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SOCIAL SECURITY

JOURNAL OF WELFARE AND SOCIAL SECURITY STUDIES

Jerusalem, Israel

Foreword by the Director-General of the National Insurance Institute of Israel • The Welfare State - Continuity, Change, or Dissolution? • Defining Needs for Neighborhood Services in Arab Urbanizing Settlements of Israel. Application of the Value Stretch Model in Social Policy Planning • Organizational Dilemmas in Community Neighborhood Organization. The Jerusalem Experience • The Insignificant Other- How Social Marginality is Symbolically Constituted • Overprotection Versus Discrimination in Legislation for the Disabled (Work Injury and General Disability) • Some Issues in the Use of Dependency Tests for Determining Eligibility for Long-Term Care • Evaluation of Community-Based Residences for Persons with Mental Retardation • The Power of Physicians in the Welfare State: Analytic Framework and Israel Case Study • The Health Insurance Law. Background, Principles and Implementation

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CONTENTS

Foreword	Yossi Tamir	5
The Welfare State - Continuity, Change, or Dissolution?	Prof. Yosef Katan	9
Defining Needs for Neighborhood Services in Arab Urbanizing Settlements of Israel: Application of the Value Stretch Model in Social Policy Planning	Baruch A. Kipnis and Yael Aspis	31
Organizational Dilemmas in Community Neighborhood Organization: The Jerusalem Experience	Prof. Hillel Schmid	52
The Insignificant Other: How Social Marginality is Symbolically Constituted	Prof. Haim Hazan	72
Overprotection Versus Discrimination in Legislation for the Disabled (Work Injury and General Disability)	Bracha Ben-Zvi	89
Some Issues in the Use of Dependency Tests for Determining Eligibility for Long-Term Care	Sarit Baitch-Moray, Allan Zipkin and Brenda Morginstin	103
Evaluation of Community-Based Residences for Persons with Mental Retardation	Prof. Arie Rimmerman and Dr. Chaya Schwartz	123
The Power of Physicians in the Welfare State: Analytic Framework and Israel Case Study	Prof. Yael Yishai	134
The Health Insurance Law: Background, Principles and Implementation	Shlomo Cohen and Reuben Steiner	171

FOREWORD

The National Insurance Institute is happy to present to the professional community and to its regular readers the fourth issue of the *Social Security Journal* in English. As in the past, the volume includes selected articles which appeared in the Hebrew editions of *Social Security* over the past two years. Like the previous volume, it does not focus on a single topic, but rather presents a variety of topics which together provide an updated picture of what has been happening in Israel in the different fields of social welfare: problems high on the public agenda, the different approaches to these problems, achievements and failures.

The opening article by Yosef Katan relates to statements made in certain political and social circles to the effect that the welfare state is in the process of disintegration. Based on public attitudes towards governmental involvement in welfare as well as on concrete social policies, it is maintained that although the Israeli welfare state has achieved only part of its original objectives, and in spite of the changes it has undergone, supposedly leading to the formation of a heterogeneous welfare arena, there are indications of growing awareness of both the risks involved in an intensive privatization process and of the importance of continuing governmental involvement in welfare. Such awareness may lead to a "balanced welfare state", characterized by fruitful cooperation between various organizations, including the government sector, rather than to its disappearance

In view of the growing role of communal services in welfare, some of the relevant dilemmas concerning both the Arab and the Jewish sectors are dealt with in two different articles.

In the first, the "Value Stretch" model, initially employed by Della Fave in 1974, is used in order to explore and define the needs for 13 neighborhood services by the residents of Arab urban settlements in Israel, undergoing extensive modernization processes. On the basis of a sample of over 600 interviewees in four settlements, three of the model's stretches were defined: the "satisfaction gap", the "reconciliation gap" and the "value stretch" (the sum of the first two) were measured and analyzed. Neighborhood roads and health services were found to be the most important for the "well-being" of the population. Employing test statistics,

it was found that the model stretches of the 13 neighborhood services are both place and class differentiated. The findings are important in defining the essential services for different population groups, and in ranking them by the level of importance that each population group attaches to the service. The "Value Stretch" model permits the planning of service allocation resources according to the priorities of the population involved, and in appropriate stages.

The other paper, by Hillel Schmid, describes, analyzes and evaluates the merger of Neighborhood Self Management Organizations (NSMO's) and Community Service Organizations (CSO's) in Jerusalem. Since its establishment, the merged organization has been trying to establish a strategy in an attempt to gain public and institutional legitimacy. The following five main dilemmas the merged organization faces are. the dilemma of unique identity and conceptualization of the merged organization achieving political and public legitimization, the role and functions of the board of directors, professional vs. political values and the need to restructure the organization. Analysis of the dilemmas based on the theoretical background is suggested.

Concerning claims that social practices which seek to "rehabilitate" liminal groups often also inadvertently reinforce these groups' exclusion as "others", the fourth article, by Haim Hazan, illustrates this by drawing on two examples from the Israeli field. One is the media event of the "Teletrom for the Elderly", in which the aged were constructed as a symbolic type. The second is the rhetorical construction of an urban renewal setting as a new community. Both examples demonstrate the elusive discourse of "rehabilitation", "support" and "renewal" whereby social others are seemingly incorporated into society but are practically excommunicated to symbolic enclaves where the individual remains subjected to its stereotypization.

Three articles relate to specific groups covered by welfare programs: the disabled, the elderly population receiving long-term care benefits and mentally retarded persons.

In view of inequity in the rights of the various types of disabled, with generous benefits being accorded to those who were injured at work as opposed to smaller allocations to those eligible under General Disability, Bracha Ben-Zvi proposes to combine the two different disability schemes into a single system which will give a single definition of disability - the one presently used under General Disability - for all persons suffering from impairment, regardless of its source or cause. The benefit, however, will be

linked to the disabled person's average income prior to the onset of impairment.

Five years after inception of Long-Term Care Insurance, which grants long-term care benefits to eligible elderly, two issues related to the evaluation of dependency tests are examined. The first issue, raised by Sarit Baich-Moray, Allan Zipkin and Brenda Morginstin, is the question of uniformity in the determination of eligibility: are the tests administered equally to all claimants? Secondly, what is the correlation between the individual score components of ADL (activities of daily living) and eligibility determination? To what degree are these individual components also uniformly measured in the dependency tests? Findings are presented which support the use of dependency tests as a reliable tool for identifying the target population. These are supplemented by the analysis of survivors' assessment of both those eligible and those rejected. Assessment of the need for constant personal attendance, however, showed considerable variation, raising questions as to uniformity of its application. Analysis of the dependency test demonstrates a hierarchy in ADL scores related to personal functioning. Profiles of dependency are identified for those rejected as well as for those who were eligible.

In the last 15 years there has been an expansion of community residential programs for adults with mental retardation. The need for an evaluation of these programs has been supported by a recent national study of all community-based residences for the above population. The purpose of the article by Arie Rimmerman and Chaya Schwartz is to present the rationale for evaluation of community-based residences for the mentally retarded population, and to review three core methods of evaluation: (1) development progress, (2) environmental adequacy, and (3) organizational performance. In every one of the three evaluation categories the common instruments used for measurement are presented. The article ends with an examination of the implications for the Israeli reality.

The following paper, by Yael Yishai, addresses the dimensions and sources of physicians' power and its constraints. Power (professional, economic, and political) is perceived as a product of (a) the policy arena (political, administrative, professional and public); (b) the environment (political and medical market); (c) physicians' organizational resources. Physicians' power may be curbed by constraints emanating from economic, professional and public factors. The analysis of the Israeli case study reveals the sources and constraints of the physicians' power. Constraints are less visible here than in other western countries, Israeli physicians having

exerted their influence mainly in the professional domain; less so in the economic and political domains. Although they have successfully vetoed policy proposals relating to health insurance, their past participation in the formulation of health policy has been rather limited.

The article by Shlomo Cohen and Reuben Steiner, presenting the background and principles of the Health Insurance Law, as well as the lessons learned from the first year of implementation, which concludes this issue, was included as an exception, not having appeared in any of the previous issues of *Social Security*. The Editorial Board felt that, due to the far-reaching changes introduced by the law into Israel's health system, the article would be of considerable interest to readers abroad.

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

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

Yossi Tamir
Director General
National Insurance Institute of Israel

THE WELFARE STATE - CONTINUITY, CHANGE, OR DISSOLUTION?

by Prof. Yosef Katan*

Introduction

The "Welfare State", the initial development of which was seen in different countries in Europe at the end of the previous century, has undergone a slow process of formulation during the first half of the present century and has enjoyed accelerated development since the Second World War. This development has been felt particularly in the western countries, but the basic concepts of the welfare state have also begun to penetrate other countries on the American continent, Asia and Africa.

The development of the welfare state in various countries was reflected in a great increase in government spending on social services, an increase in social legislation, the initiation and development of services, programs and interventions aimed at coping with a wide variety of social problems and needs, and in the direct intervention of the government in providing different social services.

In the 1970s and 1980s, this development came to a halt in a number of countries, and in some of them there was even a reduction in government expenditure on welfare and in the scale of social services in some fields. At the same time, a process of privatization was begun in many countries, made evident by nongovernmental factors (voluntary organizations and private commercial organizations) entering the field of welfare. These elements had already been involved in this area, but from the middle of the 1980s onwards they became more deeply-rooted and diversified.

In recent years there have been an increasing number of claims not just that the development of the welfare state has come to a standstill, or that there is a partial withdrawal of services in a number of areas, but rather that the welfare state has totally collapsed. There are those who speak of this

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collapse as a given fact, and there are those who are somewhat more cautious in their assessment and describe it as a state of slow disintegration. According to this version the welfare state is like a chronically and incurably ill patient, whom the doctors are trying to revive by means of artificial respiration, but whose demise, sooner or later, is inevitable. For example, Stoesz (1987), who several years ago surveyed the development of the welfare state in the United States and assessed the likelihood of its existing in the future, determined that the chances of this were very slight and that most of the proposed changes in its patterns of action suggested by public opinion leaders, professionals and investigators in the field of welfare would in fact lead to its destruction (in his words, "zeroing out the welfare state").

Talk of the collapse of the welfare state is heard both in neo-liberal and conservative circles, who from the very outset objected to the existence of such a state, and in left-wing circles, many of whom, if not all, supported it. These circles complain about its limited results and its minimal contribution to the creation of a more egalitarian and just society.

The decline of the welfare state is related to a number of factors. Some of these are cited by scholars and politicians of neo-liberal and conservative orientation (Murray, 1984; Glaser, 1988), and some by scholars and politicians with left-wing orientation (Offe, 1984).

The identification and diagnosis of these factors, which will be briefly summarized below, are based in part on a systematic analysis of various data and in part on the ideological and political concepts that nurture selective interpretations of the development of the welfare state in different countries.

First, there is the inherent inability of a government to deal successfully with a wide range of problems and topics, including coping with social problems more appropriately dealt with in the free market. According to this point of view, government intervention in these matters is inefficient and in fact leads to results that are the opposite of those hoped for: a greater degree of poverty and the increased dependency of distressed population groups.

Second, the heavy burden of financing the social arrangements and programs made necessary by the existence of the welfare state endangers the economic stability and the growth potential of the country and harms its ability to compete in the international arena and attract external investments. According to this point of view, most welfare states are in a state of fiscal crisis and have difficulty attracting and providing the financial

resources required to support the diversified system of social services that they have established. A drastic cutback in government expenditure on social services and the cancellation of various social programs are therefore imperative and unavoidable.

Third, there is the erosion of public support for the welfare state for a variety of reasons, including the refusal to bear the heavy burden of taxes necessitated by the existence of comprehensive and expensive social services, and a lack of faith in the government's ability to function. It is claimed that it is precisely those population groups which have improved their financial situation and social standing thanks to the welfare state, that have now withdrawn their support from it, because they are no longer dependent on its assistance. Inherent in the existence and success of the welfare state, therefore, lie the seeds of its demise.

Fourth, is the undermining of the compromise reached in various western countries between the different political parties and social strata, a compromise which enabled the development of the welfare state, especially after the Second World War. This compromise was worked out mainly between liberal groups who aspired to the continuing existence of the capitalist regime, and social-democratic groups who wanted centralized planning and comprehensive government intervention in the economy and in society.

The compromise was largely based on the existence of interests which were mutually complementary. The liberals, who represented people of means, understood that social stability was an essential condition for economic development and growth, and that in order to achieve this, it was therefore necessary to have a welfare state involving wide-scale government intervention in social and economic areas. At the same time the social-democratic groups came to the conclusion that the best way to improve the situation of the weaker members of society was by a gradual social reform and not through radical social change. Disappointment with the communist regimes further reinforced this approach.

In recent years deep cracks are appearing in this compromise, arising mainly from the fact that certain groups (especially the moneyed and the private employers) are unable to come to terms with the heavy price they have to pay for the welfare state (restrictions on the free use of capital, high rate of taxation, comprehensive social benefits for employees and so on), which make it hard for them to compete in the international market, and especially to challenge countries with more restricted welfare state arrangements and fewer salary benefits. Sometimes the reaction of the

moneyed people is to reduce their investments in production, or to invest in other countries in which there are fewer restrictions on the use of capital. These actions are liable to harm the economic growth and the ability of the country to attract the resources needed to fund its social expenditure. These circles are therefore trying to achieve a real reduction in the scale of the welfare state and a weakening of its influence.

At the same time there is a growing awareness among various left-wing groups that the welfare state as operated by capitalist regimes is limited in its ability to influence the way the economic system functions and to bring about real social changes that will eliminate poverty and distress, reduce social gaps and bring about a more egalitarian and just society.

Therefore, according to these approaches, there are significant inherent contradictions (such as the need to compete in the international arena, the need for investment and economic growth, as against the need for high social expenditure), in the very fact of the existence of the welfare state in the form in which it has developed in western countries, which contribute to an undermining of the compromise which served as a basis for its development and also promote the process of its collapse.

Alongside the perception that, as a result of all the above-mentioned factors, there is no future for the "welfare state", which is nearing its end, there exists a different view which holds that the welfare state is alive and well and does have a future (Taylor-Gooby, 1991). This view makes several assumptions, some of which are based on empirical evidence.

First, the involvement of government in the sphere of social service, which forms one of the central principles of the welfare state, enjoys the support of many sectors in the public such as: pensioners (who constitute an increasing percentage of the population of western states) and their families, many of the users of the public health services, poor families and people with various disabilities. These population groups are dependent in large measure on the assistance given to them by the welfare state and therefore continuous support and massive involvement of the government in social affairs. Some of these groups possess political power which is not negligible.

Second, welfare organizations owned or funded by the government employ a large number of people (professional and non-professional), who, for humanitarian and professional reasons as well as out of self-interest, are in favor of the continuation of the existing situation in which the government plays a central role in various social areas.

Third, in influential and powerful political circles, there is still an abiding

awareness of the vital nature of government intervention in the field of welfare in order to prevent political collapse and to ensure social stability.

Fourth, many of the services provided by the welfare state are based on legislation which it would be difficult, or even impossible, to change because of the opposition of various elements, such as political parties, pensioners' organizations, trade unions, professional associations and consumer organizations. The recent massive workers' demonstrations in France against Government plans to change social security arrangements provide a striking evidence to this opposition.

Alongside the factors damaging the welfare state, undermining its foundations and contributing to its decline, there are therefore other factors geared to ensuring its continued existence and to frustrating attempts to dismantle it. Those who support the continuing existence of the welfare state make the claim, among others, that a considerable number of the apparently factual statements made by opponents of the welfare state, such as the claim regarding the "heavy burden" it imposes on the economy of the state, serve in fact to cover up a basic ideological stance which rejects in principle any state intervention in the social arena.

The questions that this article seeks to answer are: How strong is the influence of the different factors mentioned above? Has the welfare state indeed already collapsed, is it in an advanced stage of collapse, or is it in fact perhaps maintaining its position while making various adjustments to its structure and patterns of functioning? Do the claims regarding its collapse heard from both sides of the ideological-political fence in fact reflect the reality existing in different countries, or are they an expression of hidden or openly expressed desires, or perhaps a mistaken interpretation of the significance of the developments taking place in various welfare states? What is the influence of these changes on the nature of the welfare state in the first half of the 1990s?

The importance of examining the claim of collapse lies in this: the very fact of the question being raised and the uncritical emotional response it stimulates are liable to engender a dynamic that will reinforce the pessimism vis-à-vis the future of the welfare state, create an atmosphere that will undermine belief in it and thus encourage those elements who are trying to disintegrate it.

The following sections of this article are divided into two main parts. The first part is devoted to the identification of various indicators by means of which it is possible to examine the question of the collapse. In the second part, available information from various countries regarding two of these

indicators will by described and analyzed: the attitude of the public with regard to the welfare state and the scale of government expenditure on social services. The concluding part of the article will be devoted to a discussion of the data and an examination of its significance regarding possible patterns of future development of the welfare state.

Indicators for Studying the State of the Welfare State

The uniqueness of the welfare state lies in the fact that it has adopted the principle according to which the state, by means of various mechanisms at its disposal (organizational systems, legislative initiatives, taxation system and so on), has the responsibility, obligation and ability to provide an appropriate response to the basic needs of its citizens, such as basic income, education, health and housing. The rights of citizens to a decent living, health, education, and housing, have in fact become - in most of the welfare states - basic rights representing an integral element of the array of human rights that a state has to guarantee, like the right of organization and free speech, the right to own property and so on.

This attitude contradicts the approach based on the neo-liberal ideology which aspires to a market economy and a maximum reduction in state intervention in the field of welfare and other areas, and calls for placing more responsibility on the citizens themselves and on the organizational frameworks to which they belong, such as the family network and various voluntary organizations. The collapse of the welfare state, if it is in fact taking place, is liable to be expressed, therefore, through a number of key indicators:

A. There is a loss of public support for the principle of state responsibility for the welfare of its citizens and a growing support for the principle of individual responsibility. The political support and legitimization given by the public to the welfare state in the years following the Second World War are what enabled it to develop and therefore one of the main conditions likely to accelerate its collapse is the broad-based erosion of this support.

B. Since one of the chief features of the welfare state is a high level of government expenditure on social services, the collapse of the welfare state must be reflected by drastic cuts in this expenditure.

C. A large-scale reduction in government expenditure on welfare must be reflected in the wide-scale cancellation of various social services run by the government, in the limitation of government aid to non-governmental welfare organizations, in the reduction of the scale of existing services and

the cessation of development of new government services or government-funded services.

D. Since social legislation is one of the key expressions of the government's obligations in the field of welfare, and a major factor in the acceleration of the development of social services and the increase in social expenditure, the decline of the welfare state should be reflected in a freeze in social legislation, and significant changes in existing legislation in order to reduce their scale and content, such as a real change in the criteria of eligibility for services.

E. Coupled with the reduction in government expenditure and the cut in social services, we should be seeing the accelerated development of non-government sectors and the market becoming the central force replacing the government in supplying social services.

In this article, we will relate mainly to the first two indicators public opinion regarding the welfare state and the scale of government expenditure. We will try to provide an answer, if only partial, to the following questions: Does the public continue to see the state as being responsible for the welfare of its citizens? Is public opinion on this subject uniform, or does it change with regard to one form of welfare of another? Over and above its basic attitude, does the public support the continued functioning of government-public services in the field of welfare, or would other arrangements tied in with market functions perhaps be preferred? Is the public ready to continue paying high taxes, as required by the need to fund public welfare services? Is there in fact a decline in government expenditure on social services, bringing about a reduction in various social programs? Are non-governmental organizations making a massive entrance into the field of welfare and filling the space formerly held by government organizations?

Various items of information touching on these questions, in a number of major welfare states, combine to form an overall picture which demonstrates that in these countries, although there are changes in public support for the welfare state and patterns of government functioning in the area of social services, there is no evidence indicating the collapse of the welfare state or suggesting that it is in a state of rapid decline; on the contrary, there are various indications pointing to the continued existence of the welfare state, even though it is undergoing various changes arising from economic, political and ideological changes taking place in the world. In the following section of the article, the subject of public support for the welfare state will be examined.

Public Opinion Regarding the Welfare State

Based on the work of Coughlin who summarized a series of investigations into public opinion regarding the welfare state carried out in Australia, the United States, Britain, West Germany, Denmark, France, Canada and Sweden, in the 1960s and 1970s, Doron (1987) indicates the existence of widespread public support in these countries for the idea of the welfare state and the social security it provides for its inhabitants. Public opinion polls carried out in a number of countries during the 1980s and the beginning of the 1990s, which will be reviewed below, indicate for the most part the continuation of this support.

Public opinion polls based on a representative sample of the population of Britain (Jowell, Brook and Taylor, 1991) show that in 1991, 90% of interviewees felt that the provision of medical care had to be the government's responsibility. Moreover, the overwhelming majority of interviewees felt that the education services and basic arrangements for income maintenance also had to remain the responsibility of the government. On the other hand, only about 24% saw full employment as an aim that the government had to ensure.

On the basis of other public opinion polls carried out in Britain, Taylor-Gooby (1991) notes that there is support for different aspects of the welfare state among supporters of the three main political parties in Britain - proponents of the Conservative party mainly supported programs providing social benefits to the elderly (who are a very significant element in the government's expenditure) and the handicapped; Labor voters, of course, supported government intervention in a greater number of subjects, and especially in income maintenance, housing, child benefits and unemployment benefits; the Liberal-Democrats placed particular emphasis on their support for government intervention in the area of education. On the basis of these public opinion polls, which express a tendency towards the continuation of public support for government intervention in key social issues, Taylor-Gooby adopted an optimistic attitude regarding the future of the welfare state.

Judge and Solomon (1993), who summarized and analyzed public opinion polls carried out in Britain in the second half of the 1980s and the beginning of the 1990s, and specifically examined the public's position with regard to the health services, point out that although there is a degree of dissatisfaction with a number of aspects of the functioning of the National Health Service, this does not amount to an objection to the very existence of

this organization. On the contrary, the British National Health Service enjoys solid and widespread public support.

In this connection, the question arises: why has the public in Britain, despite this attitude, continued to allow the Conservative government, which aspires to reduce government intervention in the field of welfare, to remain in government for a long period of time, and not returned the Labor party to power?

It appears that the period of Conservative control has proved to the British public that despite the neo-liberal rhetoric (heard especially from Margaret Thatcher), the changes that have taken place in reality in the scale and nature of government intervention in the field of welfare have been modest (this topic will be discussed at greater length below). Another possibility is that the subject of welfare is not one of the top priorities of British voters and therefore the attitudes held by many of them in this area did not determine the way they vote.

The picture arising from public opinion polls held in the United States on the attitudes of the public to different subjects in the field of welfare is not very clear and indicates a degree of ambivalence. Stoesz (1987), who summarizes a number of nationwide surveys carried out at the end of the 1970s and in the first half of the 1980s, points to non-uniform findings. While in 1976 60% of the interviewees noted that in their opinion government expenditure on welfare was too high, in 1982 this number had fallen to 48% and in 1983, to 43%. That is, during these years public opinion opposition to government intervention declined. On the other hand, a 1983 survey shows that only 34% of interviewees agreed with increasing government intervention as a solution to social problems. Marmor, Mashaw, and Harvey (1990, who also summarize public opinion polls held in the 1980's in the United States on welfare subjects, note that most of the programs which could be included in the framework of the US. Government activities in the welfare arena are strongly supported by the public.

A further and more up-to-date look at public opinion in the United States with regard to welfare issues is provided by two surveys carried out in recent years, which related to Federal Government intervention in specific service fields and included nationwide samples of the population. One of these surveys was carried out in 1990, and examined public attitudes towards the policy of social security and medical services for the elderly (Day, 1993). The findings of this survey show that most of the interviewees supported an increase in government expenditure on social benefits for the

elderly; only a very small minority (about 3%) felt that this expenditure should be reduced; the rest of the interviewees supported maintaining this expenditure at current levels. It is interesting that support for increasing the expenditure was characteristic of every age group (64% among ages 18-49, 66% among ages 50-64, 60% among ages 65-74 and 53% among those over 75). The majority of interviewees from the different age groups (81% to 90%) also supported increasing the medical aid program for the elderly.

Although the findings of these surveys are not uniform, they do point to the existence of a wide base of public support for the intervention of the Federal Government in a number of key areas in the field of welfare. These findings do not, therefore, provide support for the assumption that the long-time tradition in the United States of a negative attitude towards government intervention in various fields and a supportive attitude towards the free market would necessarily be reflected in a total public negation of government intervention in welfare. At the same time it should be emphasized that public support as reflected in these surveys is mainly given to programs with a clearly universal aspect, such as education, health and income maintenance. There is considerably less support for specific aid to the unemployed and the poor.

Public opinion polls carried out in Sweden also indicate a continuation of wide public support for comprehensive government intervention in the area of welfare (Olsson, 1989, 1991).

Public support for the welfare state in these countries is expressed not only in individual attitudes, as seen in the surveys, but also in the actions of various organizations and pressure groups (such as political parties, pensioners' associations, organizations of handicapped people and residents of distressed neighborhoods), who work in favor of the continuation and even the increase of state intervention in specific areas of welfare.

