they are aware of them, are directly acquainted with them and are most interested in solving them. The solution of the various problems of the rehabilitees by themselves is likely to constitute a supplement and complement to the general rehabilitation process. Those rehabilitation officials who act as instructors have received special training in the framework of the Rehabilitation Department. They try to stress the principles of the self-help groups: every participant helps and is helped, every group must have defined goals, the groups consist of equals, the group must encourage ability to assume responsibility and achieve self-realization.

The purpose of the various self-help groups set up by the rehabilitation officials is to develop a group of active people among the rehabilitees receiving services from the Department. During his participation in the group, the rehabilitee undergoes a process of socialization leading to growth and development. The process consists of a number of stages:

1. *Creation of a primary basis — confirmation and stress of the existing* need.
2. Creation of group cohesiveness among the members and determination of initial identity.
3. Internal institutionalization and planning of activities, distribution of tasks, crystalization of procedures and norms.
4. Group activity together with maintenance of contact with community factors and coping with threatening objects.
5. Introspection — to continue or stop the activity, following the achievement of the group goals.

This group framework prepares its members for greater responsiblity and independence and causes a change in their lives.

Up to now, twelve self-help groups have been established in various rehabilitation units in Israel. The intensive instruction given to them generally lasts three to six months. Groups which continued to operate afterwards on their own continued to receive support and counselling from the instructors. Approximately half of the groups organized themselves to set up a social club which operated within the framework of a community center or other community framework. The organization of a self-help group has its own specific character in each place, according to the rehabilitation unit, the members of the group and the local conditions. An outstanding example of this is the group of disabled people which established a club in Rishon LeZion (Reinhold & Hershkovitz, 1986).

As stated, the development of new treatment trends, as described, is not a substitute for but an addition to the traditional rehabilitation processes. In other words, the rehabilitation workers continue to deal with rehabilitation by means of vocational training programs in various courses, or study programs and individual training, case work and the like. They continue to deal with the welfare of the disabled persons who are entitled to various benefits such as financial aid to solve problems of mobility and housing pensions for victims of hostile actions and work injuries etc. However, applicants who do not achieve the principle goal of integrating into work, after completing their vocational training in the course of the traditional rehabilitation process, are given another opportunity in the placement process.

The Placement Process

The last stage, which is the climax of the rehabilitation process is placement in suitable employment. This is the stage in which the rehabilitee is expected to put into practice what he has learned and absorbed in the rehabilitation process in order to find suitable work. As a result of these expectations which mean that the applicant has "already graduated", a regression may appear accompanied by a feeling of helplessness and fear of undertaking anything or entering the stage which clearly indicates that soon he will be cut-off from the rehabilitation service, i.e. that the applicant "has succeeded or not succeeded in the rehabilitation process". This is also a stage in which questions of the rehabilitee's independence and responsibility arise.

In the placement process, the applicant must mobilize all his powers of initiative, responsibility and persuasion. For this reason it sometimes happens that many rehabilitees experience a feeling of failure; verbally, they actually express their desire to work but fail in arranging work for themselves in practice. The rehabilitation official often hears such expressions as: "They're not prepared to take me on because I'm disabled"; "The Boss wasn't there, I'll retutn next week".

A new factor appearing in the placement process which did not exist in the rehabilitation process is the rehabilitee's need to prove his capability to objective persons outside the Rehabilitation Department which do not have a treatment, supportive and understanding approach towards people with disability. These persons make their decisions on the basis of economic profitability and output.

Various groups can be discerned among the rehabilitee population that reaches the placement stage. Some of them manage to get work on their own (by exploiting social contacts and various acquaintances) and some obtain work with the assistance of the employment agency, whereas others fail to find work in spite of all the assistance offered to them. The latter are in fact those who reach the situation of regression and helplessness despite the fact that they have passed a rehabiltation process similar to that of others.

As regards the population which expresses a wish to work but fails to do so, the Rehabilitation Department decided to adopt the technique of Job Clubs. These are workshops for seeking employment in which certain changes were made to suit Israeli conditions (Gordon, 1983). As stated, this technique is suitable for a certain type of population, particularly people with various degrees of disability who are interested in returning to work following diagnosis and have decided on their professional goals or have been trained in a new vocation or those who can do unskilled labor. The method, developed and practiced mainly in the United States (Azrin and

Beselel, 1980), is *meant to cultivate the art of finding* work among the unemployed, especially those who belong to vulnerable groups which include disabled persons. The method is based on the behaviouristic approach which advocates a change in attitude and behaviour by means of reinforcement, models for imitation. ets. with regard to problems of "here and now" without going into the initial contexts of these problems. The methods used in job clubs concentrate on one section in the rehabilitation continuum: preparing the rehabilitee to seek and find proper work.

The job club includes:

1. Developing communication skills, learning how to best present oneself before a potential employer.
2. Developing the ability to locate information on the labour market in various ways.
3. Easier entry into the field of job-seeking with the help of guidance and instruction.
4. *Bringing the rehabilitee to a situation of maximum functioning in job-seeking.*

The workshop is based on the principle of operating people which leads to getting things done. The activity is intensive and stimulates people to talk, to act in a proper way, to adopt a positive attitude towards the world of employment, to focus on their healthy side and emphasize their positive abilities and qualifications. The job club's approach encourages the expansion of the potential occupational repertoire of each rehabilitee.