The subject of public support for the welfare state and government intervention in the provision of social services in Israel has not been sufficiently examined to date. A partial and indirect view of this question is given by a public opinion poll carried out with a country-wide sample representing the adult Jewish population in Israel (not including kibbutzim and settlements beyond the Green Line) whose findings are presented by Peres and Ya'ar (1992). The survey findings indicated that 33% of the interviewees expressed full support for the capitalist approach, or a positive attitude towards it; 24% were at the opposite end of the spectrum and described themselves as supporting, or tending to support, the socialist concept; 43% placed themselves in the center - between capitalism and

socialism. 62% of interviewees expressed complete or moderate agreement with the proposal to levy higher income tax on those in the top 10% income bracket; only 26% objected to this, and the rest said that they had no opinion on the subject. 64% of interviewees supported government aid to factories in state of crisis and only 36% objected. A small majority (54%) agreed to the continuation of the trade unions' support for work tenure; 46% objected to this. On the other hand, most of the interviewees supported the proposal that the unemployed, as a condition for receiving unemployment benefits, should have to undertake professional retraining, agree to move to a place far from their home or even earn less than they had earned in their previous place of employment.

The picture emerging from these findings is not uniform, but it shows, as Peres and Ya'ar point out, that most of the Israeli public avoids 'corner' solutions, it certainly does not want centralized planning and state control of the economy, but neither does it support the uncontrolled operation of the free market, their conclusion is that: "although the Socialist ethos has lost its dominance, it has not ceased to exist. Its main values: economic equality and full employment, are still accepted, and the demand for government intervention in order to promote these ends is still heard".

As we have said, the survey did not directly examine questions concerned with state intervention in the welfare services. But if we assume that the findings of the survey are relevant also to the field of welfare, this survey can be added to those carried out in other countries, which express the continued support of the general public for the central principles of the welfare state.

Is the public support for continuing government intervention in key welfare areas accompanied by a willingness to pay the price involved? Is the public prepared for the high level of taxation to continue, or does it support a reduction in the level of taxes, which would lead to a reduction in the welfare expenditure?

The only research carried out on this subject which we identified is the one reported by Day (1993), which presents and analyzes the findings of a nation-wide public opinion poll carried out in the United States in 1991. The survey reveals that the overwhelming majority of interviewees preferred a slight rise in taxation over a reduction in health services for the elderly, and objected to the imposition of taxes on social security benefits paid to the elderly. The findings of this survey related to medical services and social security payments for the elderly. It is not clear what the attitude of the interviewees would have been had they been asked to state their degree of

willingness to bear the tax burden necessary to provide services for other population groups such as the poor, single-parent families and so on. This question, therefore requires more comprehensive and systematic study.

The information available to us with regard to the degree of willingness of the public in different countries to back up their support for central elements of the welfare state with an agreement to pay the taxes necessary to keep a comprehensive system of welfare services in operation, especially services aimed at the weaker population groups, is therefore very limited.

The second topic we are going to discuss in this article - an examination of the concrete developments that have taken place in recent years in the welfare state - will be reviewed in the next section.

Developments and Changes in the Welfare State

What is the current situation of the welfare states? Are they in fact headed towards disintegration? Are they experiencing a process of drastic reduction in government expenditure on welfare, of cancellation of state programs, and of a growing process of privatization of social services?

The following discussion provides a partial answer to these questions, by reviewing the developments in several welfare states, including Israel.

Britain is, perhaps, the country in which the political conditions that have been created are most favorable for the erosion of the welfare state. At the end of the 1970s the Conservative party came to power, led by Margaret Thatcher, one of whose main stated goals was to change the face of society in Britain while eroding the welfare state. Thatcher not only fought welfare state provisions with fiery rhetoric based on a clearly neo-liberal ideology; she also brought to bear the apparatus of power available to her in her attempts to bring about drastic cuts in government expenditure on welfare and the cancellation of various social programs. During most of her tenure Thatcher enjoyed widespread public and party support, which ought to have enabled her to carry out her social policy, which sought to reassert the supremacy of the free market and to affect a wide-scale reduction in government intervention and involvement in various fields. Did Thatcher in fact succeed in accomplishing her social aims?

In recent years several stydies have been published in Britain trying to sum up and evaluate the mark left on the welfare state in Britain by the Thatcher era, which lasted some ten years (Hills, 1990; Marsh and Rhodes, 1992; Manning and Page, 1992; Marsland, 1993). Their conclusions are not uniform, but they do agree on the existence of a gap between the rhetoric opposing government intervention and the reality as manifested by the

social services actually provided, and concur in the opinion that the welfare state emerged from the attacks on it alive, albeit with clipped wings. This conclusion is based on a number of facts: income maintenance arrangements, which represent the British welfare services' largest expenditure, suffered limited damage and various attempts to make real cuts in their amount and scope failed; the National Health Service, which is one of the cornerstones of the welfare state in Britain, maintained its status, although it has undergone a number of changes in its method of operation; and the British government and local authorities continued to fund and provide a wide variety of additional social services. At the same time, a number of changes were introduced in the area of welfare, mainly during the last years of the Thatcher government. These changes included: broadening the scope of voluntary and private organizations as providers of welfare services such as education, health, personal services, and housing, even though the financing of these services remains the responsibility of the government and the local authorities; a substantial cut in government expenditure on housing; encouraging the sale of homes previously owned by local councils to their tenants; cuts in government expenditure on personal services, aimed mainly at the weaker sectors of the population; development of awareness of consumer rights, including the right to choice of services; and placing a greater emphasis on involvement on the part of the local community and its various elements - including family support networks - in providing welfare services. The system of welfare services in Britain is therefore more mixed than in the past. Le Grand (1991) suggests that it represents a quasi-market, where services are supplied by a wide variety of non-government organizations while funding of these services and regulation of their provision continues to be the responsibility of the government and the local authorities. Some of these changes, such as the increased involvement of consumers, do not conflict with ideas that are accepted also by supporters of the welfare state.

Most researchers therefore concur that Thatcher did not bring about the dissolution of the welfare state in Britain; nor did she undermine its basic principles, even though she did succeed in introducing a number of changes whose possible implications for its development in the future are not yet clear.

The central patterns and features of the welfare state have also been preserved in the Scandinavian countries, which had developed a very advanced system of welfare services. In Sweden (Olsson, 1990), the growth in government expenditure on social services was halted, but no significant

cuts were made. There was even an increase in expenditure in a number of fields (especially services for the elderly and children), leading to an increase in the number of people employed in the public sector. However, this increase was accompanied by a reduction in expenditure on other services. Furthermore, although there was no expansion of social programs funded by the government during this period, there were also only moderate cuts made in existing programs.

The formation of a new center-right Government in 1991, has accelerated certain developments that weakened the Swedish welfare state. The new Government has cut its expenditure on social services, trimmed numerous social benefits and stimulated non-government organizations to enter into the welfare services arena (Olsen, 1996; Sander, 1996).

The return to power of a Social-democratic Government in 1994, has moderated these actions, but did not stop many of them. While the intensity and breadth of these changes are significant from a Swedish perspective, they are relatively minor compared with the modifications that occured in other countries such as Britain. Furthermore, some of the basic features of the Swedish model of welfare, such as the emphasis on universality, high Government expenditure on social services, and large public sector, maintained their status (Meidner, 1993; Olsen, 1996).

Several scholars (Meidner, 1993; Olsen, 1996) who assess the condition of the welfare state in Sweden and possible developments in the future, note that due to economic and political changes it will continue to undergo changes, but they believe that despite the changes it will preserve its central characteristics.

A similar situation is also characteristic of Norway. An examination of two significant indicators of the existence of a welfare state - the scale of the transfer payments to households, and level of taxation - between the years 1978 and 1986 (Ringen, 1993) indicates an expansion of the welfare state in Norway. However, this expansion took place mainly during the beginning of the period, and later on there was a stabilization of expenditure on transfer payments and a reduction in the level of taxation, which was halted in 1982. The assumption is that the future development of the welfare state in Norway will be characterized by stability: that is to say there will not be an expansion in scale, but neither will there be a reduction.

A further perspective on the development of the welfare state in Norway is provided by Selle (1993), who examines the role of voluntary organizations in that country. Selle points to three main trends: first, in Norway (and in Scandinavia in general), the acceptance of government

responsibility for the welfare of the population is still well ensconced. Secondly, the voluntary organizations that have been operating in Norway for many years also support the principle of public responsibility and work in full cooperation with the government. Thirdly, the ideological and economic changes taking place in European countries in recent years are leaving their mark on Norway, too, and are expressed, inter alias, by the opening up of many more opportunities for activity on the part of voluntary organizations and other frameworks (such as work places) in the field of welfare. At the same time, Selle casts doubt on the ability of these organizations to take advantage of the new opportunities presented to them.

A review of the condition of the welfare state in Australia and New Zealand - two countries that fulfilled a pioneering role in the development of advanced welfare services - also indicates a mixture of continuity and change (Graycar and Jamrozik, 1990, 1991). In these two countries the principles of the welfare state have been preserved in the fields of health and education, but there have been a number of changes in the social security system. These changes have been characterized by the introduction of selective elements - such as the use of means test in order to determine the right to receive financial support - that have led to a reduction in the number of those benefiting from income maintenance programs. Furthermore in these countries the number and scope of the voluntary and private organizations acting as suppliers of personal services (some of them funded by the government) has actually grown (Hoatson, Dixon and Sloman, 1996).

The situation in the United States is far more complex (Krager and Stoesz, 1993; Salamon, 1993). From the very beginning, the welfare state that developed in this country did not accord to the accepted European model. To this day there is no system guaranteeing health insurance to all citizens. Nor does the United States offer its citizens universal arrangements for income maintenance such as those existing in other western countries. During the war on poverty in the 1960s, a wide variety of social programs aimed at helping distressed populations were developed, but most of these programs were canceled after Nixon was elected president at the end of the 1960s. A further blow to the welfare programs and to government expenditure on various welfare issues came during Reagan's presidency in the 1980s. In this period the infiltration of voluntary and private organizations into the arena of welfare was further deepened, and the

tendency of voluntary organizations operating in this field to offer their services for a fee was increased.

At the same time, even in the United States, where the ethical and political environment making it difficult for a welfare state to develop, there are a number of comprehensive welfare arrangements in effect, which continue to contribute to the welfare of weaker populations groups. The most striking among these are: the public education system, social security and medical insurance for the elderly, handicapped, and poor families, and food stamps for the poor (Marmor, Mashaw and Harvey, 1990).

It appears, therefore, that in the countries described above the trend towards growth and development of the welfare state has been halted and a number of changes in its character have been introduced. But the gap between these changes and any dissolution of the welfare state is very great.

In Israel too, as in other welfare states, the claim that the welfare state is being eroded is sometimes heard (Doron, 1993). This erosion is attributed to the weakening of support for it, to a decline in its political legitimization, and to economic difficulties that strengthen the position of those circles that support the reduction of public expenditure on welfare. Are these claims justified? Are they reflected in the concrete developments occurring in the Israeli arena? In the context of this paper we will describe certain trends that may provide an answer to these questions.[1]

First, the overall government expenditure on social services[2] (income maintenance, education, health, personal services, Immigrant absorption, employment and housing), which totaled NIS 21,802 billion in 1980, rose to NIS 30,196 billion in 1990 and reached NIS 43,788 billion in the 1995 budget. That is, between 1980 and 1995 social expenditure rose by about 100%.

What is especially noticeable is the constant gradual rise in expenditure on income maintenance throughout the whole period. Expenditure on education, health, and personal services actually fell between 1980 and 1985, but began to rise again from 1985 onwards. However, the rate of increase varies between the different services. Spending on housing and absorption, which rose and fell during this period, reflects the variations in the number of immigrants coming to Israel at the end of the 1980s and the beginning of the 1990s. Particularly noteworthy is the new expenditure in

1. Data on Israel are based on information published by the Center for Social Policy Studies in Israel (Katan, 1993; Kop, 1995).
2. The sums are given in 1994 prices and relate to the regular budget.

the framework of the Long-Term Care Insurance Law, which began at the end of the 1980s and has in recent years become a significant component of the government's social service budget.

The increase in the scale of expenditure on social services is reflected also in the proportion of the state budget that it takes up and in the allocation of the budget between the social services and security. The proportion of expenditure on social services, which fell significantly below expenditure on security at the beginning of the 1980s (in 1980, the share of security expenses in the overall national budget was 39.5%, while the social services received about 32%), shot up to over half of the budget by 1995, at which time it enjoyed more than twice as big a share of the budget as security.[3]

The increase in expenditure on social services is reflected also in the increase in their share of the GNP, which has risen from about 18% in 1980 to 22% in 1995.

Secondly, the significance of the growth in expenditure on social services can only be understood after an examination of the relationship between it and the growth in the numbers of users of these services. An examination of the variations in per capita expenditure in specific fields of service indicates a number of trends:

In the field of education, although expenditure increased in real terms during the 1980s and the early 1990s, a comparison between the average expenditure per pupil in 1980 and 1991 shows that, at every stage of education except for kindergarten education, there has been a decline in this expenditure. The smallest decline was in elementary education (about 2%), the greatest in higher education (about 35%), however the increase in government spending on education in the years 1992-1995 contributed to a significant change in this situation. During this period, there was also a steep decline in per capita expenditure on health, although there was some improvement in the situation in recent years.

On the other hand, in the field of income maintenance - the largest part of the expenditure on social services - there was a growth in average expenditure per capita. For example, the average expenditure per capita on old age and survivors allowances - which was NIS 5,507 in 1980 (at 1990 prices) - had risen to NIS 7,368 by 1990; this represents an increase of about 34%.

An examination of the overall government expenditure on personal services indicates an increase in expenditure on certain population groups

3. The data are after deduction of repayment of debts.

such as the elderly (mainly because of the implementation of the Long-Term Care Insurance Law), the mentally retarded and the physically handicapped, and a reduction in expenditure on other population groups, such as children and youth. Furthermore, the expenditure devoted to funding the salaries of social workers employed by local welfare departments, responsible for the provision of personal services has not kept up with the great increase in the number of people applying to these departments. These facts therefore indicate a decrease in government expenditure aimed at a number of sectors of the personal services.

Further noteworthy developments that have taken place in recent years in the social services arena in Israel include:

A. An expansion of the scope of social legislation during the 1980s. Of particular note are the Income Maintenance Law, guaranteeing a minimum income to every citizen in Israel; the Long-Term Care Insurance Law, which created a revolution in the level of expenditure on the elderly and the scope of services provided to elderly people in need of auxiliary nursing; various protection laws, such as the law against domestic violence and the law against abuse of minors and the defenseless and the National Health Insurance Law which ensures the provision of a basket of health services to every Israeli citizen.

B. The reinstatement of child allowances for the first and second children for families of up to three children and the provision of equal rights in this area for the entire population.

C. The failure of attempts to impose a tax on old age allowances.

Along with these developments, which reflect the continuation, and even a considerable expansion, of government involvement in and expenditure on social services, the government has taken a number of steps that tend to suggest a contrary trend:

A. Implementation of the Long-Term Care Insurance Law by private and voluntary organizations.

B. Transfer of a number of services that belonged to the government, such as hostels for the handicapped, to voluntary and private organizations. At the same time, the government continues to function as the principal provider of funds for these services and as supervisor of their activities. The social service sector has therefore become more mixed from the point of view of the elements operating in it. At the same time, the process of privatization of the social services is being carried out slowly, and at this stage touches mainly on transferring responsibility for the provision of certain services to non-government organizations while maintaining

government involvement in funding the services and supervising their allocation.

C. Making the conditions of eligibility for unemployment benefits more stringent.

The data presented above reflects a general trend towards continuity. Although there has been a decline in certain areas, in other key areas there were developments and expansions. The data presented above do not therefore provide any indication of a collapse of the welfare state in Israel. However, the figures, repeated year after year, showing the scale of poverty in Israel and other revelations regarding continuing distress, show the limitations of the welfare services in Israel and their failure to eradicate poverty and distress.

The overall picture emerging from the above review of the situation in a number of countries shows that their development as welfare states is characterized by different trends, reflecting a mixture of continuity and change. The continuity is expressed in a number of ways: a continuation of comprehensive government involvement in key welfare fields, and especially in the areas of health, education, and income maintenance; the growth, although moderate, in real government expenditure on certain other social services; the continued existence of various social programs; and even the development of new social programs in a number of fields.

Yet there are a number of signs of change in the welfare sphere: a decrease in government expenditure on a number of social services (especially personal welfare services); the cancellation of a number of social services; decentralization of services; spurring up of the process of privatization, bringing about a reduction in the government's role as a supplier of services and increased involvement of non-governmental organizations in the area of welfare (as providers of services financed on the one hand by the government and on the other by the consumers); increased competition between organizations, providing consumers with greater choice; and increased involvement of informal support networks, especially family networks.

There are those who hold that, in the light of these changes, the concept of the "welfare state" should be replaced by that of a "welfare society", giving expression to the increasing role played by various social agents in the sphere of welfare and to the abandonment of the government's monopoly. Thus, the welfare state becomes more mixed and variegated. However, these changes are taking place in different countries to varying degrees and are creating several types of welfare states.

Among the supporters of the welfare state, attitudes to these changes vary: some view them with considerable alarm and suggest that sooner or later they will lead to its paralysis. According to this version, the gradual changes that are expressed by, among other things, the growing privatization process, are likely to lead to the abandonment of the key principles of the welfare state, and thus to prepare the ground for its dissolution. Some of the results of these changes, such as the erosion of personal services, the development of trends towards selectivity, and the creation of segregated services for weaker population groups, are described as evidence of these dangers

On the other hand, there are those who view these changes as indicating awareness of a number of limitations inherent in the design of the welfare state as it took shape after World War II, and as reflecting an effort to adapt its structure and patterns of activity to the economic, ideological, and political changes occurring in the western world. Furthermore, some of these changes, such as: the weakening of the level of control exercised by the government and its bureaucratic apparatus; the decentralization of welfare services coupled with emphasis upon the role of the local community; the strengthening of the involvement of informal social networks and non-government organizations; the introduction of the element of competition into the field of welfare; and the increased autonomy of consumers, are seen as steps that are imperative if the shortcomings of the welfare state are to be overcome. According to this view, these changes are likely to enable it to transcend some of its limitations and continue to fulfill its key functions.

Continued monitoring of the changes the welfare state is undergoing in different countries will enable us to identify the direction it will pursue and to assess whether it would lose its principal characteristics or develop new patterns that will enable it to continue to fulfill its chief aims.

Conclusion

This paper has tried to examine the reliability of the claims heard in certain circles that the welfare state is collapsing. Data regarding public opinion on various social issues and concrete developments taking place in a number of welfare states, including Israel, were used as a basis for this examination.

A survey of the situation in these countries shows that the welfare state has indeed failed to realize many of the goals it set for itself, but it also shows that the welfare state has not disintegrated and is not even necessarily headed for dissolution. At the same time, the welfare state is undergoing changes resulting in the creation of a more mixed and varied field of welfare

in which, to varying degrees of intensity and reciprocity, different sectors are participating: the government, voluntary organizations, private commercial organizations, work places, and informal systems.

Alongside those who claim that these changes conflict with the basic principles of the welfare state and undermine its foundations, there are also others who claim that these are necessary steps, which will enable it to adapt itself to the changing circumstances at both national and international levels. At this stage it is still hard to assess the shape that the mixed welfare state will take in different countries, the place that the central government and the non-governmental organizations will occupy, and the aspirations with regard to the scope and level of services to be provided to the various population groups, especially the weaker groups.

At the same time, various signs point to increasing recognition in several countries that there are dangers in accelerated processes of privatization, and that the continued wide-scale involvement of the government in the field of welfare is vital.

Bibliography

Day, C. (1993), "Public opinion toward costs and benefits of social security and medicare", *Research on Aging*, 15(3): 219-298.

Doron, A. (1987), *The Welfare State in a Period of Transition*, Jerusalem, Magnes, (Hebrew).

Doron, A. (1993), "The erosion of the Social Democratic elements in the Israeli social policy", *Mifne*, 1:16-21 (in Hebrew).

Glazer, N. (1988), *The Limits of Social Policy*, Harvard University Press.

Graycar, A., and Jamrozik, A. (1991), "Social welfare in Australia and New Zealand", in: Elliott, D., Mayadas, N. and Watts, D.T. (eds.), *The World of Social Welfare and Services in an International Context*, Springfield, Ill, Charles C. Thomas Publishers: 261-278.

Graycar, A., and Jamrozik, A. (1991), "Welfare and the state in Australia", Social Policy and Administration, 25(4): 271-283.

Hartman, A. (1993), "Writing a new story about America", Social Work, 38(2): 125-126.

Hills, J. (1990), *The State of Welfare in Britain Since 1974*, Oxford: Clarendon Press.

Hoatson, L., Dixon, J., and Sloman, D. (1996), "Community development, citizenship and the contract state", *Community Development Journal*, 31(2): 126-136.

Jowell, R. Brooke, L. and Taylor, B. (1991), *British Social Attitudes: The 8th Report*, Honts: Social and Community Planning Research.

Judge, K. and Solomon, M. (1993), "Public opinion and the National Health Service: Patterns and perspectives in consumer satisfaction", *Journal of Social Policy*, 22(3): 299-327.

Katan, Y. (1993), *The Development of Personal Social Services: Processes and Trends in the Eighties and the beginning of the Nineties*, Jerusalem: The Center for Social Policy Studies in Israel (in Hebrew).

Kop, Y. (ed.) (1995), *Allocation of Resources to Social Services 1994-1995*, Jerusalem: The Center for Social Policy Studies in Israel (in Hebrew).

Krager, J.H. and Stoesz, D. (1993), "Retreat and retrenchment: Progressives and the welfare state", *Social Work*, 38(2): 200-212.

Le Grand J. (1991), "Quasi-markets and social policy in Britain", *Bitachon Soziali*, 37: 32-45 (in Hebrew).

Marmor, T.R., Mashaw, J.L. and Harvey, P.L. (1990), *America's Misunderstood Welfare State*, New York: Basic Books.

Marsh, D. and Rohdes, R.A.W. (eds.), (1992), *Implementing Thacherite Policies: Audit of an Era*, Open University.

Marsland, D. (1993), "Let's replace self-pity with self-reliance", *The Sunday Times*, October 31.

Meidner, R. (1993), "The rise and fall of the Swedish model", *Yalkut for Socialist Thought*, 31 (in Hebrew. Translated from *Studies in Political Economy*, August 1992).

Murray, C. (1984), *Losing Grounds*, New York: Basic Books.

Offe, C. (1984), *Contradictions of the Welfare State*, London: Hutchinson.

Olsen, G.E. (1996), "Re-modeling Sweden: The rise and demise of the compromise in a global economy", *Social Problems*, , 43(1): 1-20.

Olsson, S.E. (1990), "Swedish social policy: Towards the year 2000", in: Elliott, D. Mayadas, N. and Watts, D.T. (eds.), *The World of Social Welfare. Social Welfare in an International Context*, Springfield, Ill: 91-109.

Peres, Y. and Ya'ar, E. (1992), "To take from the rich, to give to the poor", *Democracy*, pp. 26-30.

Ringen, S. (1993), "Income dependency in Norway", in: Hansen, E.T. et al. (eds.), *Welfare Trends in the Scandinavian Countries*, special issue of *International Journal of Sociology*, Vol. 23, No. 2-3: 3-16.

Salamon, L.M. (1993), "'The marketization of welfare: Changing nonprofit and for-profite roles in American welfare state", Social Service Review, 67(1): 16-39.

Sander, G..F. (1996), "Sweden after the fall", *The Western Quarterly*, Spring, 46-71.

Selle, P. (1993) "Voluntary organizations and the welfare states: The case of Norway", *Voluntas*, 4(1): 1-15.

Stoesz, D. (1987), "Privatization: Reforming the Welfare State", *Journal of Sociology Social Welfare*, 14(3): 3-19.

Taylor-Gooby, P. (1991), *Social Change, Social Welfare and Social Service*, Hemel Hempstead: Harvester, Wheathsheaf.

DEFINING NEEDS FOR NEIGHBORHOOD SERVICES IN ARAB URBANIZING SETTLEMENTS OF ISRAEL: APPLICATION OF THE VALUE STRECH MODEL IN SOCIAL POLICY PLANNING

by Prof. Baruch A. Kipnis and Yael Aspis*

Introduction

A modern approach to the planning of public policy in a democratic, pluralistic state must recognize the special character of the socio-cultural groups which comprise this state. The extent of the need for neighborhood services on the part of the population of the Arab urbanizing Moslems and Christians of Israel, is the objective of this article. The identification of basic needs and of the extent levels of "giving up" to "essentiality" among various population groups will be carried out with the help of the "value stretch" model. The study will examine to what extent the "giving up" of one service or another is similar or different among the various groups according to their demographic, social, economic and cultural attributes, as well as by type of settlement they live in. In addition, the "value stretch" model will be presented as one of the tools by which the public at large may participate in determining the social needs, for which a welfare policy should be formulated (for a detailed discussion refer to Schnell and Kipnis, 1989).