The *main emphasis is placed on the assumption of responsibility* by the rehabilitee for the job placement process, that is to say, location of a suitable place of employment and taking the necessary steps to obtain the employment. The rehabilitees are taught how to "sell themselves" successfully to an employer, despite their limitations; how to present their capabilities and advantages to show that it is worthwhile employing them; how to speak up for themselves during an interview with a potential employer; how to locate a possible place of employment and how to obtain an interview and get the job. All this means that the rehabilitee is taught that he is *responsible for finding* work with the help of the tools that he receives at the workshop. Hence it is also clear that this is a significant example of the development and independence of the client which demonstrates in a practical way the approach that advocated helping applicants to help themselves.

The achievements of the job clubs are reflected first and foremost in the larger number of job placements. The rehabilitation workers trained to instruct in the job clubs were enthusiastic about the new technique

(The National Insurance Institute, 1983). According to Gordon's opinion (Gordon, 1953, p. 9), the job clubs attained very important achievements and "it appeared that even those who have not yet managed to find work and certainly those who have done — acquired readiness to accept responsibility, to become independent of others and gain self-confidence. They learned to refrain from explaining every failure by their disability and learned about fields of employment of which they had never thought before".

Summary

The trend to encourage disabled persons to assume responsibility for independent living was comprehensively expressed in an innovative program for urgent and intensive rehabilitation treatment (Givoli et al., 1988). In the framework of this program a concentrated workshop was held which dealt with various aspects of the rehabilitation process from its start (diagnosis) through various stages (coming to terms with disability, vocational tendencies, social activity, etc.) to its completion (ways of seeking employment). This program is, as stated in the introduction to the section on the workshops, a faithful reflection of the Rehabilitation Department's work program and it fits in well with the goal that the Department set for itself: to make rehabilitees do things systematically instead of "doing things for them" and leaving them in a passive condition. Accordingly, the workshop used methods mentioned above together with other new ideas. The workshop succeeded in making disabled persons help themselves, revealing hidden strengths, and developing various activities (Givoli et al., 1985).

According to the staff's point of view, the workshop for urgent and intensive rehabilitation treatment saved many workshop hours. The actual current costs were also low. Thus it may be summed up that in comparison with the regular rehabilitation process, the workshop proved itself both in terms of the rehabilitation results and in terms of the low cost per treatment hour. As regards the rehablitation workers, we learned the lesson that when goals are defined clearly it is easier to create rehabilitation treatment techniques relevant to the goals or derived from them.

The treatment processes consolidated in the Rehabilitation Department also testify to the fact that we are more conscious of and seek the connection between the treatment input and output. In other words, clear goals lead to clear treatment technology which make it possible to assess whether the treatment methods led to the achievement of the goals set.

Since the workshop for urgent and intensive rehabilitation treatment encompassed most of the principles and techniques developed in the Rehabilitation Department in order to increase disabled persons' independence and responsibility, even though in a brief and concentrated way, it appears that it is possible to generalize about the results of this workshop with regard to all the approaches and techniques of the same trend. In other words, the increased responsibility and independence of the disabled persons improves and streamlines rehabilitation processes from a cost viewpoint too.

Indeed, there still remain many questions concerning the continuation of the trend of increased responsibility and independence among disabled persons. For example, which type of disabled persons can benefit from this trend? Is it possible, and if so how, to apply this trend to work with individuals and not only with groups? How should one organize in order to reinforce the trend of responsibility and independence? Should the trend be given a legislative expression?

The combination of work with groups in various frameworks such as orientation workshops, self-help and job-seeking together with the Rehabilitation Department's treatment program was an innovation in itself compared with the traditional individual treatment in which only the rehabilitation worker and the rehabilitee participated. Moreover, the various forms of group meetings stressed the importance of the role the disabled person plays in his rehabilitation process, in contrast to the far greater responsibility that the "rehabilitation expert" takes upon himself in the individual frameworks of worker-client relationships. However, in each of the various groups too, additional innovations can be found compared with the individual treatment process. For instance, in the orientation workshops the participants were enabled to define for themselves the meaning of rehabilitation instead of having it made for them by the counsellor. In the self-help groups it is the participants, not the instructor, who define (diagnose) the problem. They also decide which is the best way to cope with the problem defined. In the job-seeking workshops the participants are taught job seeking and work absorption skills instead to being referred to placement officials.

There are many examples of innovations in the new treatment trends and they are particularly outstanding in the urgent and intensive treatment workshops in which a combination of techniques learned in the various group activities was used. But it seems that the principle importance of these trends lies in the increased emphasis placed on the client's responsibility, independence and participation. It appears that these trends also improve the achievements of traditional professional rehabilitation. In addition, it emphasises the values fo the democratic society. In the light of all this, it is our opinion that the efforts devoted to the development and advancement of these trends should be continued.

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