Background

One of the main tasks of social policy planning is to equally allocate public services. The allotment of social and welfare services is one of the most researched topics today, the outcome of the fact that contemporary society is characterized by a process of continued increase in the level of expectations for personal and environmental welfare. On the other hand, there is at the same time, a process of continued diminishing resources which are essential in meeting these expectations (Pinch, 1985; Barr, 1987;

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Schnell and Kipnis, 1989). The success or failure of the service-providing system is determined on a neighborhood community basis, in which each and every neighborhood and community determines its own potentials and constraints. As a rule, one may say that the "welfare state" is responsible for providing the needs of the public at large and of caring for its social and economic security (Walker, 1981; Barr, 1987).

The development of the welfare state has been formulated and influenced over time by various political, economic and social factors, and in accordance with the particular approach and central political movement popular at the time (Higgins, 1981; Doron, 1985). The universal obligation of the "welfare state" to care for the welfare of its citizens, has increased demands for continual improvements in the standards and in the qualities of social welfare services. The question, therefore, is, what is a "proper" social policy, and on whom should the burden of development of public services be imposed (Alterman, 1989).

In the past decade we have witnessed the growing strength of conservative circles in Britain and in the United States, known as "Thatcherism" or "Reaganism" (Pinch, 1985). This process has taken place in other Western democracies as well (Fraser, 1984; Pinch, 1985). Those who supported this trend challenged the scope of activities of a welfare state, the way it functions and its very existence. In the opinion of the conservatives, the state is not the only source of welfare. According to this conception, the task of providing social services is simply to provide a guaranteed minimum requirement of social needs and safety, particularly for those individuals who are not able to reach this minimal level of welfare on their own.

Due to economic, demographic and political changes, public resources available to social services are being continually reduced in most Western democratic nations (Doron, 1985). Many Western nations have been forced to continually confront economic problems such as a slowdown in economic growth, inflation and deflation, unemployment and dwindling of the public means (Barr, 1987).

Some of the solutions which have been proposed in order to deal with the problem of the growing gap between public supply and demand, involved the "privatization" of some of the government's functions. The idea behind the "privatization" approach is that any product or source can be funded either privately or publicly, and could be produced and supplied by both these sectors. Note that the notion of "privatization" is in conflict with the notion of a "welfare state" (Barr, 1987). Corazim and Meler (1987), Kop

(1989) and others identify similar processes in Israel, which has been suffering from economic problems such as inflation, lack of growth and growing unemployment, leading to a policy of cutting back public budgets, particularly in the field of welfare.

There are various criteria for more "equitable" allotment of resources for public welfare services. Of these, five are especially noteworthy:

1. The "equitable approach". This criterion maintains that an equal portion of welfare should be available to all persons. Equitability or justice is done when all services are spread out equally in space (Battimer, 1979).
2. Allotment in accordance with "needs". According to this criterion, society must meet the needs of its citizens and not leave them to the forces of the private market. In order to implement this policy, the various needs must be identified, and the discriminating relationship between persons justified (Lucy, 1981; Pinch, 1985).
3. Allotment in accordance with the "extent of demand". According to this criterion, an equitable distribution is based on meeting the demand for services. Services should be supplied to those who demand them.
4. Allotment in accordance with "preferences". According to this criterion, demand is the way to express the residents' preferences. Its disadvantage is that not all preferences are properly reflected by demand alone, and non-use of a certain service may stem from many other causes.
5. Allotment in accordance with "readiness to pay". This principle assumes that a service is an economic product, and its user must pay for it. By determinating price, demand is reduced and the service might become a non-economic good (Browning and Browning, 1983).

This article will present a method of evaluating the needs of the population invovled, and in our case - the urbanizing Arab population in Israel, known for its serious shortage of municipal services, particularly of its neighborhood services. This shortage is growing due to the process of modernization which the Arab population is undergoing, and as a result, their state of "take off" in expectations for a personal standard of living and of quality of life.

The methodology employed, the "value stretch" model, is a convenient and effective tool for citizens' participation in determining their needs and their future. "Citizen participation" is being perceived in the Western world more and more as a central value of modern planning in a democratic society. The "Citizen participation" is a situation in which people, who are not elected or appointed members of the municipal government, take part in the decision-making process regarding the programs relevant to them

(Churchman, 1985). As such, the community at large takes an active role in the process of improving their own standards of living by means of identifying values, identifying the leadership, and creating a "human agency" that could influence the processes of change in the community. By its participation, the population is led to take part in the process of making and implementing decisions regarding its future state of being.

Various theoretical approaches have evolved with the objective of defining the essential conditions (cultural, social and organizational) required in order to achieve active citizens' participation. Particularly notable is the distinction between "partnership" and "participation" of the residents in the social, physical, and institutional systems. The term "partnership" refers to a process originating from "above" by the public, in which local or State institutions initiate - for various reasons - the partnership of citizens in the decision-making activities. "Participation", on the other hand, refers to an organizational initiative springing from "below". This is a grassroots activity by local residents in order to promote common local interests (Langton, 1978).

Arenstein (1969) refers to citizens participation as a basic value. Arenstein claims that participation of an individual in determining his future is a basic right inherent in the essentials of a democratic society. She presents an eight step ladder of possible citizens' participation, beginning with providing much authoritative power to the residents, and ending with various ranks of non-participation, such as therapy and manipulation.

There were a few who claimed that a basic principle of democracy is that a citizen is the best judge of his own interests. This principle is manifested in the participation of citizens in the policy-determining processes, in which they take advantage of the opportunity of promoting their own interests or the interests of the public at large. An active participation of citizens' groups in the making of the decisions regarding themselves and their immediate environment, may promote diversified interests, of all the social groups of the community, thus bringing into light the needs of members of the low socioeconomic classes, who usually do not tend to participate in any organized framework. Another claim is that citizens' participation in the decisions made in small geographical units (a neighborhood, a factory etc.) is something they can understand, and they view it as an important factor affecting their daily lives. As a result, people reveal a strong motivation to participate, and are ready to do so. It follows, that citizens' participation is more active and more significant when it takes place in small geographical units.

According to Verba and Nie (1972), the quality of the participation is evaluated according to the number of opportunities provided by the political system to its citizens, both as individuals and as groups, to participate in designing a public policy in areas important to them, determining thus their own life styles and well-being. Lu-Yone, Churchman and Alterman (1981) present six goals which could be attained by citizens' participation. Over and beyond the pragmatic aims, such as responding to the will of different groups, mobilization of support and legislation of political change, they relate to the participation process in social, educational and psychological goals. True partnership is a long process of dialogue between the authorities and the citizens, a process leading to a change in the positions of both sides, reducing the degree of alienation between them and intensifying the feeling of a connection between the citizens and the settlement and the community in which they reside. One of the aims of citizens' participation is to design plans which are suited to the wishes of the different groups involved by utilizing the information and experience available to them, and by matching the ends to the needs and to the desires of their users.

Citizens' participation in the decision-making of their neighborhood level has begun to take-off in Israel only in recent years as an outcome of the Neighborhood Renewal project initiated by the Government in 1977 (Lu-Yone, Churchman and Alterman, 1981; Churchman, 1988). In the Neighborhood Renewal project, "residents were given a central and active role in the planning and implementing of the project". All this, in order to confront feelings of alienation and helplessness that have been defined as central components of social distress of the renewal neighborhood residents. Neighborhood residents who participated in the Steering Committees of the Renewal Project, constituted 50% of its members, and played an important role in the preparation and in the supervision of the renewal plan (Shapiro and Liron, 1984; Liron and Shapiro, 1988).

Neighborhood Self-Management Councils, established in the 1980s at the initiative of the Jerusalem Municipality and with the participation of Joint-Israel, is another example of citizens' participation at the neighborhood level. The overall purpose of the project was to improve and integrate services, to promote self-management in the city neighborhoods, and to increase the involvement of the residents. The Self-Management Councils on the neighborhood level are based on the notion of a close partnership between the service suppliers and its consumers (Hasson, 1989).

The Value Stretch Model

Most methodologies used to evaluate plans and public services are based mainly on objective measures. However, it is known that a human being also behaves according to his own perceived subjective needs. It thereby follows that any attempt to explore the problems of any population, or to evaluate the applicability of programs and of services for any population, should also employ a system of subjective measures. This is particularly true for modern, pluralistic societies or for those societies undergoing a process of induced modernization, such as the Arab population of Israel. The subjective measures, which may be distinguished by place and by culture, tend to combine the experience of the past and present of individuals and of social groups, and to determine their expectations and preferences for their future needs of quality of life (Schnell and Kipnis, 1989).

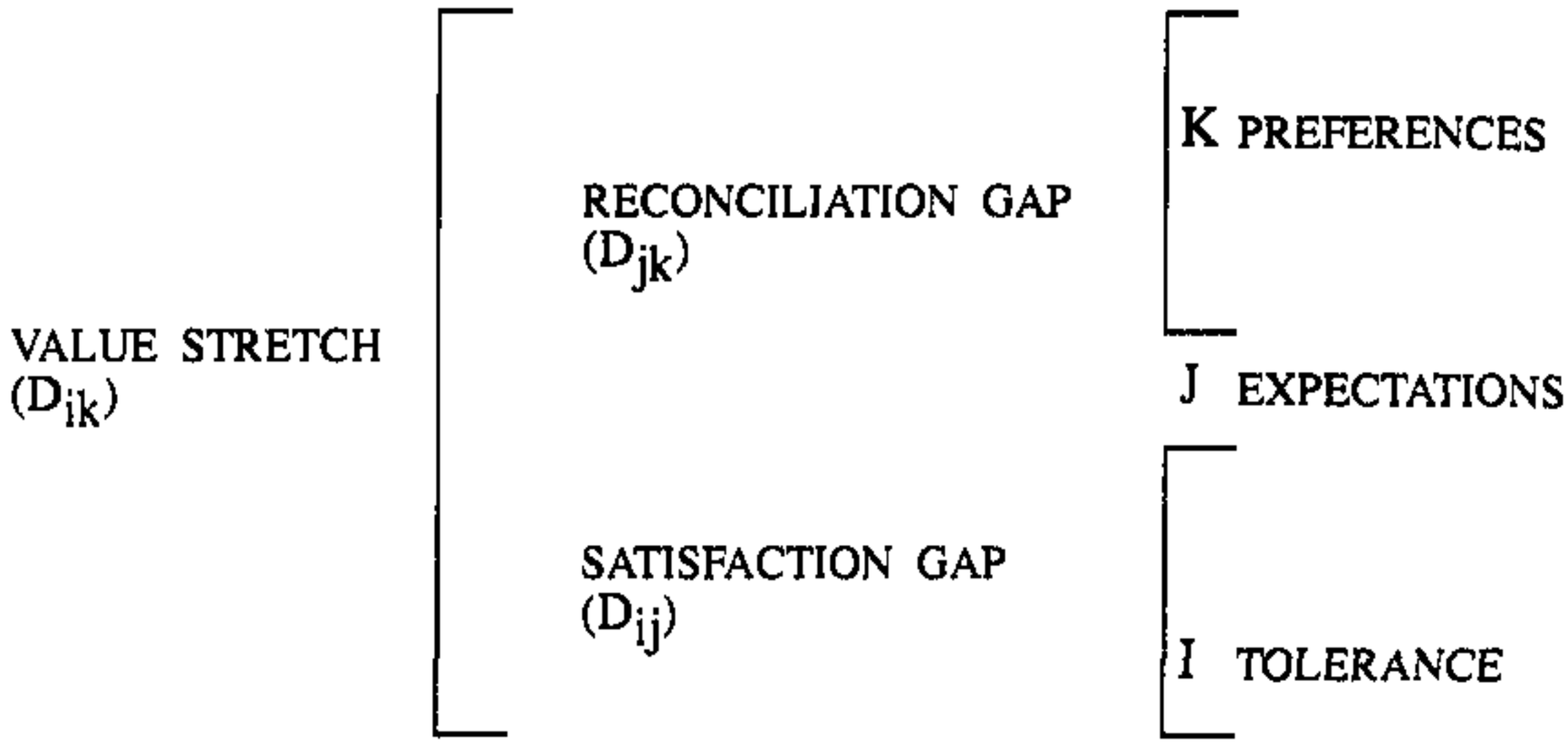
The methods of subjective evaluation of social needs are diversified, and many of them are presented by Kipnis and Ventriss (1984) and by Schnell and Kipnis (1989). The common methods are usually based on field surveys, applying Matrice or "Likest" ladders, and cognitive map questionnaires. Other methods include Delphi (Dalkey and Rourke, 1981) and "nominal group" techniques (Delbecq and Van De Ven, 1971).

The research methodology of this paper rests on the "value stretch" model developed by Della Fave in 1974. The model was applied and improved in a number of studies conducted by Kipnis (1978), Kipnis, Aspis and Berhad (1991) and Kipnis and Berhad (1991) on the subject of housing for minorities; Kipnis and Mansfeld (1986) and Kipnis (1988) on the subject of occupation; Mansfeld (1995) on the subject of tourism. and by Schnell and Kipnis (1989) who proposed a conceptual framework for well-being social policy planning for a pluralistic society.

As a basis for the "value stretch" model, rests the assumption that the individual's quality of life "stretches" along a range at the top of which lies the "preferences level" (K), which describes a situation perceived as ideal, and at the bottom of which lies the "tolerance level" (I), which is the lowest level that the individual is willing to tolerate regarding the consumption of a certain good or service. In the middle is the "expectations level" (J), representing the level of services which the individual expects to receive or to consume within a given period of time, say five years. In order to reach this level, the individual must mobilize his resources and make all the efforts to achieve it (Fig. 1).

The value stretch is, therefore, the measurable gap between three absolute values which are defined for each individual as preferences, k, expectations,

Fig. 1. The "Value Stretch" Model



i, and tolerance, j. These values for population groups are K, J and I, respectively. Three measurable gaps (stretches) are formed between the three levels of the model, as follows:

1. A "Satisfaction Gap" is the range between the "tolerance level" and the "expectations level"' defined as d_{ij}. It simulates the gap between the very lowest quality of life that the individual is willing to accept and that which he expects to achieve within a given period of time (five years).
2. A "Reconciliation Gap" (d_{jk}), is the range between the "expectations level" and the "preferences level". This is the gap between the personal goal which the individual perceives as achievable within a given time period, and that which he defines as his highest level of an ideal situation he is willing to attain in the distant future.
3. A "value Stretch" (d_{ik}), is the gap between the "tolerance level" and the "preferences level". This gap is the sum of the "satisfaction" and the "reconciliation" gaps, and it represents the gap between the very basic needs of the individual, defined at the tolerances level, and the ideal quality of life that the individual strives to reach in the distant future.

It is possible to apply the "Value Stretch" model at the group level. In this case, the average of the individuals' gaps is calculated to create the group's "Satisfaction Gap" D_{JI}, the group's "Reconciliation Gap" D_{JK}, and the group's "Value Stretch", D_{IK}.

The idea behind the value stretch model is that the values of the three gaps between the three levels vary, so it is assumed, in accordance with the socio-economic status of the individual, the environment in which he lives, and according to his stage on his life cycle. Therefore, three assumptions are

set forth for the analysis. The first is, that in establishing public policy for the provision of services and goals symbolizing a quality of life, one should relate to a set of normative values, including those which are universal, and those which reflect the nature of the community and the society involved. These change over time, reflecting the emerging technological innovations, and as a reaction to changes in the individual's perception of his world. Although the gaps reflect the values of every individual, we assume that they may be described collectively for every social group to which that individual belongs.

The second assumption is that the physical and the social environment in which a person lives, tends to create behavioral norms and a system of expectations about his living environment, including the level of neighborhood services he expects to enjoy or use.

The third assumption is that the demand for neighborhood services of a "core family" is determined and influenced by the stage in the family life cycle. It states that different population groups, which have different social, cultural, or environmental groups of references will have different values, norms and expectations, which are unique to them alone. By employing the F test statistics over the group's three stretch values, we examine the extent to which the various groups of Arabs defined in this study, differ in their attitudes toward neighborhood services.

The Sample

In the spring of 1989 a random sample was conducted among men and women aged 19-45 in four settlements representing different types of Israeli Arab settlements. The villages were: I'bllin, an urbanized village with a mixed population of Christians and Moslems located in the suburbs of metropolitan Haifa; Jatt (in the "Triangle"), representing a small urbanized village populated by Moslems in the Yiron valley region; Sakhnin, representing a large urbanized village with Moslems (the majority) and Christians (a small minority), at the heart of the Galilee. and the city of Nazareth, a mixed Moslem-Christian Arab city, which is the largest Arab city in Israel.

The sample was drawn out from the settlements 1989 voters' lists and it was adjusted to proportionally cover all the spatial segments of the settlement: its core, its inner and its outer ring.

The size of the sample was planned in such a way so that there would be at least 100 questionnaires for every village settlement and 250 questionnaires for Nazareth. The size of the sample was determined in order to

comply with the requirement for $\alpha = .0.05$ level of significance and a sampling error $\alpha < 10\%$. In all, 614 interviews were conducted, yielding 609 workable questionnaires.

The Research Hypothesis

Two groups of hypotheses were defined. The first group of hypotheses has to do with the essentiality of the service involved. Its central hypothesis was that there is a significant difference in evaluating the essentiality of neighborhood services among the following social groups: women and men, Moslems and Christians; groups belonging to different levels of education; groups at different stages of their "life cycle" stages; groups belonging to different economic status; and the people living in Nazareth as opposed to those living in the urbanizing villages.

The second group of hypotheses relates to the "value stretch" and its central hypothesis was that there is significant variance in defining the "satisfaction", the "reconciliation", and the "value stretch" gaps among the above population groups, defined as independent variables. It should be stressed, that the larger the gaps, the greater is the extent of compromise on the essentiality of a given neighborhood service. Small gaps usually reveal a low level of compromise.

The interviewee was asked to reply to the following questions: "if you could chose a residential neighborhood for your own family, which of the following neighborhood services do you think should definitely be in an ideal neighborhood" (preferences); "which following neighborhood services do you expect to find in your neighborhood (lets say) in five years from now" (expectations); "which of the following neighborhood services you can not give up, that is, it is imperative to have them in your neighborhood now" (tolerance). For each one of the questions, the interviewee was asked to scale the degree of necessity from 1 (not important at all) to 5 (most desirable).

Methodology

A variance analysis test (an F test) was conducted, in order to determine whether the gaps in the evaluation of neighborhood services among those belonging to different population groups are significantly different. A significant variance between groups will be defined when the calculated F value is higher than the value of F at a significance level of $\alpha = 0.05$. F values larger than the above, indicate that the groups differ from one

another in determining the necessity of the neighborhood service involved. In addition the following analyses were carried out:.

1) For each one of the three levels of the model: "preferences", "expectations", and "tolerance", in which the interviewee was asked to grade from 1 (not important) to 5 (most desirable), three answers were calculated: high (average score 4-5); medium (average of 3); and low (average of 2-1). The average value indicates how important that service for the group is. A high average in all the three levels of the value stretch model reveals that the group perceives that neighborhood service as highly important.

2) The average values of the model's gaps: "satisfaction", "reconciliation" and "value stretch", were calculated. The extent of the gap indicates the level of "compromising" on that particular service. A small gap indicates "non-compromise" or a low level of compromise, while a large gap indicates a high level of compromise on attaining that service by the group involved. For each individual the model gaps were measured at a range from maximum of 4 and +4 (the indicating gaps distance between i and j; between j and k; between i and k). For example, $d_{ik} + 4$ might stand for a case in which $k = 5$ and $i = 1$.

3) Identification and evaluation of the measured gaps between the value stretches for each one of the independent variables. This was carried out only for those stretches found to be significant in the F test. At the first stage, three levels of the model were defined for each person sampled: his "preferences" - k, his "expectations" - j, and his "tolerance" level - i. The average values of the above were then calculated for a few "service baskets", including each service, when n represents the number of services in the "basket". The larger service basket, with $n = 13$, contains all the 13 neighborhood services involved. Other "service baskets" were the educational basket ($n = 3$); clubs ($n = 2$), and open spaces ($n = 3$).

At the second stage, three stretch values were defined for each individual, as the gap between the model's three values levels, as follows:

d_{ij} - the individual's "satisfaction gap"

d_{jk} - the individual's "reconciliation gap"

d_{ik} - the individual's "value stretch"

In addition, the gaps (D) of the social group were calculated and these were defined as D_{ij}, D_{jk}, and D_{ik}, for the three stretches, respectively.

The analysis was then applied to the three service "baskets":

1) All neighborhoods' services (a basket with $n = 13$).

2) Educational services (a basket with n = 3) - kindergarten - elementary school - high school.
3) Clubs (a basket with n = 2) - youth clubs - clubs for adults.
4) Open spaces (a basket with n = 3) - public garden - sports ground - playgrounds.

Each neighborhood services (n = 1) was then analyzed separately.

Results

As for the hypotheses, there is significant variance in the evaluation of the essentiality of neighborhood services among the different population groups under consideration. The discussion that follows will deal with each one of the hypotheses separately. The first item would be the neighborhood service baskets which were found to be most basic and essential.

Table 1 shows the value stretch model's values for each of the service baskets. Note how 41% of the interviewees were not willing to compromise on the existence of the entire "basket" of services (n = 13). At the "preferences" level, however, close to 90% of the sampled participants ranked high all the services, that is, they indicated that they expect to have them in their neighborhood in the future.

At the "tolerance level" close to 44% of the interviewees were not willing to compromise on the availability of open spaces at their neighborhood; 36.4% were not willing to compromise on clubs for youth and adults, and about 34% voted high for educational services. The apparent difference between the relatively low "tolerance level" of educational services as

Table 1. Tolerance, Expectations and Preference Values of Service Groups Ranked by their Highest Tolerance Value

Service Value	Tolerance (i)				Expectations (j)				Preferences (k)			
	high	med.	low	total	high	med.	low	total	high	med.	low	total
all services (n = 13)	41.1	16.0	42.9	100.0	50.4	14.2	25.4	100.0	89.7	3.7	6.6	100.0
open spaces (n = 3)	43.7	22.1	34.3	100.0	64.7	15.6	19.7	100.0	93.2	3.9	2.9	100.0
clubs (n = 2)	36.4	18.7	44.9	100.0	60.9	23.1	23.1	100.0	84.6	6.5	8.9	100.0
educational services (n = 3)	34.1	17.1	48.8	100.0	61.0	14.3	24.7	100.0	93.5	2.6	3.8	100.0

Source: field study 1989.

compared to that of open spaces, is explained by the fact that not all of the residents require these services at the present stage of their life cycle. Open spaces, on the other hand, are perceived as more "universal" for all groups defined by their life cycle. At the "preference" level, representing the group's long-term goals regarding neighborhood services, very high rates were found: 93.2% ranked high the "open spaces" basket, 93.5% the educational, and 84.6% gave the "clubs" group the highest grade.

Table 2 presents the rank order of the thirteen services scaled according to their ranked score at the "tolerance level". The table shows that the highest value was given to streets and sidewalks (84.0%); this means that most of the people were not willing to compromise on the existence of streets and sidewalks in their neighborhood. At the "preference level", service reaches 98.8%. Seventy three percent stated that clinical services should not be compromised on, while at the "preferences" level, 97% indicated that they are most desirable. The service given the lowest score at the "tolerance level" was the old-age homes; only 9% claimed it to be

Table 2. Scale of Tolerance, Expectations and Preference Values of All Services Ranked by their Highest Tolerance Value

Value service	Tolerance (i)				Expectations (j)				Preferences (k)			
	high	med.	low	total	high	med.	low	total	high	med.	low	total
streets and sidewalks	84.0	7.4	8.6	100.0	94.2	3.0	2.8	100.0	98.8	0.4	0.8	100.0
clinic	73.7	9.0	17.3	100.0	84.1	7.4	8.5	100.0	97.0	1.5	1.5	100.0
playgrounds	48.3	21.8	92.9	100.0	67.3	14.1	18.6	100.0	94.7	3.5	1.8	100.0
sports fields	45.9	22.8	31.3	100.0	62.8	18.2	19.0	100.0	92.1	4.6	3.3	100.0
youth clubs	41.8	20.6	37.6	100.0	58.8	18.9	22.3	100.0	89.7	5.4	4.9	100.0
kindergarten	39.6	12.8	47.6	100.0	66.5	14.1	19.4	100.0	96.5	1.5	2.0	100.0
elementary sch.	38.9	17.4	43.7	100.0	65.0	12.0	23.0	100.0	94.1	1.8	4.1	100.0
public open spaces	36.8	21.5	41.7	100.0	63.7	14.8	21.5	100.0	92.6	3.8	3.6	100.0
mosque/church	34.7	17.2	48.1	100.0	51.9	16.9	31.2	100.0	84.0	6.6	9.4	100.0
adult club	30.9	16.9	52.2	100.0	48.3	19.0	32.7	100.0	82.1	6.6	11.3	100.0
day-care center	26.0	10.8	63.2	100.0	50.9	14.3	34.8	100.0	87.8	4.4	7.8	100.0
high school	24.6	18.9	56.5	100.0	51.6	16.7	31.7	100.0	90.0	4.6	3.4	100.0
old-age home	9.0	10.3	80.7	100.0	19.0	14.3	66.7	100.0	62.3	6.1	31.6	100.0

Source: field study 1989.

essential, as opposed to 62.3% who prefer to have an old-age home exist in their neighborhood in the future.

The research hypotheses referring to the variance in the evaluation of the essentiality of neighborhood services by different population groups, yield the following results: The group "satisfaction gap" (D_{ij}), the group "reconciliation gap" (D_{jk}) and the group "Value Stretch (D_{ik}), were measured on a continuum ranging from a maximum -4 to +4, indicating the distance between i and j, between j and k, and between i and k. Although our analysis will mainly focus on the "satisfaction gap", in some areas it will also deal with the "reconciliation gap" as well. As a rule, and referring to the "satisfaction gap", it can be stated that the smaller the gap, the closer is the individual or the group to their expected level of neighborhood services.

Analysis of variance (F test) was used in order to reveal whether the variance among the different population sub-groups defined earlier is significant. In keeping with the hypotheses, there is significant variance in the definitions of the "satisfaction gap", the "reconciliation" gap and the "value stretches" among the different populations, distinguished by attributes such as gender, education, life cycle, economic status, and place of residence. Table 3 shows the stretch gaps for which F is significant at $\alpha = 0.05$. Again, the wider the gap the higher is the propensity of the sub-groups to "compromise" on the level of services provided by the "service basket" in question. On the other hand, a narrow gap testifies to a low level of compromise.

In the "satisfaction gap", the following population sub-groups revealed a significant variance in their need for neighborhood services: religion, education, life cycle, economic status, and place of residence. The only exception is gender, meaning that men and women evaluate the necessity of the overall neighborhood services equally. The highest value on the F for the "satisfaction gap" and the "value stretch" is yielded by type of settlement (place of residence). The second highest F value is assigned to life cycle, and the third is to religion. Yet, the hypotheses that population sub-groups which belong to different economic classes will evaluate the need for neighborhood services differently, was accepted, albeit at a low level of significance.

The hypotheses regarding the difference in the evaluation of the essentiality of the neighborhood services among different population groups, were examined also in connection with the educational baskets of neighborhood services. Table 4 shows the gaps for educational services

Table 3. Average Values of the Stretch Variables for all Neighborhood Services in Cases Where F is Significant at $\alpha = 0.05$

Variable	Satisfaction Gap (D_{ij})	Reconciliation Gap (D_{jk})	Value Stretch (D_{ik})
Gender			
men		0.898	
women		1.045	
whole sample		0.973	
Religion			
Muslim	0.670		1.663
Christian	0.508		1.459
whole sample	0.605		1.578
Education			
0-8 years	0.701		
9-12 years	0.562		
13+ years	0.578		
whole sample	0.605		
Life Cycle			
single	0.694	1.116	1.810
married			
1-4 years	0.826	0.840	1.606
5-20 years	0.434	0.897	1.331
21+ years	0.467	0.944	1.411
whole sample	0.605	0.973	1.578
Economic Situation			
bad	0.492	1.163	
medium	0.597	1.013	
good	0.664	0.837	
whole sample	0.605	0.973	
Place of Residence			
urbanized village	0.750	1.124	1.874
Nazareth	0.423	0.783	1.205
whole sample	0.605	0.973	1.578

Source: field study 1989.

whose F value was found to be significant at $\alpha = 0.05$. Four population attributes disclosed significant F value at the D_{ij} level. These were sub-groups distinguished by life cycle, by place of residence, by religion and by economic status. Most of the characteristics that were found to be significant at the D_{ij} level were also significant at the D_{jk} level. An exception is, surprisingly, the type of settlement. Gender, although it scored a significant F, its value was marginal. At the D_{ik} level, our hypotheses were proven only for population sub-group distinguished by life cycle and by type of settlement. The hypothesis stating that men and women tend to evaluate educational services differently was proven, but at a lower level of

Table 4. Average Stretch Values for Educational Services Group in Cases of Significant F Value at $\alpha = 0.05$

Variable	Satisfaction Gap (D_{ij}))	Reconciliation Gap (D_{jk})	Value Stretch (D_{ik})
Gender			
men	0.976	0.973	
women	0.786	1.217	
whole sample	0.880	1.160	
Religion			
Muslim	1.025	1.020	
Christian	0.677	1.208	
whole sample	0.880	1.097	
Education			
0-8 years			
9-12 years			
13+ years			
whole sample			
Life Cycle			
single	1.113	1.365	2.478
married			
1-4 years	1.458	0,852	2.309
5-20 years	0.465	0.911	1.376
21+ years	0.325	1.285	1.610
whole sample	0.880	1.097	1.976
Economic Situation			
bad	0.650	1.243	
medium	0.816	1.170	
good	1.060	0.941	
whole sample	0.880	1.097	
Place of Residence			
urbanized village	1.092		2.219
Nazareth	0.612		1.672
whole sample	0.880		1.976

Source: field study 1989.

significance. A comparison among averages of the groups at the D_{ij} range shows that men tend to compromise on educational services in their neighborhood more than women.

The hypotheses regarding the difference in the gaps in reference to clubs for youth and adults were proven significant according to type of settlement, life cycle and religion (Table 5). The hypotheses that there is a

Table 5. Average Stretch Values for Club Group in Cases of Significant F Value at $\alpha = 0.05$

Variable	Satisfaction Gap (D_{ij})	Reconciliation Gap (D_{jk})	Value Stretch (D_{ik})
Gender			
men			
women			
whole sample			
Religion			
Muslim	0.580	1.193	1.773
Christian	0.464	0.914	1.378
whole sample	0.543	1.071	1.606
Education			
0-8 years			
9-12 years			
13+ years			
whole sample			
Life Cycle			
single	0.391		
married			
1-4 years	0.609		
5-20 years	0.607		
21+ years	0.732		
whole sample	0.534		
Economic Situation			
bad		1.365	1.960
medium		1.064	1.618
good		0.951	1.434
whole sample	1.071	1.606	
Place of Residence			
urbanized village	0.674	1.329	2.003
Nazareth	0.359	0.748	1.107
whole sample	0.534	1.071	1.606

Source: field study 1989.

difference in evaluating the need for clubs at the D_{ik} level between men and women, between highly educated and those with a low level of education, and according to the stage of a person's life cycle, were rejected due to non-significant F values.

In the "open spaces" basket it was found that in the "satisfaction gap" and in the value stretch" there is a distinction according to type of settlement, religion and life cycle. These were found to be significant on the F test at a level of $\alpha = 0.05$ (Table 6). The hypothesis, that the

Table 6. Average Stretch Values for Open Spaces Group in Cases of Significant F Value at $\alpha = 0.05$

Variable	Satisfaction Gap (D_{ij})	Reconciliation Gap (D_{jk})	Value Stretch (D_{ik})
Gender			
men			
women			
whole sample			
Religion			
Muslim	0.576	1.130	1.705
Christian	0.482	0.771	1.252
whole sample	0.541	0.973	1.514
Education			
0-8 years			
9-12 years			
13+ years			
whole sample			
Life Cycle			
single	0.609	1.152	1.761
married			
1-4 years	0.706	0.873	1.579
5-20 years	0.406	0.863	1.269
21+ years	0.472	0.846	1.317
whole sample	0.541	0.973	1.514
Economic Situation			
bad		1.170	
medium		0.999	
good		0.853	
whole sample		0.853	
Place of Residence			
urbanized village	0.660	0.973	1.971
Nazareth	0.393	1.312	0.940
whole sample	0.541	0.973	1.540

Source: field study 1989.

characteristics of populations attributes of gender, education and economic status are distinguishing in regard to open spaces, was rejected due to non-significant F values.

A rank order of average gaps at the "satisfaction gap" and of the "reconciliation gap" are presented in Table 7. The rank order allows us to identify the services on which the sample of Arab population is not willing to compromise, and which have a very high level of necessity (essentiality)

Table 7. Ranking Order of Average Gaps for Stretches in Each One of the Neighborhood Services

Service	Satisfaction Gap (D_{jk})		Reconciliation Gap (D_{ij})	
Sidewaks and streets	1.	0.278	1.	0.213
clinic	2.	0.319	2.	0.427
sports fields	3.	0.411	6-5.	0.990
old-age home	4.	0.453	13.	1.394
youth club	5.	0.498	9.	1.026
mosque/church	6.	0.499	7.	1.008
playgrounds	7.	0.502	3.	0.938
adult club	8.	0.571	10.	1.117
public garden	9.	0.771	5-6.	0.990
elementary school	10.	0.785	8.	1.010
high school	11.	0.8426	12.	1.319
day-care center	12.	0.985	11.	1.250
kindergarten	13.	1.011	4.	0.962
minimum value		0.278		0.213
maximum value		1.011		1.394

* 1 - do not compromise → 13 - high compromise.

in the eyes of the Arab population of Israel. At the "satisfaction gap" the services were ranked in accordance with the averages received at the overall sample. According to these averages, the neighborhood service ranked in the first place is sidewalks and streets, followed by the clinic, and in the third place by sports fields. The services revealing a high level of compromise are: kindergarten, day-care center and high school. At the "reconciliation gap", the services graded as most essential are: sidewalks and streets, clinic and playgrounds. The services graded as non-essential at this "gap" are: old-age home, high school and day care center. These findings show that the Arab population of Israel is not willing to compromise, in the short and medium term, on streets and on a clinic in their neighborhoods.

Concluding Remarks

The research hypotheses, assuming a differential need for neighborhood services among population groups defined by their demographic, social, economic and cultural attributes and according to type of settlement, were proven. Our findings indicate that the attributes type of settlement, religion

and life cycle, are the most suitable for predicting the need for neighborhood services. The attributes gender, level of education and economic status, on the other hand, were found too weak in order to predict the necessity of these services. The most essential neighborhood services are streets and sidewalks and a clinic, revealing a very low tendency to be compromised by the Israeli Arab population.

The key question is, how should one design a public policy for the provision of neighborhood services for a pluralistic minority society living in a situation of induced modernization processes. Our research proposes that a workable approach to the construction of such a public policy should recognize the unique needs of every social and cultural sub-group of that society, and should channel the policy elements to comply with their diversified needs (Kipnis and Ventriss, 1984; Schnell and Kipnis, 1989). Such an approach does not necessarily perceive the main functions of a social policy in the sole terms of equality, economic effectivity and social justice, but also in terms of freedom of choice of the people involved. The central principle in the perception of a pluralistic and modern society is that *every individual and each social group has its own unique nature, its own* value system, and its own perceptions of its needs. It is further argued that the values of the individual and of his social and cultural group, should be expressed and fulfilled by the social policy in the widest socio-political context (Schnell and Kipnis, 1989).

The main characteristic of most Arab settlements in Israel has been as a place of residence. The main efforts of the municipality have been aimed at supplying physical infrastructures and at the provision of the essential social services to a continually increasing population (Meir-Brodnitz, 1986). These efforts have further been stimulated by a demand to provide those essential services in increasing quantities and improving qualities, at least equal in standards to those of Israel at large.

Yet, very little attention has been given so far to the development and the provision of essential neighborhood services. The lack of and/or poor quality neighborhood services, have a negative impact on the people involved and result in a low level of social welfare both for the present and future residents and of their children.

The "value stretch" model, it is argued, serves as a workable subjective analytical tool in evaluating the level of existing and of future essential quality of life elements of a given population. In our case, neighborhood services to the Israeli Arab population, being a minority population, within the context of Israel at large, and pluralistic within terms of religion,

education, economic well being, the "value stretch" model allows a clear cut observation of what is important as well as critical for a given population group according to its own actual needs.

Bibliography

Alterman, R. (1989), "Developer obligation for public services in Israel in a comparative perspective", working paper, Haifa: The Technion, Center for Urban and Regional Studies.

Arenstein, S. (1969), "A ladder of citizen participation", *Journal of the American Institute of Planners*, 35: 216-224.

Barr, N. (1987), *The Economics of the Welfare State*, Stanford, Ca.: Stanford University.

Battimer, A. (1979), "Erewon or Nowhere Land", in: Gele, S. and Olson, G. (eds.), *Philosophy in Geography*, Dordrecht: D. Reidel, pp. 9-37.

Browning, E.K. and Browning, J.M. (1983), *Public Finance and the Price System*, London: Macmillan.

Churchman, A. (1985), *Citizens Participation and Cooperation in the Urban Renewal Project*, Vol. 31, No. 3-4: 342-362 (in Hebrew).

Churchman, A. (1988), "Citizen participation in the Neighborhood Renewal Project", *Megamot*, 31/3-4: 342-362 (in Hebrew).

Corazim, Y. and Meler, Y. (1987), "Cuts in social services from the view point of social workers", Society and Welfare, 8: 103-113 (in Hebrew).

Dalkey, N. and Rourke, D. (1981), "The Delphi Procedure and rating quality of life factors", in: *Experiments Assessments of Delphi Procedure with Group Value Judgements*, Los Angeles, Ca.

Delbecq, A.M. and Van De Ven, A.H. (1971), "A ggroup process model for problem identification and program planning", *Journal of App. Bhv. Sci.*, 7: 462-492.

Doron, A. (1985), *Welfare State in Changing Society*, Jerusalem: The Magnes Press, The Hebrew University (in Hebrew).

Enden, E. (1983), *A Model of New Neighborhoods in Arab Villages in Northern Israel*, Haifa: Master Thesis, Department of Geography, the University of Haifa (in Hebrew).

Felsenstein, D. and Razin, E. (1993), "Post-industrial processes and their impact on the spatial organization of Israel", in: *Israel 2020. A General Plan for Israel for the 21st Century*, first stage report, Haifa: the Technion (in Hebrew).

Fraser, D. (1984), *The Evolution of the British Welfare State* (2nd. ed.), London: Macmillan.

Hasson, S. (1989), *Neighborhood Self-Management in Jerusalem. An Experiment in Urban Management*, Jerusalem: Jerusalem Institute for Israel Studies (in Hebrew).

Higgins, J. (1981), *States of Welfare: Comparative Analysis in Social Policy*, Oxford: Blackwell and Martin Robertson.

Kipnis, B.A. (1978), *Housing Aid for the Arab Sector*, Haifa: The Applied-Scientific Research Institute, the University of Haifa, (in Hebrew).

Kipnis, B.A. (1988), "The Value Stretch model - A methodology for social mobility analysis: The case of the metropolitan field of Haifa, Israel", *Planologische Nieus*.

Kipnis, B.A. and Barhad, A. (1991), *Housing in the Druze and the Cherkes Villages of Israel: Existing Conditions and Housing Aid Policy Considerations*, Haifa: The Haifa and Galilee Research Institute, the University of Haifa (in Hebrew).

Kipnis, B.A. and Barhad, A. (1991), *Housing in the Druze and the Cherkes Villages of Israel: Existing Conditions and Housing Aid Policy Considerations*, Haifa: The Haifa and Galilee Research Institute, the University of Haifa (in Hebrew).

Kipnis, B.A., Apis, Y. and Barhad, A. (1991), *Housing in the Urbanizing Arab Villages of Israel: Moslems and Christians. Existing Conditions, Normative Changes and Housing Aid Policy Considerations*, Haifa: The Haifa and Galilee Research Institute, the University of Haifa (in Hebrew).

Kipnis, B.A. and Aspis, Y. (1992), "Neighborhood services in the Arab villages of Israel: Value stretch model", *Horizons in Geography*, 33-34: 103-118 (in Hebrew).

Kipnis, B.A. and Aspis, Y. (1994), "The application potentials of the value stretch model for social policy planning: The case of neighborhood services", *Social Security*, 42: 52-69 (in Hebrew).

Kipnis, B.A. and Mansfeld, Y. (1986), "Work place utilities and community patterns - Are they class and place differentiated?", *Pro. Geogr.*, 38: 160-169.

Kipnis, B.A. and Ventriss, C. (1984), "Operationalizing quality of life issues: From general goals toward workable objectives" (Memo.).

Kop, Y. (ed.)(1989), *Allocation of Resources for Social Services 1988-89*, Jerusalem: The Center for Social Policy Research (in Hebrew).

Langton, S. (1978), Citizen Participation in america: Essays on the State of the Art, Lexington (in Hebrew).

Liron, L. and Shapiro, S. (1988), "Public participation in planning and administration: Evaluation criteria and their application in Neighborhood Renewal Project", Society and Welfare (in Hebrew).

Lu-Yone, H., Churchman, A. and Alterman, R. (1981), *Citizen Participation in the Neighborhood Renewal Project. Experimental Application of Renewal Methods of Israel's Neighborhoods in Distress*, Haifa: The Technion, The Na'aman Institute (in Hebrew).

Lucy, W. (1981), "Equity and planning for local services", *Journal of the American Planning Association*, October, pp. 447-457.

Mansfeld, Y. (1995), "The value stretch model and its implementation in detecting tourist class differentiated destination choice", *Journal of Travel and Tourism Marketing*, 4/3:71-91.

Meyer-Brodnitz, M. (1969), "Latent urbanization in Arab villages", *Environment Planning*, 6-9 (in Hebrew).

Meyer-Brodnitz, M. (1986), "Urbanization, suburbanization and regional integration: Semantics and planning policy for Arab settlements in Israel", *Horizons in Geography*, 7-8: 105-124 (in Hebrew).

Pinch, S. (1985), *Cities and Services. The Geography of Collective Consumption*, London: Routledge and Kegan Paul.

Schnelll, I. and Kipnis, B.A. (1989), "Well-being in a pluralistic society: Toward a policy - oriented methodology", *Geoforum*, 20(3): 303-313.

Shapiro, S. and Liron, L. (1984), *Involving Citizens' Representatives in the Administration of the Neighborhood Renewal and Rejuvenation Project*, Ramat Aviv: The University of Tel Aviv: Pinhas Sapir Center for Development (in Hebrew).

Soen, D. (1976), *Patterns of Use and Activity in a Dwelling Unit and their Impact onHousing Standards*, Tel-Aviv: The Interdisciplinary Center for Technological Research and Forecasting (in Hebrew).

The Central Bureau of Statistics (1994), *Statistical Abstracts of Israel 1994*, Jerusalem.

Verba, S. and Nie, N.H. (1972), *Participation in America: Political Democracy and Social Equality*, New-York: Harper and Raw.

Walker, B. (1981), *Welfare Economics and Urban Problems*, London: Hutchinson.

ORGANIZATIONAL DILEMMAS IN COMMUNITY NEIGHBORHOOD ORGANIZATION: THE JERUSALEM EXPERIENCE

by Prof. Hillel Schmid*

Introduction

The paper describes, analyzes, and evaluates the merger of Neighborhood Self Management Organizations (NSMO's) and Community Service Organizations (CSO's) in Jerusalem into one organizational entity, the Joint Community Neighborhood Management Organization (JCNM). After four years of operating as a merged organization, the JCNM is still struggling to attain public and institutional legitimation. In this prolonged process, the new organization has encountered ideological and structural problems, which it is currently attempting to solve.

The theoretical background presented at the beginning of the paper provides a framework for conceptualizing and understanding the main topics to be dealt with in the paper. This framework will enable the reader to evaluate how effectively the organization has succeeded in attaining its goals; to study the organizational and structural dilemmas encountered by the organization; and to understand the driving and restraining forces that affect the organization's growth and development. The theoretical section will conclude with a description of the merging organizations and the new organizational entity. This description will be followed by an analysis of the main dilemmas encountered in the merging process, and the organization's prospects for establishing itself in the future.

The findings presented in the paper are based on a formative evaluation study conducted in 1994-1995 (Schmid, Unterman and Zilberman, 1994; Schmid, Unterman and Zilber, 1995). The study aimed to evaluate several aspects of the organization's development: ideological, strategic, structural, organizational, and professional. These aspects are considered in terms of their contribution toward delivery of services at the community level.

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Theoretical Background

The theoretical background integrates two theories which attempt to explain organizational behavior. The first, institutional theory, describes the process of organizational adaptation to external changes through a process of isomorphism. The second theory focuses on the process of decentralization, which entails delegation of authority from the executive level to the peripheral units that are directly involved in provision of services to the clients. Both have been shown to be particularly applicable to organizations whose principle function is to maintain or enhance social and community welfare. The following discussion will demonstrate how those theories can be used to identify the organizational issues and dilemmas faced by community neighborhood organizations.

Institutional theory assumes that the structure of certain groups of organizations such as social welfare organizations, human service organizations, and community organizations is not determined by the technology they adopt but rather by rules emanating from the institutional environment. According to Meyer and Rowan (1977:43) "Many of the positions, policies, programs, and procedures of modern organizations are enforced by public opinion, by the views of important constituencies, by knowledge legitimated through the educational system, by social prestige, by the laws, and by the definitions of negligence and prudence used by the courts". This argument is supported by DiMaggio and Powell (1983), who claim that authority, power, and institutional regulations influence the operation and internal structure of the organization. Institutional theory assumes that since organizations wish to survive they are forced to uphold these institutional rules which constitute the source of legitimacy and provide avenues for obtaining resources (Hasenfeld, 1992:35). DiMaggio and Powell (1983) suggest three processes for attaining legitimacy and resources: (a) coercive processes, i.e., through state and legal forces; (b) mimetic processes; (c) normative processes, i.e., through transmission of social norms. In this respect, institutional organizations adopt myths and ceremonies (Meyer and Rowan, 1977) which are defined as rationalized myths. They are based on an unproven system of beliefs such as professional ideologies, yet they are viewed as a rational means to achieve desired social ends. In this context, the ceremonies constitute periodic affirmation of these myths through symbolic actions such as certification and accreditation (Hasenfeld, 1992:36). By nature, human service and social welfare organizations are institutional. They derive their legitimation and

social support from adoption of the social value system adhered to in the society and the community rather than from the "unique" products they offer. When these organizations develop patterns for support and perpetuation of values, their unique content becomes less important to the constituencies that provide them with the legitimacy they need. The organizations attempt to perpetuate their goals through rationalization based on accepted ideologies (Zald, 1970; Perrow, 1970; 1972). Adoption of myths is a precondition for isomorphism that ensures a flow of resources to the organization, even though the organization does not necessarily intend to realize those myths.

The second theory underlying the organizational analysis focuses on the transition from structural centralization to federative decentralization, in which the field units engaging in provision of services to clients are delegated with authority and semi-autonomy. Decentralization can be viewed as a political process that reflects the relative power of interest groups and the actors that rally around those interests (DiMaggio, 1988). This process derives from the desire to control power and resources in the organization that make it possible to set policies, make decisions, and allocate resources. These sources of power include knowledge and information relevant for decision-making. The closer they are to the peripheral units and clients, the greater the justification for shifting the focus of decision-making to the level of peripheral units responsible for provision of services and/or products (Kochan and Deutsch, 1980; Mintzberg, 1979).

The shift to decentralization can be justified on several grounds: (a) Organizational growth, i.e.,increased scope and complexity of organizational activity. The broader the range of organizational activity, the greater the likelihood that a centralized system will obstruct decision making and impede the continuous flow of knowledge and information required for regular activity. (b) Heterogeneity of products, services, and clients. The greater the heterogeneity and diversity of clients, the more the organization needs to develop a decentralized, flexible structure that can adapt itself to the differential needs of its clients (Hasenfeld and Schmid, 1989). A necessary condition for decentralization is self restraint of top executive levels and avoidance of intervention in routine affairs, e.g., providing an opportunity for independent activity of the field units. Self restraint must be accompanied by mutual trust and understanding that in a decentralized system the central headquarters must be at least as strong as the peripheral units that have been delegated with the authority. The roles of the central

headquarters change in a decentralized structure, from direct control of most of the organizational processes to setting policies and standards, and creating managerial and professional technologies. In this way, the headquarters enable the peripheral units to operate according to the norms and standards it establishes and monitors (Schmid, 1992; Scott, 1992)/

The theoretical framework combines these approaches views processes of political and administrative decentralization as myths and symbols that are not intended to be fulfilled. Although social and community service organizations have adopted these myths, the myths have not been realized since central authorities (e.g., the government and municipalities) are afraid of losing power and control over resources. Adoption of the value of decentralization and delegation of authority enables the organization to attain isomorphism with the political environments, since it is difficult to resist these process that aims to improve the services provided to clients. The fear of change, which is generated by the redistribution of power, essentially restrains the process of decentralization whose importance is espoused by the leaders of the organization.

Joint Community Neighborhood Management in Jerusalem

Joint Community Neighborhood Management (JCNM) in Jerusalem developed in various ways. In some neighborhoods, these organizations were based at the local community center, and in others, they were based in the neighborhood self management organizations. There were also neighborhoods in which the JCNM derived from a merger of community service organizations and neighborhood self management organizations. The paper will begin by describing the organizations, and continue with a description of the new organizational entity.

A. Neighborhood Self Management Organization

Neighborhood Self Management Organizations (NSMO's) developed as part of a process of political and administrative decentralization, where the burden of political decision-making and provision of services shifted from centralized control at the municipal level to semi-autonomous organizational units operating in neighborhoods. On the political level, the goal was to shift power and responsibility for decision-making to the neighborhood residents in aspects related to setting neighborhood policy and enhancing democratic practices through elections, in which neighborhood residents elect their own representatives. Local democracy has also been promoted through community-run operations and encouragement of neighborhood

residents to assume responsibility for their own affairs. Locally elected individuals represent the interests of the neighborhood in official and municipal institutions. In this capacity, they work toward improving the quality of life and responding to the needs of neighborhood residents. On the administrative level, the aim was to change the relationship between neighborhood residents and the municipal establishment, in order to bring municipal services closer to them and introduce improvements at the neighborhood level. In this context, the Neighborhood Self Management Organizations are responsible for identifying local needs and providing social welfare, health, and urban services as well as for promoting voluntarism and developing community leadership.

The Neighborhood Self Management Organization consists of two main organs: One is the board, made up of democratically elected neighborhood representatives as well as representatives of institutions and services operating in the neighborhood (e.g., schools, health services, welfare services, environmental protection and urban planning). The board is in charge of policy-making. In this capacity, it oversees policy implementation as well as control and management of the organization. The second organ consists of professional staff responsible for the administrative operation of the NSMO's. Most of the revenue is obtained from the central municipality and mediated by an umbrella organization which incorporates all of the NSMO's in metropolitan Jerusalem (Hason and Shehori, 1991).

B. The Community Service Organization

The other partner in the merger is the Community Service Organization (CSO). Historically, the CSO was established as a vehicle for social integration, and its espoused goals were as follows: To create opportunities for positive social interaction between different social groups by promoting common social norms and cultural values and by providing a sense of community among their constituencies (Beck, 1977; Hasenfeld and Schmid, 1989; Macarov, 1978; Macarov and Yanay, 1975; Perlman and Jones, 1967; Yanay, 1982). The community service organization has been viewed as a vehicle for promoting community development and cohesion, as well as for integrating immigrants and socially deprived populations into the mainstream of society. The CSO can also accommodate itself to the unique characteristics of the local residents and to adapt its services to the specific needs of that population. Moreover, its target population is broadly defined as all of the residents in the community. By encouraging the concept of membership, the community center attempts to encourage citizen participa-

tion in its activities (The Israel Association of Community Centers, 1980:6). The CSO provides socialization and recreation services rather than rehabilitative or ameliorating services. The wide variety of socialization services ranges from recreation programs to education and cultural programs. In this context, the CSO also attempts to promote the ideology of citizen participation in political decisions.

Each CSO is incorporated as a voluntary organization with a public board that represents the municipality as well as various social service agencies and citizen groups. Although CSO's are affiliated with the Israel Association of Community Centers, which selects and hires the center's director, much of the budget and operation of CSO's is locally determined. In this regard, CSO's can be contrasted with other welfare organizations whose policies, budgets, and programs are determined by the central authorities

Comparative analysis reveals several differences between the NSMO's and CSO's. The following Table presents these differences, which derive from ideological, strategic, structural, administrative, and organizational aspects of the two entities.

Table 1. Comparative Analysis of Neighborhood Self Management and Community Service Organizations

Feature	Neighborhood Self Management Organizations	Community Service Organizations
1. Organizational ideology and espoused goals	Political and administrative decentralization through democratization of urban processes; citizen participation in decisions, advocacy, liaison, and lobby.	Initiation of social interaction between different interest groups; promotion of common social norms and cultural goals, establishment of a sense of community among the residents.
2. External environment	Stable, certain. Ensures a steady flow of resources from the municipal authorities to peripheral units.	Unstable, turbulent, dynamic and heterogeneous.
3. Organizational Culture	Based on the ideological values of democratization, urban processes, decentralization of services, representation, and citizen participation. Formal, bureaucratic system based on defined division of labor between elected representatives and professional staff. Formal system of status and symbols.	Based on values adhered to in voluntary organizations which provide social and community services; an informal, organic system with permeable boundaries between professional staff and clients, characterized by an informal status system.

Table 1 continued

4. Organizational Strategy	Strategy of cooperation and tight coordination between peripheral, municipal, and government authorities. Proactive strategy for identification of needs. Strategy of specialism in urban issues.	Strategy of generalism and diversification of services and programs in a broad range of social, cultural, and community services. Maintenance of checks and balances in an attempt to avoid discrimination between different socioeconomic strata of the population.
5. Organizational Structure	Formal, mechanistic, bureaucratic. Based on formal procedures and institutional arrangements. Mechanisms of close cooperation and a centralized process of supervision and con-trol.	Informal, organic, flexible. Based on the principle of loosely coupling organizational activities between administrative units. Sporadic, informal communication. Control and monitoring are decentralized between units.
6. Financial Resources	95 percent of the revenue derives from centralized municipal authorities; 5 percent derives from fund raising for development of specific programs.	Funding is based on enrollment economy, where 60-70 percent of the revenue derives from sale of services, 30-40 percent derives from government, municipal, or other public resources.
Professionals, mainly in urban planning and provision of basic municipal services such as sanitation and transportation.	Professionals in the field of informal education, focusing on social, community, cultural, sport and recreational services.	
8. Governance	Board elected in democratic, secret, personal elections. Members include neighborhood residents as well as representa-tives of local and professional services (schools, social welfare services, etc,).	Nominated board, consisting of representatives from government and municipal services as well as representatives of professional services. The members are not necessarily neighborhood residents.
9. Target Population (Clients)	Anyone living within the geographic boundaries of the neighborhood.	Primarily neighborhood residents, as well as recipients of special services who do not live in the neighborhood.
10. Service Technology	Based on urban and physical services defined according a division of labor between the central municipality and neigh-borhood self management.	A broad range of indeterminate, undefined service technologies corresponding with a variety of activities ranging from recreational activities to family counseling , where intervention is highly individualistic.

Comparative analysis of the two organizational systems reveals several differences between them. These differences are reflected in Table 1, which outlines the ideological, strategic, structural, managerial, and organiza tional features of each type of organization. The Neighborhood Self Management Organization aims to promote democracy by establishing neighborhood institutions that operate according to the principle of local representation. This ideology has given rise to an organizational culture that encourages citizen participation and involvement in decision making. The mission of the CSO is to serve as a vehicle for community development, socialization, and reeducation of community residents. In contrast to NSMO's, CSO's are characterized by an informal organizational culture, where the status of staff members is determined by their professional expertise and not by their formal positions. Other salient differences are in governance and sources of funding. In keeping with the ideology of democratization through elections and citizen representation, the board of the NSMO is elected, while the board of the CSO is appointed and represents several interest groups. With regard to sources of funding, NSMO's derive most of their revenue from the central municipal authority, and are therefore dependent on its policies and practices. CSO's derive most of their revenue from marketing programs and services based on an "enrollment economy" (Zald, 1970). According to this strategy, programs and services are determined on the basis of consumer demand, which is expressed as paid enrollment. Services that attract enrollment survive, whereas those that do not are discarded, unless they are underwritten by an external sponsor such as a government agency.

NSMO's and CSO's share the following basic principles in common: Self management, community development, leadership development, providing solutions for a broad range of interest groups and citizen participation. These principles provided a convenient basis for merging the two organizations into one organizational entity (the JCNM) (Schmid, 1995).

The Joint Community Neighborhood Management (JCNM) is autonomous. The public board and professional staff assume responsibility for policy-making, while urban and social services in the neighborhood are consolidated. The merged organization is responsible for hiring staff as well as for initiating programs, fundraising, and developing innovative programs and projects. Its goal is to move away from the patronizing, authoritative image of the central authority and independently create a climate of equitable partnership. The local JCNM's operate autonomously. They have an elected board and professional staff in charge of setting neighborhood

policies, coordinating social and physical services in the neighborhood, initiating and implementing programs, mobilizing resources, and developing projects.

The local JCNM's do not compete with or threaten the central municipality. Rather, they complement it and serve as a channel of communication and negotiation between the neighborhood and the government, municipal, and voluntary authorities.

A interim evaluation of organizational performance reveals several achievements. At the same time, JCNM's have encountered organizational and structural dilemmas that typify the formative stage of organizational life, and that may threaten or impede their development if they are not responded to effectively.

The JCNM's have made contributions on several levels. On the level of ideology, it seems that the merger has succeeded in achieving its goals. The new system has internalized the ideological messages as well as the social, political, economic and other values characterizing the merged organizations (e.g., democracy, elections, political and administrative decentralization, citizen participation). Contrary to the research findings regarding mergers that failed due to the encounter between different organizational cultures (Buono, Bowditch, and Lewis, 1985; Cartwright and Cooper, 1993; Marks and Mirvis, 1986). the present cross-cultural encounter has not generated any serious conflict that could pose major obstacles in the merging process. The ideological consensus between the merged organizations has also made it easier for the JCNM to establish its existence as a community organization that consolidates services and incorporates all of the local institutions and organizations in the neighborhood.

With regard to human resources, considerable progress has been made in the attempt to adapt the staff to the tasks of the JCNM. During the first stage of the merger, some of the professional staff members feared they would lose autonomy and control, and many workers resigned. Other workers felt a sense of uncertainty regarding working conditions and salaries. Over the years, however, this perspective has changed. The staff has been stabilizing (although in some neighborhoods there is still a high rate of turnover), and the leaders report that their roles have been enlarged and enriched.

Analysis of board and executive decisions reveals that a considerable amount of time is devoted to urban issues whereas relatively little time is devoted to social and community issues. Analysis of financial reports submitted by some of the JCNM's also reveals a decline in the income and

expenditures for most of the social and community activities, compared with a net increase in activities related to construction of infrastructure for security or physical-urabn infrastructure. The initial stages can also be characterized by an attempt to define the role of the headquarters, to establish work patterns, to delineate areas of interest and activity, and to stabilize the relations between the headquarters and the local JCNM's, and between the JCNM's and the departments of the municipality.

Notwithstanding these achievements, the new organization has encountered several problems and dilemmas that will be dealt with in the following sections.

A. The Dilemma of Unique Identity and Conceptualization of the Joint Community Neighborhood Management Organization

The merger of CSO's and NSMO's created a hybrid organization whose goal is to maximize organizational synergy and attain a relative advantage over other community organizations in the neighborhoods - a goal that was not attained previously by either of the merged organizations. The merger integrates two types of systems. One system specializes in provision of social and community services, while the other specializes in provision of urban services on the neighborhood level. The merged entity seeks its unique identity as a social system responsible for providing social services previously delivered by the CSO's, or as an organization responsible for urban development of the neighborhood. The combination of functions that appear to be loosely connected, elicits the question: What type of entity is the joint community neighborhood organization? Is it a community organization? Is it a center providing multiple services - a bureaucratic subsystem of the central municipal authority that provides services in neighborhoods (Litwin, 1993)? At this stage, it seems that the JCNM is not sovereign since it lacks the legal authority possessed by the central municipality. The argument that the division of labor between the JCNM and the central municipal authority should be determined on the basis of the relative advantage of each organization creates ambiguity and uncertainty in the relations between the organizations. This ambiguity can be utilized by the JCNM to pursue new directions, but its power (as well as many of its resources) is controlled by the central municipal authority which has not yet taken a final stand regarding the future of the new organization.

B. Political and Public Legitimation

Human service organizations do not function independently. Rather, they are part of the external environment. The organization must be legitimized by the environmental constituencies which provide resources needed for the organization's survival. In this way, the organization becomes dependent on the environment, which controls its activity (Benson, 1975; Pfeffer and Salancik, 1978; Thompson, 1967).

Although the merged organization has formally attained recognition and official accreditation from the municipal and government authorities, on an informal level it still lacks broad legitimation for its independent existence, for its unique identity, and for its programs. This applies particularly to the attitudes of politicians and of the municipal administration, as well as to the attitudes of the community residents.

On the political level, there are basic disagreements about the need for an independent JCNM alongside central municipal authorities. Politicians argue that the JCNM is a redundancy of municipal services and prevents citizens from having direct access to the central municipal authorities. According to this view, the JCNM has no legal rights or status, and is not allowed to set urban policy. In the same vein, it is argued that the JCNM uses resources which would be better utilizes if they were managed by the departments of the municipality. According to this view, there is a conflict between the interests of the neighborhood and the interests of the city as a whole. Thus, the neighborhood perspective is sectoral, and places the interests of the neighborhood before the interests of the city, whereas municipal politicians and the municipal administrations take the needs of the entire city into account without discriminating between neighborhoods and residents. It is argued that the JCNM's should only represent the neighborhood residents in municipal institutions. According to this view, the exclusive authority to make decisions should be given to the municipal politicians and administration. Similar views have been espoused by the department directors, most of whom also express doubts about the right of JCNM's to exist as separate entities. These directors claim that the JCNM is a voluntary organization, and as such it has no legal authority to act. In their view, the JCNM lacks the appropriate tools, means, and human resources to handle municipal issues, which require a high level of expertise.

In contrast, there are those who justify the existence of the JCNM, emphasizing its operational flexibility and capacity to handle affairs more effectively than the departments of the municipality. The JCNM is accessible and available to local residents, and is better able to respond to

their needs than the bureaucratic municipal institutions. According to this view, the JCNM provides an effective buffer between the residents and the municipality, mitigating demands and settling conflicts on the local level without intervention from the municipal system.

At the same time, legitimacy is also needed by the residents. Recent surveys have revealed that the rate of participation in neighborhood elections, which are part of the democratic process, is relatively low (20% on the average). Moreover, their familiarity with the activities of the JCNM is extremely limited (about 65%-70% of the local residents are not familiar with the programs or never received information about them). Similarly, they do not believe they have any influence on the policies of the JCNM, nor do they feel that they are involved in designing new programs or improving existing ones (about 63% of the residents). About 50% of the residents even claimed that the JCNM does not encourage citizen participation in its different committees and programs (Schmid, et al., 1994;1995).

C. Board of Directors

The activity of the Board of Directors is characterized by ideological and functional aspects. From an ideological perspective, it is clear that the elected board of directors manifests the democratic process of citizen participation in decisions about the character and image of the neighborhood. At the same time; however, the elected board of directors is largely a new oligarchy whose members are involved in struggles for prestige, power, and status. Consequently, they may find themselves removed and alienated from the citizens they are supposed to represent. The research findings indicate that in the initial stages of its existence, the board is primarily concerned with finding a pattern for functioning. It devotes most of its time to definition of roles, and formation of work relations with professional staff. During the subsequent stages, some of the public boards move toward institutionalization of processes, stabilization, and establishment based on principles of efficient administration. Successful attempts have been made to involve citizens in committees aimed toward enhancing awareness of the importance and potential contribution of the JCNM to the community. At the same time, other boards of directors have continues their power struggles for control of the JCNM. Thus, instead of advancing the goals of the neighborhood, these committees have focused on attainment of power and resources.

These findings elicit questions regarding the effectiveness of the board

and its ability to achieve the goals it was elected to promote. It should also be noted that the term of office for board members is three years - a period that may be too short to achieve the espoused goals of the organization, especially since the process of creating patterns of organization and management took over a year in some neighborhoods.

D. Professional versus Political Values

The encounter between politicians, who are motivated by personal interests to achieve more power, and the professional staff, which emphasizes professional goals, jeopardizes the stability and functioning of the organization. The dynamics of democratic elections and representation do not necessarily correspond with the efforts of professionals to base the work of the organization on principles of rational, efficient management. The emergence of local-neighborhood leadership plays an important role in management of the neighborhood and representation of neighborhood interest in government and municipal authorities. However, these leaders should maintain boundaries in their contact with the professional staff. Emphasis on power can impede the development of the organization and inhibit the use of professional knowledge required in complex environments. Moreover, when power is emphasized, staff members will not be selected for positions on the basis of their abilities and achievements. Only if professionals take a forceful, bold and cautious stand against political pressures and consider the politicians' motivations while attempting to involve them in organized efforts can the regular activity of the organization be ensured.

E. Restructuring the Organization

In the process of merging, the new organization must adapt its structure, patterns of management, and human resources in a way that corresponds with the needs of the clients. Such adaptation is necessary, since the JCNM is a hybrid organization combining various functions. This calls for an organizational structure that can respond to the problems resulting from the merger. These functions cover a broad range of tasks: enhancement of the organizational culture, establishment of a common professional and organizational language for all the subsystems, internalization of organizational goals, and establishment of common ideology. There is a need to adapt the organizational and professional units to the needs of the population in order to create an effective system of high quality services. The need for adaptation also derives from the growth of the organization,

which calls for changes in structural and management of human resources. On the structural level, there is a need for tighter integration between the various activities of the organization; and on the administrative level, the staff members need to adapt to the new tasks. The former program coordinator at the CSO must be capable of coordinating and integrating the various neighborhood organizations while serving in the JCNM. The former director of the CSO must also be capable of adopting an integrative approach that combines different levels of organizations operating in and outside of the neighborhood. Similarly, former CSO's directors must be able to negotiate with the municipality and government officials at different levels, and to implement a comprehensive approach toward neighborhood management, which goes beyond management of the community center.

Discussion and Conclusion

The attempt to merge social and community roles with urban functions in the neighborhoods of Jerusalem is interesting and challenging. However, this attempt may also threaten the central municipal authority. The effectiveness and contribution of new organization can be evaluated in the context of the municipality's effort to decentralize services, to enhance service effectiveness, and to bring the services closer to the community residents. In light of the size of the organizations and their geographic distribution, there is a need to shift authority to the neighborhood units. Decentralization requires efficient, controlled delegation of authority and responsibility to the parties that are close to events in the field. The goal is to create a rational decision-making process, to help organizations react promptly to changing needs and conditions without being subject to the complex bureaucracy and decision-making procedures in the centralized system

The development of JCNM's has been problematic, since psychological, human and structural obstacles have created a situation of uncertainty regarding the growth of the organization. The central municipality has acknowledged the importance of decentralization and communalism, but has yet to internalize them. Rather, it has only adopted them as symbols that can be used for mobilizing public legitimacy.

The behavior of the municipal authority is well explained by the institutional theory, according to which organizations that adopt accepted social myths or accepted symbols (e.g., decentralization, communalism , empowerment, and citizen participation) do not focus on the products and services they provide for clients. The central municipal authority does not

seem to emphasize decentralization or development of strong communities that can change the checks and balances of power in the city. Rather, it views decentralization as a political process where authority and power are shifted to peripheral units. This process is opposed by politicians, who may find themselves in conflict with the neighborhood representatives elected in their own community. It is also opposed by the municipal administration, which is afraid of losing control of resources. The argument that JCNM's do not have the structural, professional, or human resources to deal with municipal affairs is partially correct. AT the same time, however, rather than impede the development of staff members, activities should be directed toward training and preparing them to deal with these affairs. This tendency is characteristic of centralized systems, which prefer to concentrate authority in hands of the executive staff and believe that no one else is capable of implementing the activities. Hence these systems do not see any justification for training them.

Communalism and decentralization are directed toward the same goal - to strengthen the neighborhood and change the function of the central municipal authority. A strong community can develop self-reliance and reduce municipal intervention in management of local affairs. This kind of community generates leadership and mutual commitment among the local residents, who are motivated to take responsibility for what happens in their community. Consequently the central municipal authority views the JCNM as another bureaucratic branch that provides services to the neighborhood residents, identifies and represents their needs. In this situation, however, the JCNM will be in danger of becoming a formal, mechanistic entity that cannot respond rapidly to changing environmental conditions. Only if the municipal system begins to understand and internalize the true meaning of decentralization can the JCNM succeed in establishing itself as an organization with a legal and legitimized status. Decentralization is accompanied by changes in the function of the municipal authority. Authority and power are delegated to the neighborhood units, while policy-making, allocation of resources, professional training, and organizational control remain at the level of the municipal administration. The municipal administration should act as a professional leadership that creates innovative knowledge and advanced service technology. It should constantly aim to identify voids. where needs have not been met with an appropriate response. Decentralization is oriented toward clients, and gives them top priority as the main beneficiaries of municipal social and urban services. Decentralization involves changing priorities in assignment of

professional and organizational staff. The existing pyramid, which contains an accumulation of organizational fat at the apex (headquarters) level, should be reversed so that the top level of executive management is limited and the field units are reinforced with professional, skilled, dynamic, and creative practitioners who are able to adapt to changing environments. Decentralization requires restructuring, and involves a shift from a patronizing, elite, conservative system to a decentralized system where the central focus is the community.

The figure below describes the organizational and structural patterns in

Figure 1. Organizational and Structural Patterns in the Development of the Local Joint Community Neighborhood Management

Patronage

I

* Patronizing administration
* Centralized authority controlled by the bureaucratic municipal authority.
* Elected representatives and bureaucrats know what is best for the residents.
* Implementation of municipal policy from the "top down".
* Use of power and authority based on organizational hierarchy.

III

* Patronizing, authoritative administration.
* Understanding the need for decentralization due to environmental and social trends.
* Accumulation of communication barriers.
* Decentralization where control is motivated by ideological and utilitarian considerations - "from the top down".
* Controlled delegation of authority.

Centralization of Authority

Political and Administrative Decentralization

II

* Decision-making by municipal politicians and bureaucrats
* Partial, limited understanding of the need for citizen participation.
* Adoption of myths and symbols of participation and empowerment.
* Apparent participation of community leadership and residents.

IV

* Delegation of authority and power to neighborhood authorities.
* Perception of the neighborhood organization as a mechanism for promoting the needs of residents.
* New division of labor between municipal bureaucracy and peripheral units.
* The neighborhood organization is a partner in planning and implementation.
* Development of neighborhood leadership.

Empowerment

the development of the local Joint Community Neighborhood Management Organization.

The figure presents four quadrants divided along two axes. One is the "patronage-empowerment" axis, and the other is "centralization of authority versus political and administrative decentralization". Patronage refers to the patronizing authoritative behavior that characterizes the top executive levels. This level of management dictates policies, and the executive staff perceives it as possessing knowledge and expertise. According to this perspective, other levels of the organizational hierarchy do not make a substantial contribution to development of creative thinking, planning, and decision-making processes in the organization.

Empowerment refers to the process in which powerless people acquire the ability to influence others and to assume roles that have social value (Sadan 1993:53). Empowerment creates opportunities for democratization of processes, as local residents begin to control their lives by using neighborhood, family, and voluntary systems as mediators in provision of services (Sadan, 1993:54).

Centralization-decentralization refers to the extent to which various levels of the organizational system are involved in decision making. In a centralized structure, decisions are made at the executive level without involving or consulting with the other levels of the organization. In a decentralized structure, authority is delegated from the executive level to the lower levels, who participate in the decision-making process.

The four quadrants (marked I-IV) illustrate the development of the JCNM. The first quadrant portrays an organizational pattern in which management is authoritative, patronizing and centralized. Directives and guidelines flow from the "top down", without involving or consulting with the other levels of management in the organization. The leaders of the organization are guided by the recognition and self confidence that they know "what is good for others". They use the power of their formal and legal position to control organizational resources and dictate policies to the entire system.

The second quadrant represents a combination of centralized authority and attempts to empower workers and citizens. The leaders of the system adhere to the principle of centralization and are wary of losing power and control. At the same time, they understand that certain social trends cannot be ignored. Hence they adopt symbols such as empowerment as a condition for isomorphism with the external environment. Empowerment is symbolic, but there is no intention to put it into practice.

The third quadrant represents a combination of patronage and political and administrative decentralization. In this situation, the leaders of the organization reach at least some degree of understanding that the organization can no longer be managed according to patterns of patronage, and that it is justifies to delegate power and authority to the neighborhood political and administrative levels so that they can manage their own affairs. The changes occurring in the organization and its environment, the need to develop mechanisms for monitoring and identifying needs on the one hand and mechanisms that can provide rapid responses to rapidly changing needs on the other, forces the leaders to reduce the extent of their patronage and recognize the rights of other parties to manage their own affairs, as long as supervision and control are provided from the top.

The fourth quadrant portrays the combination of political-administrative decentralization and empowerment. In this situation, it is recognized that the affairs of the organization and the community cannot be managed "from the top", and that authority, power, and responsibility must be delegated to the field units that are in direct contact with the clients. The process of decentralization is accompanied by empowerment, which encourages the citizens to build an independent community that participates in democratic decisions about its own affairs.

Ideally, the JCNM aims to adopt a model that largely fits the characteristics described in the fourth quadrant. However, the situation of the organization at the present stage of development is closer to the description in quadrants II and III. In sum, the ideal model has yet to be achieved, since policy makers prefer to maintain the status quo and prevent the JCNM from gaining power in the neighborhoods and communities.

Bibliography

Beck, B.M. (1977), "Settlements and community centers", *Encyclopedia of Social Work* (16th ed.) New York: National Association of Social Workers.

Benson, J.K. (1975), The interlocking network as a political economy", *Administrative Science Quarterly*, 20(2): 229-249.

Buono, F.A., Bowditch, J.L., and Lewis, J.W. (1985), "When cultures collide: The anatomy of a merger", *Human Relations*, 38: 477-500.

Cartwright, S., and Cooper, C.L. (1993), "The role of culture in a successful organization marriage", *Academy of Management Executive*, 7(2): 57-70.

DiMaggio, P.J., and Powell, W. (1983), "The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields", *American Sociological Review*, 48: 147-160.

DiMaggio, P.J. (1988), "Interest and agency in institutional theory", In: L.G. Zucker (ed.),

Institutional Patterns and Organizations: Culture and Environment, Cambridge, M.A.: Ballinger, pp. 3-21.

Hasenfeld, Y., and Schmid, H. (1989), The community center as a human service organizations", *Nonprofit and Voluntary Sector Quarterly*, 18(1): 47-61.

Hasenfeld, Y., (ed.) (1992), *Human Services as Complex Organizations*, Mewbury Park: Sage Publications.

Hason, S., and Shehori, N. (1991), *The Ramot Joint Community Neighborhood Organization: The Idea, the System, and Urban Implications*, Jerusalem: The Jerusalem Institute for Israel Studies (Hebrew).

Israel Association of Community Centers (1980), "Proposal for goals, principles and strategies in community centers", Jerusalem: The Israel Association of Community Centers (Hebrew).

Kochan, M., and Deutsch, K. (1980), *Decentralization*, Cambridge, MA: Oelgeschlager, Gunn and Hain.

Litwin, H. (1993),, Neighborhood self-management in Jerusalem: Planning issues and implementation dilemmas", *Administration and Society*, 25(3): 335-352.

Macarov, D., and Yanay, U. (1975), "Some preliminary findings concerning community centers in Israel", *Journal of Jewish Communal Services*, 51: 332-340.

Macarov, D. (1978), "Progress and problems in community centers: The Israeli experience". *Community Development Journal*, 13: 107-163.

Marks, L.M. and Mirvis, P.H. (1986), "The merger syndrome", *Mergers and Acquisitions*, 20(1): 70-76.

Meyer, J.W. and Rowan, B. (1977), Institutional organizations: Formal structure as myth and ceremony", *American Journal of Sociology*, 83: 340-363.

Mintzberg, H. (1979), *The Structuring of Organizations*, Englewood Cliffs, N.J.: Prentice Hall.

Perlman, R., and Jones, D. (1967), *Neighborhood Service Centers*, Washington, D.C.: US. Department of Health, Education and Welfare.

Perrow, C. (1970), *Organizational Analysis: A Sociological View*, Belmont, CA: Wadsworth.

Perrow, C. (1972), *Complex Organizations: A Critical Essay*, Glenview, ILL: Scott, Foresman.

Pfeffer, J., and Salancik, G.R. (1978), *The External Control of Organizations: A Resource Dependence Perspective*, New York: Harper and Row.

Sadan E. (1993), *Empowerment in the Context of Community Planning: A Theoretical Development*, Unpublished doctoral dissertation. Haifa, Israel: Technion Technological Institute (Hebrew).

Schmid, H. (1992), "Relationships between decentralized authority and other structural properties in human service organizations: Implications for service effectiveness", *Administration in Social Work*, 16(1): 25-39.

Schmid, H. (1995), "Merging community service organizations: Analysis of a case study", *Nonprofit Management and Leadership*, 5(4): 377-391.

Schmid, H., Unterman, Y., and Zilberman, G. (1994), *Formative Evaluation of the Community Neighborhood Organizations*, Research Report 1. Jerusalem The Hebrew University of Jerusalem, The Paul Baerwald School of Social Work.

Schmid, H., Unterman, Y., and Zilber, T. (1995), *Formative Evaluation of the Community Neighborhood Organization*, Research Report 2. Jerusalem: The Hebrew University of Jerusalem, The Paul Baerwald School of Social Work.

Scott, W.R. (1992), *Organizations, Rational, Natural, and Open Systems*, Englewood Cliffs, N.J.: Prentice Hall.

Solomon, B.B. (1985), "How to really empower families? New strategies for social work practitioners". *Family Resource Coalition Report*, 3, pp. 2-3.

Thompson, J.D. (1967), *Organization in Action*, New York: McGraw-Hill.

Yanay, U. (1982), *Community Centers in Israel as Service Delivery Agencies*, Unpublished doctoral dissertation. Hebrew University of Jerusalem.

Zald, M.N. (1970), Political economy: A framework for comparative analysis" In: M.N. Zald (ed.), *Power in Organizations*, Nashville, Tennessee: Vanderbilt University Press.

THE INSIGNIFICANT OTHER: HOW SOCIAL MARGINALITY IS SYMBOLICALLY CONSTITUTED

by Prof. Haim Hazan*

1. Introduction

The problem of narrowing the gap between needs and resources has been considered a prominent issue in the professional discourse of social work and as such will provide a conceptual archimedal point in the unfolding of this article. Despite the fact that the chief concern of this article is neither methods of social intervention nor issues of social policy, preliminary observation is necessary in order to provide a backdrop for our central argument that often the public intervention approach leads to the constitution of its subject as an object of estrangement, marginality and ostracism. The theoretical direction in which this argument will be developed does not deal with emergence of stigma and dependency, but rather with the cultural molding of symbolic removal from the social context.

Professor Jonah Rosenfeld, outlining the various fields of social work, states that a prerequisite for straightening out the social inconsistencies is "admitting to the faulty nature of existing social arrangements and the need to amend them as far as possible".[1]

In our method, this "far as possible" is not only the result of "social arrangements", but serves as a societal boundary marker beyond which intervention and specialization will be of no avail. The existence of this boundary marker can be attributed not only to structural, institutional and organizational barriers, but also to the presence of cultural, symbolic codes; invisible fences marking out human categories whose very existence is

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1. There is no doubt that this article, written by Rosenfeld (1984) represents a central dilemma of Social Work. The present article has no intention of dealing with discussions or professional discourse conducted on this issue within the discipline of Social Work.

nothing more than a representation of social arrangements.[2] A number of these categories are then constituted as territories inhabited by the social other, the misfit, the threat, the stranger. The apparent paradox is that often the very attempts of intervention intent on constructing ties and bridges between us and them do little more than add additional pickets to those fences, thus hindering the possibility of breakthrough or contradiction. How then, does the aspiration to undermine the dependency between provider and recipient of services, between the controller of resources and the needy become a mechanism of constituting the needy as the other?[3] Can this be the offshoot of a bureaucratic system whose very nature constitutes the object of its care as void of characteristics beyond those which it dictates, or perhaps it is possible to identify processes, ushered in by bureaucracy, whose very essence, development and comprehension are lodged in the evolvement of modes of representation within contemporary culture?[4]

2. The Constitution of the Other as a Context Free Object

A central, widely accepted thesis in sociology claims that the process by which an individual becomes acquainted with the social world occurs through relationships with perceived images of significant others. This learning process not only embraces internalization of the profile of the internalized other, but also the perception of characteristics of others who are of less significance for the individual. These are the shadows cast by reference groups with which the individual identifies and whose presence is experienced in the delineation of social boundaries beyond which the undesirable and the threatening lie.

These entities occupy the position of strangers existing in the realm of the cultural threshold which separates "inside" from "outside", or to draw on the theme of the home which is near, familiar and a source of security, as

2. This issue constitutes one of the foundations of cultural anthropology. A detailed discussion, pertinent also to the subject of this article, can be found in Douglas, 1966.
3. This sociological perception of social constitution is based on the idea of social phenomenology, principally as conceptualized by Schutz (1971) and Berger and Luckman (1967). The work of Foucault (1980) provides a unique and special contribution to this subject.
4. This idea pertains to what has become known as a post-modern approach. Literature in this theoretical trend views, inter alia, the narrative on culture as being part of reality, and claims that boundaries between signifier and signified have become blurred. This literature is prolific and varied. On the subject of aging, for example, see Featherstone and Hepworth's article (1991), which applies this approach and deals with its problematics.

opposed to the forest which is distant, foreign and steeped in uncertainty. This cultural no-mans land which divides these two territories is peopled with liminal social characters such as witches, fiends, heroes, fools, saints, cripples, androgynouses, mythological figments of the imagination and their counterparts.

All are lined up within the compound of social taboo characterized by sacredness or sacrilege which render those placed there as ambivalent images of enchantment and terror, attraction and repulsion.[5] These social entities sometimes serve as the focus of ceremonial activity or the axis of religious ritual. This cultural twilight zone, which mingles myth and reality, dream and experience is the soil which nurtures beliefs and opinions about people perceived as belonging to this zone. In this manner, social images are spun which cast stereotypic characteristics on entire sections of the community and entrench and nurture their status as ex-territorial vis-a-vis the normative system which directs everyday life and dictates its boundaries.

This article deals with the symbolic process by which this unique social status is created and established. Our contention, therefore is that the projection of the social image of a given community as "beyond the lines" could be the product of the reverse intention of integration and support. The understanding of this process calls for a theoretical discussion of the possibility of transferring a random social subject from within to outside the boundaries of a given social order. In other words, it becomes necessary to investigate the conditions under which a community of individuals becomes designated to the marginal category of social "strangeness" or "otherness".

The central theoretical difficulty of this discussion lies in the very assumption of extra-contextual existence due to the fact that situations or individuals are generally entangled within a web of circumstance which anchors them to specific time and space. Notwithstanding, when the familiar categories which facilitate the comprehension of time, space and meaning lose their ability to serve as coordinates for the identification of context, a situation emerges in which accepted principles of social order are disengaged allowing the possibility of extra-contextuality to be entertained and realized.

The crumbling of these three dimensions of existence - time, space and meaning - has so far attracted limited sociological attention due to the fact that the main thrust of sociological enquiry has been concentrated on parameters of the familiar social order on one hand, and on the other, due

5. See Douglas, 1966.

to the fact that key concepts of sociological terminology employed in the analysis social phenomena are themselves context-bound. "Role", "mobility", "socialization", stratification and other basic terms which serve as pillars of sociological parole, are little more than intellectual scaffolding through which the existing social order is not only described and analyzed but even constituted and maintained.

With the exception of expressly context-free sociological approaches such as structuralism, socio-biology and social evolutionism, issues of severance from social context, the dynamics of the disappearance of social chronological time, disengagement from familiar social space, and the loss of meaning, have brought forth three respective intellectual perspectives, each of them will be discussed in the framework of this paper, albeit partially and suggestively.

Time: The departure from the socially sequenced time of planned routine which is based on knowledge of the past and preparation for the future, has been afforded extensive anthropological interest in the framework of the disciplines interest in ceremonies in general, and rites of passage in particular.[6] The latter constitutes symbolic structures aligned with social performance and characterize the transition between identities. Initiation and coming of age ceremonies serve as a familiar and common example of this type of ceremony which is usually conducted on the continuum of the life course. In ceremonies of rites of passage, three stages can be identified, the first of which is disengagement and marks the separation from a place in the social order. The third stage - reunion - denotes the assumption of a new social status, and the second, central, and most important among the three, serves as the laboratory and mechanism through and by means of which the passage itself is negotiated. The crux of this phase, known as the marginal or liminal stage, lies in the complete and total exclusion of the subject of the ceremony, the initiate, from the social order to the extent of forfeiting his or her humanity. This is a situation which entails degradation, trying physical experiences, blurring or blotting out inter-personal differences and transforming the initiate into raw humanity likened to matter in the hands of the social creator thus appointed. The reversal of the social order from hierarchical and differential to egalitarian (among the initiates) and unstructured is a means by which chronological time,

6. The anthropologist who introduced the term "rite of passage" into Anthropological discourse was Van-Gennep [1908] (1960). This perspective was analyzed and elaborated mainly by Turner (1969).

entrenched in social norms which direct the flow of developments, is converted into time standing still - sacred time as opposed to secular time. The community therefore evolves into a different social structure, "Communitas", in the words of Victor Turner, a system free of internal barriers, characterized by collective fraternity and mythical time. This temporal mode is expressed by exposing the initiates to the imperatives of their society through the vehicle of central myths, in the exposition of which the initiates participate, alongside the destruction of a symbolic effigy which represents, indeed epitomizes the values of their culture.

Space: For a marked period of time anthropological enquiry drew on empirical material concerned with understanding the social networks of inter-personal relationships. The modern world, even more so, the so-called post-modern world abound with patterns of communicating and comprehending meanings which do not depend on face to face relationships, often not even on acquaintance with the counterpart. This is a world in which symbolic codes float in a cultural space and are transmitted through a variety of media channels which call for neither personal nor social contact. In this manner, the symbolic space inhabited by human beings is constructed of foci of meaning and interest around which transient social worlds consolidate, their span of existence being determined by the attention afforded to a specific focus. This is an unstable, fluid and flexible space, whose incessantly changing, multi-faceted aspects render it infinite and void of coordinates.[7]

Meaning: The above analysis leads to one of the most central and hackneyed themes in the study of culture, that of the sources, components and characteristics of meaning. In a world in which familiar, symbolic codes are falling apart and cultural relativism is expropriating the place of belief in a consensual system of solid values, the disappearance and dumbness of familiar norms, identities and roles becomes the outcome of this social predicament. In other words, the social context is losing its stronghold as a locus of discipline and control. One offshoot of this contextual crumbling is the emergence of substitutes for the definition of reality in the guise of concrete human figures or contrived cultural images who are accorded superhuman, extra-contextual characteristics. The clown, the court jester, war heroes, demons, saints, martyrs and their counterparts provide examples of these symbolic types, who are usually defined by mythical

7. The perspective of the social world which claims that communication networks rather than social networks constitute the center of the modern individual's world was developed by Shibutani (1955)

characteristics which are beyond and outside of context, and therefore autonomous, transformative and transcendental. Their concrete existence provides an archimedal point for human behavior and the establishment of beliefs and opinions. Rock and movie stars bear witness to the power afforded to these symbolic types.[8]

These three concepts - rites of passage, social worlds and symbolic types - spell transformation, reversal of the social world, and disintegration of cultural order. We shall present two cultural documents which illustrate this process of replacing disorder with a different order, one in which familiar day to day criteria of time, space and meaning no longer reign. In both cases, we shall demonstrate the rhetoric employed in order to situate a phenomenon and the community identified with it into a familiar cultural context, resulting in actual exclusion from the contexts of time and space. In other words, we shall be dealing with what could perhaps be called a process of ex-communication under the pretext of promoting the idea of community and participation of those involved.

3. The Ex-Communicative Constitution of Old Age

The first phenomenon which we shall discuss is the constitution of old age as a form of cultural strangeness. This is effected, it would seem, by means of ascribing to an ambivalent symbolic code in which the overt text prescribes the integration of the aged into the community, whilst the covert or implicit text - the deep infrastructure of the explicit text - prescribes separation and disengagement. This ambivalent code can be unravelled through examination of cultural organizational units such a clubs for the aged and childrens's literature about old people. In both cases, the aged character appears in a secondary form - as part of the life cycle and social structure on one hand, and a strange, marginal and even a threat to the social order, on the other. We will attempt to decipher this ambivalent code by means of analysis of the rhetorics of cultural performance of attitudes towards old age. Old age, to our purposes, will be perceived as a system of cultural signs.[9] The importance of this analytical stance stems from the fact that it studiously ignores the social, economic and moral sources of the attitude towards old age as well as the results and implications of this attitude. Conversely, we intend to limit our description and analysis to age as a cultural language which expresses the existential dilemmas of those who

8. The symbolic type as a sociological analytical concept was suggested by Grathoff (1970) and developed by Handelman (1981, 1985) and Handelman and Kapferer (1980).
9. See, for example, Gubrium's work (1986) on the symbolic code by means of which social-professional distinctions are made between different categories of old age.

employ it. The only source for deciphering this code is language itself,[10] and for this reason it is necessary to identify its components and content. This is what we intend to do in the case before us. A basic premise guiding this analysis is that rhetoric constitutes a system of signs which create, in turn, social codes which demarcate the boundaries of consciousness and serve as indicators for social action.[11]

The case we shall describe is a media event which transpired some years back, christened by its organizers as "Tele-trom for the Elderly".[12] A day long radio and television broadcast was organized for the collection of donations for the aged, the high point of which was a charity performance of artists and broadcasters which was intended to bring the donation drive to its peak. The explicit idea which served as justification for holding the event was providing aid for the urgent needs of a community perceived of and represented as needy. Our claim is that the aged were symbolically typified as a social victim whose presence was necessary to society at large in order to accommodate moral purification and conscious cleansing. The entity which emerged in the course of the broadcast of the charity show transformed the aged from a sacrificial victim, the target of social injustice and injury, to a martyr bearing the sins of his community, subsequently allowing for penitence and salvation. This transformation will be illustrated in our analysis of the event. Four stages characterized the unfolding of the television show and scrutiny of their precept will signify the transformation of the old person from an individual present within society to a symbolic type who exists beyond society, culture and life itself.

A, Presenting Old Age as a Problem and the Aged as Social Victims

The audio-visual rhetoric which constructed the event consistently employed terminology which equated old with old-age. The aged person was represented, by various means, as a collective image who did not splinter into secondary characters, and as such lacked heterogeneity. The profile of old age, of the old individual, accommodated the general assumption of complete, unequivocal dependency on the favors of the society in which he lived.

This concept was afforded symbolic expression through the recourse to

10. An example of such an analysis can be found in the work of Katriel (1991).
11. The work of Barthes (1973, 1977) can serve as a key to such analysis of rhetoric.
12. For a detailed description and anthropological analysis of the event see Hazan, 1990b.

signifiers of old age which denoted dependency and impaired function. To this end prostheses, eyeglasses, walkers, incontinence diapers, security doors, distress centers and other protective, auxiliary measures were given prominence. All these were displayed on the screen as vital apparatus, necessary for the existence of the generalized old. Exceptions to this collective image of old age were presented as unusual and even illegitimate. In the framework of interviews conducted with residents of old age homes, one individual recounted how he had foiled an attempt to attack him. He described how four youths had accosted him in the street in an attempt to rob him. He succeeded in knocking one of them over, subduing and restraining him until the police arrived. The amazed interviewer asked in disbelief: "At your age?", in other words it was unseemly and inappropriate for a man of his age to act as a person younger and stronger thus assuming responsibility and control over his fate. This errant old person had spoiled the ranks and the next stage of the broadcast, a natural outcome of the one preceding it, was to present old age as a problem with no solution.

B. The Old Person as a Stranger[13]

There is no solution to the problem due to the fact that the old person is perceived of as an alien, a stranger, the epitome of otherness in the midst of his own society. This strangeness, the causes of which we shall elaborate in due course, calls for practices of exclusion and delimitation of old age and its representatives (old people) as separate territory. This territory, concrete manifestations of which can be found in enclaves of old age such as old age homes, pensioners clubs and geriatric wards, primarily constitutes a segregated, social-cultural category which transforms those identified with it into entities from another world. A well-known interviewer asked one of the residents of an old age home which he was visiting "When did old age catch up with you?" as if referring to an exclusive existential condition, void of continuity with whatever had preceded it.

This kind of attitude provided the preamble for questions such as "Does love exist among them [the aged]"; or "Why does nature loathe the old?"; or "Should old people be allowed to drive?" This reality of fundamental estrangement provided the suitable setting for presenting the old as inhabitants of neurological, geriatric and internal hospital wards (but not rehabilitative). When, on the other hand, a short documentary of old peoples' activities at a pensioners club was shown, the participants in the

13. For the social status of the aged as stranger see: Dowd, 1986.

activities were presented in a ridiculous light by means of showing excerpts of the play The Hypochondriac, by Moliere, which the members were putting on.

Creation of a spectacle of old age as an objective condition of otherness which lends itself neither to interpretation nor change naturally led to the issue of the obligation to help the old. Due to the fact that the plea for help constituted the central pivot of the performance, the acceptable mode of response had to be raised The expected response was also situated in an non-negotiable zone, that of the cultural value system. Biblical proverbs such as "You shall rise before the aged and show deference to the old" or "Abandon me not when I grow old" were used to support the call for help for the stranger among us. The source of legitimization in this case therefore rested on cultural, divine imperatives rather than on a personal decision based on pragmatic or ethical considerations.

C. What is the Source of the Old Persons Privilege?

Social ostracism and natures loathing are the outcomes of life on the finishing line. Old age is the prelude to death (in a society where death usually occurs at a later age in contrast to pre-industrial societies in which the highest death rates aggregated in the early years of life).[14] In the performance described there was no explicit mention of the connection between old age and death. Notwithstanding, the association between the two emerged in poetic or figurative suggestion in the songs and images of the old people who were represented as standing on the brink of obliteration. This common taboo of denying death bears the realization of our own mortality, bound to the inevitability of old age and death. Thus follows that the attempt to transform the old into a "race" is destined to failure, as put by the compere of the performance "We will all be old". The emerging dilemma is how to express the paradox of the undesirable, albeit unavoidable imperative of long life continuity intermingled with the desire to disengage old age from the stages of lifes continuum. This ambivalence becomes concrete in the form of the question underlying the performance: How to help old people whilst ridding ourselves of private inhibitions and individual responsibility.

14. For an analysis of the historical, social change see: Aries, 1983.

D. Old People as the Target for Social Penitence[15]

Representing the old as a collective apart facilitated their transformation into a target for collective guilt. The donation which viewers were requested to raise was intended for the generalized "old", and not for a specific, familiar old person. This latter persona, who arouses, in many cases, personal feelings of guilt, disappeared from the personal consciousness thus providing release from personal responsibility. This brings to mind the indulgence of the Catholic Church in medieval times, which allowed for the transferral of the burden of personal guilt on to the shoulders of the cultural system which purified the particular transgressor. The cleansing of the personal conscience by means of the victim who rouses at once feelings of pity and disgust, obligation and fear, closeness and estrangedness, was expressed in the words of then president, Haim Herzog, at the closure of the performance: "Every Israeli citizen, each as one, must put the injustice right", and in the words of the compere, who summed up the evening with the call, "to wake up tomorrow morning with a new song in your heart and go directly to the bank".

In this manner, the old person, with all his attributes of inner contradiction, severance from given context of time and space, liminal existence, physical visibility and blurred social entity, is transformed into a distinctly marginal character in the form of a symbolic type.

4. The Ex-Communicative Constitution of a Community[16]

The following case is seemingly diametrically opposed to the one previously described. It constitutes an attempt to transport "the other Israel" from its heretofore marginal status to a central position in the cultural system as well as in public consciousness. As we shall illustrate, the fate of this attempt is no different from that of the aged person who is transformed from a concrete individual, anchored in given time and space to a disembodied entity robbed of context. The object to be transmuted in the case discussed here is the resident of a neighborhood included in an urban renewal project, who is expected to exchange his underprivileged, deprived identity for one of rehabilitation and care, thereby becoming part of the establishment. This dramatic metamorphosis was to be achieved by virtually obliterating the

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15. Gouldner (1975) calls this phenomenon "moral absolution".
16. For an extensive ethnographic description of the neighborhood and community discussed see: Hazan, 1990a.

object of exchange, ignoring its cultural presence, and turning it into raw, human material.

A number of years back, a community center situated in the heart of one of the project renewal neighborhoods was publicly and ceremoniously inaugurated. The splendid building donated by the neighborhood's "twin community" in the United States contained a grand, fully equipped assembly hall, activity rooms, a library and offices. The green lawns which surrounded the center, and the swimming pool and sports fields which graced it lent the entire complex a "country club" air, which was, indeed, the term preferred by residents of the neighborhood when referring to the center. In the eyes of the local officials, the construction of the center represented the summit of their efforts and the realization of their desires - the constitution of a "community: in every sense". This after many years of fending off a negative social image which had identified the residents and their representatives with poverty, crime and backwardness and labelled the neighborhood as underprivileged and deserving of rehabilitation. Although statistics clearly showed that the crime rate among the residents was no greater than the national average, and that their standard of living as well as their level of education and housing conditions did not necessarily place them on the lowest rungs of poverty in Israel, the neighborhood was stuck with a negative image which squarely placed it in the realm of "the other Israel". The aspiration for change in the neighborhood's status and the wish to acquire an image which would secure its place in the realm of "established Israel" was at the top of the agenda of the neighborhood representatives who were in search of suitable opportunities to promote this goal. Removal of the social stain from the neighborhood entailed denial of many of its characteristics such as its ethnic composition, its geographical marginality and the welfare needs of many of its residents. Any attempt to deal with inter-ethnic disagreement, access roads, or welfare needs could potentially strengthen and perpetuate the neighborhoods negative image, despite the benefits which might be forthcoming.

In order to find an escape route from this entrapment, neighborhood leaders adopted a symbol which was not controversial and did not arouse smarting reminders of an undesirable social image. Residents of the neighborhood discovered this clean and neutral route in the guise of the concept of "community". This concept provided access to channels of communication free of both painful memories of the past as well as humiliating utterances of the present. This concept also provided a common denominator between the neighborhood and the world around it which

circumvented residues of rejection and isolation and allowed for the bridging and mending of inter-ethnic, inter-generational, inner-communal and inter-diasporal rifts. The following testimony, drawn from the act of constitution of the community within its very same neighborhood, will contribute to the understanding of ideas suggested above, as well as illustrate the essence of the concept "community" in the constitution and establishment of marginality in the society of its "inhabitants".

The inauguration ceremony of the community center took place before a large audience. Scrutiny of the personal invitation sent to the guests invited to the event exposes a number of the central characteristics of the concept of community and means of its materialization. The invitation was sent to neighborhood dignitaries, activists in the rehabilitation project, employees of the Jewish Agency, a government representative, senior municipal officials and many other guests from throughout the country and especially to donors from the twin community in the United States. The design of the invitation bears witness to its significance and leanings. The invitation was printed on fine, quality paper in two languages - Hebrew and English. Apart from the communicative function of creating a linguistic bridge between the two communities, use of the English language served to situate our neighborhood within the broader cultural milieu of the universal, modern, western world, of which the English language was a component. In this manner the neighborhood extended itself not only beyond the narrow confines of "the other Israel", but also beyond "established Israel" and Israel in general. The neighborhood becomes, at the wave of an invitation, part of the universe aspired to - that which is rational, scientific, liberated and "cultured".

Emblems of the bodies involved in the construction of the project were printed at the head of the invitation. The city in which the building was situated, the Jewish Agency, the twin city abroad, and the neighborhood itself were all graphically, emblematically, represented. The logo accompanying the graphics reveals the problematics inherent in defining the essence of the center: In Hebrew it was called a Temple of Sports and Culture, whereas in English, the term "Community Center" sufficed. It therefore becomes evident that the significance afforded to the center by the Hebrew language situates it within the contextual frame of culture and "temple" suggesting a combination of the term modern as in culture, together with a concept from the realm of religion - temple. This linguistic combination is quite common in colloquial Hebrew and is used to denote a center of activity which does not depend on specific time or place. The

concept "community", on the other hand, is identifiable with given time and place, and as we have already mentioned, members of the community were attempting to transcend the problematic boundaries which delimited their space and time, that is, the neighborhood. This internal contradiction between the imperative of belonging to existing reality and the wish to deny its prevalence, perceiving it rather a part of an alternative, more desirable life course, emerges from the remaining parts of the document before us.

Similar to an invitation to a family event such as a wedding, a Brit Mila (circumcision) or a Bar Mitzva, in our invitation the "parents"/"in-laws" are represented in the triangle of: the Jewish agency, the municipality and the neighborhood board, and the twin Jewish community. The above have the pleasure of inviting you to the inauguration ceremony of the Temple of Culture and Sport... which will take place ...".

As in the family events mentioned, the inauguration of the center can be viewed as a rites of passage ceremony; the symbolic, festive negotiation of a distinct and significant change in the identities of the participants. In the course of ceremonies boys become men; infants become the children of a people; a man and a women become a married couple; draftees become soldiers and princes become kings. And so in the ceremony, the program of which is enfolded in the invitation - a neighborhood becomes a community. The program itself spells out the essence of this "community" and a number of the actual events which took place will be described in order to provide further evidence.

A. Reception for Representatives of the Twin Community

This reception was indeed held and among the hosts who accompanied the American guests on a kind of pilgrimage procession to the community center building were members of the local youth movement who marched in military like uniforms, as well as dignitaries from different parts of the country, most prominently, a Rabbi with a reputation for returning delinquents to the bosom of religion. The army as a unifying symbol on one hand, and the Rabbi representing the feasibility of change in human identity, on the other, set the tone for the ceremony, as we shall see in due course.

B. The Inauguration of the Center

The leaders and patrons of the rehabilitation project made speeches to a select audience whose admission to the center's compound was allowed by

invitation only. In this manner a balanced, metered constellation of spectators was ensured in order to prevent hitches in the course of the event and elicit due applause for the organizers. The mezzuzas were affixed to the doorposts accompanied by the Rabbis (who was not a neighborhood resident) chanting and dancing. This is an interesting point to note in view of the large number of synagogues and Rabbi residing in the vicinity. Inviting a Rabbi from outside the neighborhood not only prevented local friction and dissent, but also afforded the neighborhood the aura of belonging to the religious establishment in its entirety. After a tour of the center's facilities, and especially - as fitting to a "Temple of Culture" - of the library, entertainment groups comprising of female residents of the neighborhood donned in original, ethnic garb, performed for the guests. The emergent picture was one of cultural diversity which originated not only from the current time and place. Moreover, the authentic residents of the neighborhood were depicted as folklore. The contrast between their "exotic" jewellery and garb and the modern European dress of the members of the adopting community constituted the former as a kind of museum exhibit in contrast to the contemporary power and vitality of the latter. This was especially pronounced considering the economic power of the latter to subjugate the subjectivity of the former to their world. The image of this cultural subordination was artistically fashioned during the next stage of the ceremony.

C. The Artistic Program in the Auditorium

The program was performed for a local, invited audience who filled the hall from door to door at the outset of the evening, but dwindled as it progressed, so that towards the end very few remained. This did not, however, prevent the program from being presented in its entirety. This included a performance by the municipal orchestra, thereby acknowledging the embracement of the isolated neighborhood into the bosom of the city to which it belonged. Acknowledgment of the neighborhoods incorporation into the city was directly forthcoming in the ensuing felicitations in which the mayor attempted to blur, as far as possible, the invisible albeit tangible boundaries which existed between the neighborhood and the other sections of his city. Speeches were also made by other dignitaries, most notably a senior government minister who even read out a congratulatory telegram from the Prime Minister. Additional speeches were made by representatives of the neighborhood and the project, as well as by delegates of the twin

community. The general idea conveyed was that the neighborhood had now ceased to be what it was once known to have been. It was thus no longer the scene of crime, poverty, backwardness and ostracism, but the venue of ever-widening circles of belonging to an Israeli metropolis, identification with "established Israel", and recognition of belonging to the entire Jewish nation and modern, western society. The "community" had usurped the "neighborhood", changed its name and adopted one with a contemporary Israeli ring, conjuring up images of the military and political elite, in place of the former name loaded with negative and humiliating images.

The artistic performances which followed the speeches echoed the main message which had already been disseminated. The center's dancers appeared in a jazz number; folklore was entirely absent. The local school's choir sung tunes from musicals, mainly, "Fiddler on the Roof". The climax of the evening was the appearance of a well-known popular singer who incorporated "beautiful land of Israel" songs with which the new community could now identify, with a visual display of slides depicting past and present. The audience viewed slides of the neighborhoods miserable, neglected maabara (immigrants' transition camps characteristic of the 1950s) juxtaposed to the achievements of the present which depicted a perfectly clean, tended and orderly locality. The contrast was so blatant that any connection between the two periods seemed unimaginable. The audience was beside itself, hardly in touch with its split disposition, divided between its humiliating past inhabiting a backwood neighborhood, and the present, bearing tidings of a glorious future amongst the people, the nation and the world.

In this manner, in a breath of rhetoric, a community was born: a sterile, media product, freed of the burden of stigma, stripped of local authenticity and exposed to innumerable interpretations and unlimited combinations of other symbolic codes. In other words, a social world had been constituted at the center of which a social concept stood, a commonplace symbol around which networks of communication, but not social networks, would emerge and then change. The person, in this case the neighborhood resident, is no more than an unnecessary, disturbing factor. His stable, physical presence, tying him to definite time and place, serves only to impede community rhetoric which strives to traverse local boundaries and reach a distant, more desirable destination - the nation, the state, the western world.

5. Discussion

Whilst the flesh and blood, aged person was transformed into a context-free symbolic type, the resident was stripped of his local being and emburdened with a likewise, context-free social world. In both cases these cultural images were fashioned and ensconced as finite, liminal entities whose contrived marginality and purposeful strangeness served clear socio-cultural objectives: In the first case - dealing with the existential problem of confronting death and nothingness in a society which does not equip its members with appropriate symbolic tools; in the second case - escape from the entrapment of cultural stigma, the price being the blotting out of its bearer. In both cases the human subjects forfeited both their visibility and their significance.

The question as to how these subjects construct their world once a symbolic web has been spun around them, removing them from the cultural center of gravity, warrants discussion. Empirical evidence exists which suggests that alienation and disengagement may indeed serve as an opening for personal liberation and social creativity[17] once its victims become conscious of their plight. To our end, the important conclusion is that any social intervention designed to help, might well turn into a double-edged sword in the hands of its instigators, and ultimately lead to an outcome opposite from that intended,.

Scrutiny of the cultural mechanism which leads to this reversal in intentions, will reveal that the process of excommunication, which is in fact a process of dehumanization, transforms the individual as a subject acting in a given reality to an object caught up in a simulation of reality. The aged person and the neighborhood resident in the cases analyzed are not flesh and blood human being but simulations[18] of people and events. As such they are not engaged in a representative relationship with the original reality from which they emanated. When the original is replaced in our consciousness by a cultural product and the relationship between the two is perceived of as representative and reflective, this optical illusion might divest the characteristics of the simulation onto a person or phenomenon who evokes it. In this manner concepts become people, forms become clients and reports become phenomena.

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17. See, for example, Sered's (1992) study of the world of aged, religious widows in Jerusalem.
18. The concept of simulation and its implications in post-modern culture was developed by Baudrillard (1983) who notes a shift from systems of symbolic representation to closed systems of signs devoid of representation.

Bibliography

Aries, P. (1983), *The Hour of Our Death*, London: Penguin.

Barthes, R. (1973), *Mythologies*, London: Paladin.

Barthes, R. (1977), *Image, Music*, Text, London: Fontana.

Baudrillard, J. (1983), *Simulations*, New York: Semiotext.

Berger, P. and Luckman, T. (1967), *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, Garden City, NY: Anchor Books.

Douglas, M. (1966), *Purity and Danger*, New York: Pantheon Books.

Dowd, S.S. (1986), "The old person as stranger", in: U.W. Marshall (ed.), *Later Life: The Social Psychology of Aging*, Sage, Beverly Hills: Sage, pp. 147-190.

Featherstone, M. and Hepworth, M. (1991), "The mark of ageing and the postmodern life course", in: M. Featherstone, M. Hepworth, B. Turner (eds.), *The Body: Social Process and Cultural Theory*, London: Sage, pp. 370-389.

Foucault, M. (1980), *Power/Knowledge: Selected Interviews and Other Writings, 1927-1972*, Brighton: The Harvester Press.

Gouldner, A.W. (1975), *For Sociology: Renewal and Critique in Sociology Today*, London: Penguin.

Grathoff, R. (1970), *The Structure of Social Inconsistencies*, , The Hague: Penguin, Nijhoff.

Gubrium, J.F. (1986), *Oldtimers and Alzheimers: The Descriptive Organization of Senility*, Greenwich, Conn.: JAI Press 1986.

Handelman, D. (1981), "The ritual clown. Attitudes and affinities", *Anthropos*, 76: 321-370.

Handelman, D. (1985), "Charisma, liminality and symbolic types", in: E. Cohen et al. (eds.), *Comparative Social Dynamics: Essays in honor of S.N Eisenstadt*, Boulder: Westview, pp. 346-359.

Handelman, D. and B. Kapferer (1980), "Symbolic types, mediation and the transformation of ritual contexts: Sinhalese demons and Tewa clowns", *Semiotica*, 30(1/2): 41-71.

Hazan, H. (1990a), *A Paradoxical Community*, Greenwich, Conn.: JAI Press.

Hazan, H. (1990b), "Victim into sacrifice: The construction of the old as a symbolic type", *Journal of Cross-Cultural Gerontology*, 5: 77-84.

Katriel, T. (1991), *Communal Webs*, New York: State University Press of New York.

Rosenfeld, J.M. (1984), "The contribution and specialization of social work", *Hevrah Urevacha (Society and Welfare*, (2-3): 130-199 (Hebrew).

Schutz, A. (1971), "The stranger: An essay in social psychology", in: School and Society Team at the Open University (eds.), *School and Society: A Sociological Reader*, London: Routledge *& Kegan Paul.*

Sered, S. (1992), *Women and Religion*, Oxford: Oxford University Press.

Shibutani, T. (1955), "Reference groups: A perspective", *American Journal of Sociology*, 60: 562-568.

Strauss, A. (1978), "A social world perspective", in: N.K. Denzin (ed.), *Studies in Symbolic Interaction*, Vol. 1, Greenwich, Conn.: JAI Press, pp. 119-128.

Strauss, A. (1982), "Social worlds and legitimization processes", in: N.K. Denzin (ed.), *Studies in Symbolic Interaction*, Vol. 4, Greenwich, Conn.: JAI Press, pp. 171-190.

Turner, V. (1969), *The Ritual Process - Structure and Anti-Structure*, Chicago: Aldine.

Uhruh, D.R. (1983), *Invisible Lives: Social Worlds of the Aged*, Beverly Hills: Sage Publications Inc.

Van-Gennep, A. (1960), *The Rites of Passage* (Translated by M.B. Visedom and G.L. Caffee), Chicago: University of Chicago Press, Phoenix Books (1st ed.1908).

OVERPROTECTION VERSUS DISCRIMINATION IN LEGISLATION FOR THE DISABLED
(Work Injury and General Disability)

by Bracha Ben-Zvi*

1. Introduction

Israel has a broad and comprehensive system of of disability legislation which in effect provides a large array of benefits and services for its disabled population. This system covers individuals whose disability was caused by various factors and circumstances, including congenital impairments, sickness, accidents, war and hostile enemy actions.

Legislation for disabled persons was initiated as early as 1949, only two years after the establishment of the State of Israel, with the inception of the Disability Law for Persons Injured in the Israel Defense Forces. Following this law, in 1954 the Employment Injury Insurance Law was enacted as part of Israel's new National Insurance Law. Since then, legislative efforts have steadily continued, with every few years witnessing new or improved laws and regulations for the benefit of various disabled groups. However, in spite of substantial achievements in providing coverage of benefits and services for virtually all disabled individuals, there still exist serious gaps in legislation with regard to some disabled groups, due to the fact that the lengthy process of legislation over time has been ineffective in producing a single, unified, inherently rational system.

As a result, every group of disabled persons draws its rights from law or under various chapters of National Insurance Law, each group standing, so to speak, on its own, with the kinds and levels of benefits influenced primarily by the social values, policy and available resources which influenced and fed the political process and resulting legislation of the period. The result is that today in 1994, there are various disability laws for different groups of disabled persons (Procaccia and Miller, 1974) which

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have created a system of laws contracted as "patches laid on patches" with resulting inequities and gaps in the rights of the disabled.

A list of the major laws includes: The Rehabilitation Law for Injured War Veterans, Chapter 3 of Employment Injury Insurance, Chapter 6 of General Disability Insurance, Casualties of Hostile Actions Law, Disabled Victims of Nazi Persecution Law, Disabled Veterans of War Against Nazis Law, Civil Service Law for Retired Disabled Civil Servants, Long-Term Care Insurance for the functionally disabled elderly population, as well as other laws deriving from Chapter 6 of National Insurance Law, such as attendance allowances for persons eligible for benefits under General Disability, benefits for disabled housewives and child disability benefits (National Insurance Law).

There are multiple major differences among the laws: in terms of their objectives; the specific definition of disability underlying the law; the benefits and entitlements; the systems, agencies and organizations responsible for providing services, the link between benefits and Israel's tax system as well as approaches to the disabled person's work and rehabilitation potential. As mentioned earlier, these differences developed over a period of decades and reflect changing concepts, values and approaches to dealing with the problems and needs of disabled groups.

In spite of these distortions, amongst professional communities here at home and abroad, Israel's programs and legislation for the well-being of the disabled population are recognized and cited as significant achievements of a modern, western nation, a fact evidenced in international comparative studies (Berkowitz, 1989, 1990).

As a result, there is an international, professional and academic interest in the various programs implemented in Israel, some of which have earned praise for originality. During the last few years, a major example is Israel's Long-Term Care Insurance Law for the disabled elderly population (Ben-Zvi, 1993). On the other hand, several disabled groups in Israel who protest the fragmentation and distortions in the system do not share enthusiasm for these accomplishments. There is in fact a sense of inferiority among some groups relative to other groups of disabled people who benefit from more generous entitlements and greater resources.

As stated, gaps and distortions have evolved over the years and were in no small measure bound to the specific period of legislation and the resources available to the respective legislative authorities. A similar situation exists in other welfare states as well, each country having its traditions, characteristics, policy and solutions. During the past few years,

one finds among several advanced countries significant legislative activity aimed at reducing these gaps: countries such as Holland and England have been highly successful in this endeavor. Due to the complex context of legislative processes, different services and the specific character of .each country, it is of course impossible to duplicate legislative systems and services from one country to the other. It is, however, worthwhile to learn from the experience of other countries with regard to ideas and approaches aimed at reducing disparities under a unified, systematic policy for the provision of services which meet the needs of disabled people (Berkowitz, 1990).

Furthermore, the continued development of fragmented legislation over long periods of time has brought in its wake various policies, and social interest, as well as interest and lobby groups which hinder attempts to solve the complex problems which have gradually emerged, by means of a single, revolutionary reform. On the other hand, it is possible, and even necessary, to call for systematic reform based on a policy which will inscribe on its banner a professional, uniform approach that views the disabled person as a citizen equal in rights and obligations, participating as every other individual in the social, family and work life of his society. This policy should inspire legislation of entitlements for disabled persons, providing the means and resources to achieve this primary goal, while restricting and reducing other entitlements and resources which may have unfairly accumulated for some groups.

The objective of this paper is to describe the distortions which have evolved in the current system, in order to urge policy makers to reform legislation and to initiate new legislation having an underlying unified ideology and conception which will eradicate the distortions that have developed over the years and will therefore be more suitable to the present and future needs of disabled people.

2. Work Injury Compared to General Disability

The basic objective of this paper as delineated above is today accepted in theory. Therefore, I should like to move to the more practical level by describing two large groups of disabled individuals - those injured at work and recipients of General Disability benefits. These two groups, although drawing their rights from a single source - National Insurance Law, Chapter 3 and Chapter 6 - are significantly different.

The time differential between 1954, when Work Injury Insurance was enacted, and the enactment of General Disability Insurance in 1974, reflects

a transition from a spirit of generosity in Work Injury legislation to one of restricted allocation of resources for General Disability recipients. Members of this latter group harbor feelings of inferiority, resentment and anger at the unjust discrimination between the two groups.

Without delving into specific details, following is a description of the most prominent disparities, inequities and distortions between the two groups:

From the table it is apparent that there are broad differences between recipients of Work Injury benefits and those of General Disability Benefits.

Table 1. Comparison of Work Injury and General Disability Recipients

Area	*Work Injury*	*General Disability*
1. Definition of disability	The medical impairment itself (NII law, and WHO-1956, 1968, 1980)	The effect of the impairment on work ability (Miller, 1978)
2. Source of disability	Due to and at time of work (including the way to and from work)	Sickness, developmental impairment, or any other reason (not included in other specific legislation)
3. Grants (June 1994)	Housing: severely disabled - IS 21,758 paralyzed - IS 36,266 Equipment: severely disabled -IS 8,418 Paralyzed - IS 16,830	No grants
4. Medical care related to disability	Covered as entitlement under legislation for Work Injury	No coverage under General Disability legislation
5. Monthly Benefit (June 1994)	75% of the average wage in three months prior to injury, multiplied by percent of disability, up to ceiling of IS 7,974 for employee with 100% disability and IS 10,632 for self-employed with 100% disability	Basic minimum benefit, 25% of national average wage: IS 886 for single person
6. Deductions	The benefit is permanent; no tax deduction as long as impairment exists	Total benefit deducted from salary above basic benefit level
7. Rehabilitation grants during training	Up to maximum benefit level for disabled with 100% disability	Up to minimum benefit level
8. Monthly benefit for Attendance, Allowance for severely disabled	Up to 25% of benefit for 100% disability according to tests relating primarily to impairments themselves	Severe tests measuring the degree of dependency on the help of others due to impairments
9. Advance payments	For housing, mobility, rehabilitation, up to 6 maximum benefits for 100% disabled	For rehabilitation only up to 6 minimum benefits

These reflect different approaches to the two groups and spread to other areas of life which affect the disabled person's welfare and his potential for social integration. The major differences derive from the definition of work injury in terms of the degree or percentage of impairment which is subsequently translated into a permanent, lifetime benefit.

In other words, low expectations both for rehabilitation and the disabled person's prospects for adequate reintegration into society and work have created a commitment to provide the injured worker with a permanent payment in compensation for his impairment. This approach conceives of disability as a permanent condition, not given to change or development, as well as a lack of belief, or doubt, as to the injured person's intrinsic capacity for social and economic integration. It is also possible that the far-reaching generosity in other items specified in the table are related to the fact that this period of legislation (1949) closely followed the War of Independence of 1948.

The period of the 1970's was one of rapid development in the status of disabled people in society. The change in status began in the United States with the citizen rights movements in general, followed by impressive self-organization achievements by disabled groups (Dejong, 1979). Beginning with this period, we find increasingly vocal groups of disabled people calling for independent living, de-institutionalization, mainstreaming, and most recently, legislation in the United States outlawing the discrimination against disabled people in employment.

These concepts seemingly accord more easily with the definition of disability according to :"general disability", whereby a disabled person is someone whose physical impairments affect his functioning. In other words, a disabled person is a citizen equal to others in terms of entitlements and obligation, and is expected to integrate into society, family and work, and it is therefore incumbent upon society to assist in removing those obstacles which have been caused by his disability in order to enable him to achieve his rightful objectives. The significance of this approach is that rehabilitation becomes the dominant factor in policy for disabled people, rehabilitation which will provide the necessary means and services, either during the rehabilitation period or permanently, in accordance with his individual condition and situation (Ben-Zvi, 1982; Rosenfeld, 1982).

Another crucial difference between these two groups of disabled emerged as a result of social security programs designed to cover the working population. Systems of social security which have developed in recent decades spread safety nets for workers by means of work-injury insurance

in order to assure a reasonable standard of living during periods of hardship at levels similar to pre-injury income levels. The types of injuries which are compensated have greatly expanded during the last few years, with the development of knowledge and experience, as well as the conditions which are recognized as work injuries, such as occupational diseases and work-related accidents. Some of these are easily identifiable as work-related, but more and more often the connection to work is less clear. Hundreds of occupational diseases have become familiar and accepted in many countries, some of these in Israel as well, but others still remain in the realm of the ambiguous and urgently require findings and proof based on systematic medical research. It should be noted that in several countries (the U.S., Sweden, etc.) back pain and emotional stress have been recognized in spite of their complexity in terms of being work-related This situation has created much inequity between determining the validity of a clearly work-related impairment and an impairment whose source or cause required proof.

As expected, especially in view of the significant economic value to the disabled individual of having his disability recognized as a work injury rather than as belonging to the category of general disability, "bargaining" becomes worthwhile. Thus we find a rising level of various forms of litigation, the outcome of which is all too easily influenced by convincing arguments presented by highly paid lawyers. Examples of this type, which are rapidly becoming more common, have contributed to the lack of a convincing, acceptable, and systematic classification of disabled individuals within the various insurance programs, and engender resentment and anger on the part of general disability beneficiaries who have "failed" to prove a causal link between their impairment and the nature of their work.

The problems related to the definition of disability and to insurance programs raise two types of basic questions which undermine the justification usually given for the legislation which discriminates between these two groups - work injury and general disability.

1. During a period in which the disabled person is conceived of as being equal to others in society, in terms of his social and employment rights, is it not reasonable that expectations for his participation in work and his ability to earn be equal as well, whether he has been injured at work or outside of the work place? In the eventuality that work capacity has been rehabilitated, or has not even been affected, it is not justified that we regard income from employment equally, whether the person has been injured on the job or not? And if indeed the disabled person works as do

other people, it is not justified that we relate to his income in an identical fashion in terms of rights and obligations (including taxes, except for tax credits to compensate for injury-related special expenses) in order that he be able to compete on the labor market?

2. In a period where we often find partial, full or indirect scientific evidence relating certain occupational diseases the sources of which are complex and unclear, is it still acceptable to discriminate among workers who have been injured or become ill, according to the source or cause of the injury? For example, a person who works and earns a salary, who suffers a heart injury during the evening outside of work hours, with no proof of a causal link to his work, can expect, during his period of illness, a significant drop in his income to a minimum income level as a general disability beneficiary, while a worker who suffered heart failure during working hours, after some form of excitement at work, can expect to maintain his former income level while receiving a work injury benefit. Is this kind of dichotomy still viable, one which ignores predisposition to illness and accumulation of mental, emotional and other pressures at work or outside of work and the delicate interrelationships among them? Should the reliance on social security of a working person in the eventuality of injury or illness discriminate between the disabled according to source and time of injury, completely ignoring the main purpose of social security which is to assure the disabled person a level of income as close as possible to pre-injury income?

These seemingly theoretical questions become extremely relevant in everyday complex reality when disabled individuals find themselves subject to a variety of irrational situations in which mere chance will often define which category of social insurance will in effect determine their future, their economic destiny and the quality of their lives.

3. A Policy Proposal

On the basis of social and professional developments regarding the status of workers, their reliance on national programs in times of well-being as well as in times of need, and in view of the distortions that have been created over several decades, I should like to propose a policy reform which is more suited to the social concepts of our period. As explained above, the general policy which should be strived for is one in which the disabled person is viewed as a citizen of equal rights in society, family and work. In order that the disabled person be able to enjoy a life of quality as well as meaningful social and work involvement, he should be assisted in removing or reducing the impediments resulting from his disability, in order that he become

equally competitive in taking advantage of various opportunities for suitable and adequate participation in social life in general and in work life in particular.

Because of the complexity of implementing the proposal, I will relate in this paper to the first stage, i.e., proposing a uniform, consistent system of legislation for the two groups of disabled - the work injured and General Disability recipients. These two groups draw their rights from a single law - National Insurance Law, Chapter 3 and Chapter 6. One service organization - the National Insurance Institute - is responsible for the provision of social and economic services for these groups.

Following are several guiding principles for the proposed reform:

(1) Uniform definition of disability

It is proposed to adopt a uniform definition of economic disability for every injured individual, i.e., a disabled person is one who has suffered a loss or reduction in his work capacity due to impairments caused by accident, illness or birth.

Eligibility will be determined according to this definition both for those having work injuries or general disabilities, so that there will be a single "gate" or entry point in the determination of disability.

Eligibility will be defined only after determining of impairment by a physician at the first stage, after which the degree of his work and earning capacity will be diagnosed and evaluated.

(2) Occupational rehabilitation - return to work and reintegration

In accordance with the approach that every disabled person is expected to integrate into meaningful work and to earn a living, those who require rehabilitation will be eligible for a rehabilitation program aimed at meaningful reintegration into the world of work. The disabled person undergoing rehabilitation will have at his disposal auxiliary services including the means and tools required for returning to work and life at a level that can be realistically expected in view of his disability.

The rehabilitation objectives will have the following priorities:

First priority: returning the injured individual to his previous place of work, the acquisition of skills required as a result of his disability, in order that he reintegrate into work.

Second priority: returning the individual to his former place of work at a task similar to that he was previously able to perform.

Third priority: If the individual is unable to return to his former place of

work, he should be assisted in finding other suitable work of which he is capable.

Fourth priority: If the individual is unable to return to his former profession or to any work place, he should be given the opportunity to participate in a rehabilitation program which would include education, retraining or training in accordance with his preferences, aspirations and his current work capacity, in order to enable his work integration.

Finally, a disabled person who is permanently, or for a limited period of time, unable to return to any kind of partial or full work, will be provided with a pension according to the principles outlined below. For as long as he has lost his work capacity, this pension will enable him to maintain and enjoy a standard of living similar to that which he had become accustomed to prior to his disability.

Defining rehabilitation goals as outlined above constitutes a significant and decisive shift from the conservative conception of rehabilitation which views rehabilitation as a process for enabling the disabled person to attain his maximum intellectual, emotional and economic potential.

This conservative approach is viewed today by many professionals in the western world as more of an educational-developmental model, and is therefore more suitable for young disabled people having developmental disabilities who have not yet begun to work. On the other hand, the approach which derives from the rehabilitation goals outlined above is considered more suitable to the insurance model for working adults who have dropped out of work due to work injury, sickness, or other similar injuries. This model has been adopted in recent years by Holland, Sweden and the United States.

(3) Disability Pensions

Pensions will be provided to injured individuals who have lost, or suffered a reduction in their work capacity and have left the work force, partially or completely, either permanently or for a limited period of time, during which they can receive rehabilitation.

The benefit will be provided at a rate of 75% of the average wage earned prior to the injury. This benefit is aimed at enabling the person suffering from work injury or other kind of disability to maintain a standard of living similar to that previous to the injury.

A disabled person who did not work prior to his disability and who is unable to enter the world of work will receive a benefit at a minimum rate, according to his level of disability, which will enable him to maintain an

acceptable standard of living. The minimum rate will be set in accordance with the budget limitations and policy at the National Insurance Institute for populations which have for various reasons been unable to continue working and are receiving long-term, income-replacement benefits.

An injured individual who has reintegrated into the work force will no longer be eligible for a disability pension but he will be compensated for expenses which derive from his disability, in the form of either a tax credit or special benefit. This will enable him to compete equally in the work force and enjoy a reasonable standard of living.

Those who have reduced work capacity as a result of injury will be awarded a partial pension in accordance with his average earnings during the three months prior to the injury.

During the period of rehabilitation a person will be eligible for a full pension according to the above principles. This system of pensions assures a coherent, uniform and systematic approach to individuals who have become disabled, in accordance with insurance principles which in times of distress provide a standard of living relative to that which they had achieved and were previously accustomed to.

In spite of the seeming inequity in the above-described pension levels, the proposal is nevertheless based on a more just approach to the working person, to his investment in work prior to injury of illness, and to the insurance program which will cover him in time of distress. On the other hand, this proposal does not compensate or benefit disabled persons solely for their injury, once they have overcome obstacles and been successful in reintegrating into working life. The proposal is therefore closer to current professional thinking which considers the disabled citizen equal in rights and obligations to other citizens.

4. Discussion

The proposed reform has its advantages as well as drawbacks. I will begin by listing the latter:

1. There is a crucial link missing in the proposal with regard to work injury insurance. Whereas we have discussed in depth the entitlement of workers who become disabled, as well as required changes in social security legislation, the third, invaluable partner in this system is missing, i.e., the employer! In this context one must point out, that while the pioneering accomplishments of the National Insurance Institute with regard to work injury are laudable, employers, to some degree, reap the benefits of this program which largely releases them from any measure of responsibility.

Insurance payments made by employers enable them, so to speak, to shed responsibility by getting rid of injured employees. Employers profit especially in cases where the injured employee previously had reached only a low level of work capacity and subsequently lacks the flexibility and potential for work reintegration (studies have shown that high achievement and skilled employees are generally easily reintegrated after work injury). "Getting rid" of low-level workers and the lack of incentive to prevent their injury, or the obligation to rehire them after injury, becomes morally and practically acceptable since society accepts responsibility for these individuals by providing them with work injury benefits paid by the National Insurance Institute.

Moreover, for various reasons, primarily administrative ease, differential insurance contributions by employers (on the basis of previous incidence of work injury at the place of work) have been abolished in Israel, as has been the case in several other western countries. This eradicates the link between work injuries and employers, especially in terms of responsibility for preventing injury and illness at work and reemploying injured workers. In this sense, it should be pointed out that the special legislation favoring work injury in Israel has not been successful in preventing injury and illness at work.

One should not compromise on the closer involvement and increased responsibility of the employer in rehabilitation programs for injured workers. This issue must be frankly addressed and dealt with by organizations responsible for regulating and monitoring the work environment, and it should be related to the level of insurance contributions required from employers. Recently the problem has been raised in western countries such as Sweden where proposals have been made for significant legislative changes which impose upon employers responsibilities such as paying 14 days missed from work because of work injury (Olle Brafelt, 1994).

2. Another area missing in the proposal is a call for legislation which will force - or provide incentives to - employers to reemploy injured workers, whenever this is possible.

3. The proposed reform does imply a seeming reduction in the permanent income of disabled workers who have been successful in reintegrating into the working world. Are we thus "punishing" strong, disabled individuals who have managed to maintain or regain their earning capacity by not compensating them for their injury? On the contrary, the above reform includes a proposal to provide severely disabled individuals with benefits, in

addition to their salaries, which compensates for special expenditures that accrue to severe disability.

Following is a discussion of the principal advantages of the proposed reform, which will impact primarily on currently disadvantaged disabled groups:

1. Persons with general disability who, previous to their injury, had participated in work and had earnings, have been placed into economically unviable situations, being reduced to subsisting on a basic, minimum pension. The current insurance program ignores their previous status as insured workers. They thus often find themselves, after many years of having worked, facing a serious situation of economic deprivation as if they had never worked at all. According to the proposed reform their pension will be calculated at a level of 75% of their average pre-injury income, thus correcting the intolerable distortions existing in today's programs.
2. Recipients of general disability pensions are discriminated against today by harsh work disincentives which reduce their already low benefit even when their earnings are low. Under the reform, their post-injury work benefit will be calculated in comparison to their previous income, with deductions made accordingly.
3. Persons with general disability who have suffered from "borderline" impairments, whose tenuous connection to the work place is difficult to prove, will be released from a debilitating process involving the use of costly resources and successful lawyers.
4. The proposed policy reform will also benefit the system by reducing the need for detailed investigations, reviews and assessments of personal capabilities and limitations, in the process of trying to link the injury and the work place. Furthermore, both the injured person and the system will be freed from investigations of injuries incurred on the way to and from work.

The system herein proposed is aimed at correcting the above-described distortions by creating, at least for the two broad groups of disabled persons - the work injured and General Disability recipients - uniform and systematic legislation. Correcting these distortions will require legislation which may be opposed by strong groups of work injury recipients and their lobby - the Organization of Work Injured Persons.

On the other hand, supporters of reform will be those recipients of General Disability benefits who currently have low status and no representation or lobby group behind them to help support the program. It is therefore proposed that legislation address only those disabled in the

future in order to prevent irrelevant political processes from harming decision and action for reform.

Several additional disabled groups have not been addressed in this paper, including those injured under other laws, such as persons injured in the Israel Defense Forces and those injured by hostile enemy actions. As indicated in the introduction to this paper, legislative action embodies the specific period and the evolving social heritage of a country. Given the current situation in Israel, the hoped for time of peace was not yet come, a time which holds promise of future opportunities for legislative reform for these groups as well. For those very reasons, which have at their root deep social-value problems, I have also chosen not to refer in this paper to laws providing benefits for other groups, dwindling in number as years pass, who have suffered injury as a result of Nazi oppression or from having participated in wars against the Nazis.

In the interim period, after the implementation of the policy reform set forth in this paper, several pieces of legislation remain which warrant attention: insurance of disabled housewives, child disability insurance and long-term care insurance. These three groups have much in common, especially in terms of their functional dependency on the help of others in performing the activities of daily living. Much experience has been gained with the implementation of these laws, which I believe are ripe for uniform reform and legislation towards a more modern, professional policy for these groups.

Bibliography

Procaccia, U. and Miller, A. (1974), *Rights of the Disabled in Israel*, Jerusalem: The Hebrew University, Law Faculty (in Hebrew).

Miller, A. (1978), "The loss of earnings capacity as a test for determining bodily injury", *Hapraklit*, 32 (in Hebrew).

National Insurance Institute (Combined Version) (1968), *The Book of Laws*, p. 108 (in Hebrew).

National Insurance Institute Regulations, (1956), "Determining Disability levels for work injured".

Rosenfeld, Y., (1982), "Using the concept of rehabilitation in Israel and the development of a theory of occupational rehabilitation", *Social Security*, no. 23, (in Hebrew).

Ben-Zvi, B. (1982), "The essence of occupational rehabilitation", *Social Security*, no. 23. (in Hebrew).

Ben Zvi, B. (1993), "Long-Term Care Insurance - achievements and unexpected implications of implementation", *Social Security*, no. 39. (in Hebrew).

Dejong, G. (1979), *The Movement for Independent Living*, UCIR Michigan, State University.

World Health Organization (WHO) (1980), *International Classification of Impairment, Disabilities and Handicaps*, Geneva.

Berkowitz, M., Englander, Valerie, Rubin, J., Worall, J.D. (1975, *An Evaluation of Policy Rehabilitation Research*, New York: Praeger Publishers.

Berkowitz, M, International Rehabilitation (IR), International Labor Office (ILO), (1989), *Returning Work Injured Persons to the Job*, Turin, Italy.

Berkowitz, M., International Labor Office (ILO), (1990), *Rehabilitation International (IR), Returning Injured Workers to Employment*, An International Perspective.

Brafelt, Olle, (1994), *Differentiated Levies and the Prevention of Occupational Injuries*, Swedish System.

SOME ISSUES IN THE USE OF DEPENDENCY TESTS FOR DETERMINING ELIGIBILITY FOR LONG TERM-CARE

by Sarit Baitch-Moray, Allan Zipkin and Brenda Morginstin*

Introduction

Israel's Long-Term Care Insurance law, administered by the National Insurance Institute (NII), defines the obligation of the state to provide long-term care services for the dependent elderly who live in the community, as opposed to those who are institutionalized. This focus represents both a social preference, and a significant allocation of public resources.

Within the framework of the law, administrative procedures have been designed to define the target population, the conditions of entitlement, and the implementation of the law. Among the most important determining criterion is the dependency test which is administered to every applicant. This test determines the items of functional dependency as well as a quantitative scoring. The score in turn establishes eligibility level.

The use of the dependency test is first and foremost designed to ensure that the principle of equality is maintained, and that, nationwide, similar levels of dependency be translated into equal eligibility levels. To that end, the dependency test was designed to be highly structured and closed, and to be administered impartially by public health nurses. An important element of the test is the targeting requirement, that those not in need be excluded, and that those in need be included.

In the eight years since the law's inception the dependency test has been administered to more than 150,000 elderly. During this period, many research issues have arisen relating to fundamental aspects of both the law's effectiveness in reaching those most in need and in administering the dependency tests. Among these have been: the affinity between the level of eligibility and morbidity/mortality; the test's ability to discriminate between level of need; the patterns of dependency and level of eligibility; the extent to which the tests have been equitably administered. This article bids to address these questions.

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Background

The measurement of dependency has become an integral component in the evaluation of the need for long-term care in the elderly population. The testing for dependency occupies an essential role in both decision-making, and as part of follow-up and monitoring systems, whose functions are to ensure equitable implementation of the law. The inclusion of monitoring aspects has had the effect of shaping dependency into increasingly structured frameworks, where the influence of personal discretion is reduced. In the presence of a fixed policy, utilization of structured tests inclines towards optimization in the allocation of limited financial resources (Rojas-Pakes, 1981).

Along with the above advantages conferred by the employment of a structured dependency test, there are a number of unanswered questions. Some of these questions are connected to the internal design of the tests, and several are related to their use, particularly the implications of the selection criteria on the size of the eligible population (Naon,1991).

An important application of dependency tests has been to assess needs for institutional care for the elderly, for community services for long-term care, and for estimated expenditures. As both community and institutional needs grow, the necessity for better evaluation systems has become increasingly consequential.

In a review of research of dependency among the elderly (Factor and Primak, 1990), two studies showed similar patterns in functioning of activities of daily living (ADL) but were dissimilar in the pattern of IADL (instrumental) dependency. The differences between the two studies were attributed to the method of data collection: in one study functioning was measured by professionals, whereas in the second it was self-reported. These differences raised questions of reliability in measuring dependency, as well as the usefulness of these measures for estimating the scope of needs.

Method of data collection and/or lack of consistency in the areas of functioning measured can lead to a significant difference in the scope of need (Cohen and Ginsburg, 1991). Using a dependency test which consisted, in addition to ADL functions, of IADL items (e.g. washing, housecleaning, grocery shopping), the number of eligible for long-term care is 15% higher than the number using the NII dependency test. The former instrument included cognitive and mental status, weight, and other items. According to the researchers, supplementing the current assessment items with an evaluation of social factors as well as medical and mental

functioning would better evaluate needs. This is particularly true in those cases where the spouses are not functioning in IADL.

The issue of equity in targeting is frequently juxtaposed with the question of program costs. This is the situation in the United States and Europe where government policy has been continually confronted with the enormous cost of long-term care. Stone (1990) looked at the implications on the dependency rate among the elderly in the U.S. of the test standard utilized to establish dependency. The various criteria considered were ADL, IADL, length of the dependency, and type of assistance (active or passive). The rates of eligibility for home care services ranged from 1.5% when the criteria were held stringent (e.g., the elderly was dependent in at least three items of ADL for at least 12 months), to 15.5% when the criteria were more liberal (need of active or passive assistance in one area of ADL or IADL for at least 3 months).

According to Stone, these estimates emphasize not only the connection between criteria used and scope of dependency outcome, but also a conscious policy decision of the type of elderly to be included as beneficiaries. Given budget constraints, the criteria chosen reflect a value decision regarding the level of dependency for which government is willing to pay.

By using the dependency criteria contained in ADL and IADL, those who are not physically disabled but exhibit cognitive impairment are often excluded. Spector (1991) looked at the degree to which those programs whose eligibility was based on an ADL dependency also included those elderly who were either cognitively impaired or exhibited disruptive behavior. He considered four combinations of dependencies with the presence or absence of cognitive impairment and disruptive behavior. The research showed that the addition of these criteria expands the number of eligible, but more influential in widening the scope of eligibility are the number of ADL dependencies and type of assistance (active/passive) required. Stone, however, points out the inequity of using rigid test criteria for qualification. On the one hand, porportionately more benefits are granted to those who barely qualify, and on the other, those who just miss qualifying receive nothing.

According to Spector, a more fruitful direction would be to move away from a focus on eligibility criteria and concentrate more on matching the type of assistance required with a defined dependency. Focussing on eligibility criteria creates inequality, as there will always be those in need who will be below the cutoff criteria, while those who are only marginally

above the criteria will in general receive more services than they actually require.

Spector recommends creating a tighter correspondence between the level of assistance given and level of dependency, and not the presence or absence of a dependency in two or three items. A look at the principles used for establishing eligibility for long-term care show that some of the elements recommended are incorporated in the dependency test administered by the National Insurance Institute, described below.

Identification of Target Population

In 1983 about 1.6% of the elderly living in the community received services for personal care (Habib and Factor, 1987). In 1989, following the implementation of Long-Term Care Insurance, the percentage of the elderly population eligible for services was 4.5%. Today (1996), the number eligible stands at over 60,000, more than 8% of the elderly in the community (as defined by law, males aged 65 and over, and females aged 60 and over).

These data illustrate the enormous expansion in the number of dependent elderly who are receiving care, nearly all of this growth being government financed. To what extent is the targeting of needs for the elderly being met? An analysis of this issue requires a look at some demographic characteristics of the recipients.

The incidence of eligibility is correlated with sex, age and household composition (Baich-Moray and Zipkin, 1990). Eligibility rises with age, and is higher among those who live with others (particularly children) than it is among those who live alone. It is presumed that the highly dependent single elderly are less likely to remain in the community. Over half of those eligible are eighty years of age or older; and while the group aged 85 and older represent 30% of those eligible, it constitutes only 6% of the general elderly population. Controlling for age, the eligibility incidence for women is considerably higher than it is for men.

Mortality Rates Among the Eligible and among the Rejectees

Lacking external morbidity data which might validate the results of the dependency tests, mortality data was used to calculate the mortality rates of those eligible versus those who were rejected (Zipkin and Baich-Moray, 1992). In addition, survival rates were also calculated for these groups.

Table 2 shows that the mortality rate among those eligible in budget year 1990-1991 was five times that of the general elderly population (23% versus

Table 1. Distribution of Long-Term Beneficiaries by Age and Sex, in Comparison to the Total Elderly Population, 1992

Sex and Age Group	Total Elderly Population	Beneficiaries	As Percent of Elderly Population
	Total		
Total - Number	560,000	37,734	6.7
- Percentage	100.0	100.0	
60-64	16.4	2.8	1.2
65-69	28.9	9.3	2.2
70-74	20.3	15.2	5.1
75-79	17.5	19.6	7.7
80-84	11.2	25.9	15.9
85+	6.0	26.6	30.0
	Men		
Total - Number	210,000	13,734	6.2
- Percentage	100.0	100.0	
65-69	34.0	6.9	1.3
70-74	24.7	14.7	3.8
75-79	20.5	18.9	5.9
80-84	13.6	27.6	12.9
85+	7.1	31.5	28.6
	Women		
Total - Number	350,000	24,714	7.1
- Percentage	100.0	100.0	
60-64	25.9	5.0	1.3
65-69	25.6	10.5	2.9
70-74	17.5	15.4	6.2
75-79	15.7	20.4	9.3
80-84	9.7	24.6	18.2
85+	5.3	23.9	32.1

* Population figures are adjusted from the average population in 1991, *Statistical Abstract of Israel 1992* (Central Bureau of Statistics). Figures for long-term care beneficiaries are from 1992.

** Yearly average, after the local committee has assigned services.

4.4%). These data have remained stable over the time frame studied, 1989-1992. The mortality rate is calculated as the number of deaths within one year of eligibility among all those found eligible within the budget year. Although much of this difference is due, of course, to age composition, there is still a large contrast which can be attributed to a declining physical profile. In comparing mortality rates by age, there are substantial

differences in all age groups. Among the 60-64 age group (only women), one out of every seven beneficiaries died within a year of eligibility, while in the general elderly (female) population, the mortality rate was only one out of a hundred. In the most elderly group the gap has considerably shrunk, but the rate among beneficiaries is almost twice that of the general population, 31% versus 17%.

Among those rejected for long-term care, the mortality rate is intermediately placed between the two above groups - 12.1% versus 23.1% for the beneficiaries and 4.4% in the general elderly population, pointing to a group composed of disabled and frail elderly.

Table 2. Mortality Rates by Population Type and Age, 1990/91

	Mortality Rate by Elderly Population Type		
Age Group	General	LTC Beneficiaries	Rejectees
Total	4.4	23.1	12.1
60-64**	1.0	14.3	6.9
65-69	1.9	19.9	10.0
70-74	3.4	19.7	9.6
75-79	5.6	22.1	12.2
80-84	9.0	23.8	15.0
85+	16.7	31.0	19.4

* Annual mortality rate is calculated from the date of first eligibility until date of death.
** Women only.

Survival tables of the eligible demonstrate further the targeting of those receiving long-term care (Table 3). Among those who applied for long-term care in 1988, approximately half were still alive four year later, in 1992. Looking at survival by eligibility level, 60% of those rejected in 1988 were still alive in 1992. Only 29% of those eligible for long-term care at the increased level of assistance survived four years or more from the date they were first eligible.

A Description of the Dependency Test utilized by the National Insurance Institute - Principles and Administration

The purpose of the test is to examine as objectively as possible functioning in the basic activities of daily living, and to evaluate the degree of dependency. A public health nurse carries out the test in the applicant's home. During this visit, impressions are also recorded of the physical environment, personal appearance, and the existing formal and informal structures for home care already provided. These data are used, among other purposes, to validate the dependency test score.

Table 3. Survival Rates Among Applicants for Long Term-Care, by Year of First-Time Eligibility and Eligibility Level*

Year of First-Time Eligibility**	Total during Year	Percent Alive After: One Year	Two Years	Three Years	Four Years
		All Applicants			
1988	34,794	79.8	67.2	57.0	48.8
1989	24,103	79.7	69.0	60.8	#
1990	19,962	79.8	70.4	#	#
1991	16,171	80.3	#	#	#
1992	25,049	90.3	#	#	#
		Rejectees Only			
1988	13,701	84.2	75.4	67.4	60.3
1989	9,531	83.4	77.0	71.0	#
1990	7,739	85.4	80.5	#	#
1991	5,543	87.0	#	#	#
1992	6,930	91.1	#	#	#
		All Beneficiaries			
1988	21,093	77.0	61.9	50.2	41.4
1989	14,572	77.3	63.8	54.2	#
1990	12,583	76.5	64.5	#	#
1991	10,628	76.9	#	#	#
1992	18,119	91.9	#	#	#
		Beneficiaries Of Lower Eligibility Level			
1988	15,159	81.1	66.8	55.4	46.5
1989	11,610	80.3	67.4	57.9	#
1990	10,332	80.0	68.4	#	#
1991	8,882	79.6	#	#	#
1992	15,194	91.9	#	#	#
		Beneficiaries Of Higher Eligibility Level			
1988	5,934	66.6	49.5	36.9	28.5
1989	2,971	65.3	49.6	39.5	#
1990	2,251	60.5	46.3	#	#
1991	1,746	63.1	#	#	#
1992	2,925	80.0	#	#	#

* Annual mortality rate is calculated from the date of first eligibility until date of death.

** Years 1988, 1989 and 1990 relate to the budget years which began in April and ended in March. The year 1991 consisted of the period April-December, 1991. The year 1992 was a calendar year.

\# Not relevant.

The test evaluates functioning in the following areas: mobility within the house, dressing, washing, eating and drinking, and continence control. In addition, the need for constant personal attendance is evaluated. The dependency test has legal status and forms the basis on which eligibility is determined.[1]

A detailed description is recorded for each activity requested by the public health nurse, and not an evaluation by the nurse of what the applicant is capable. This method is deemed more objectively reliable, and more open to critical evaluation.

The test is based on the idea of dependency on others, and excludes as a dependency the use of various physical aids if no active or passive assistance is required.

In addition to the test of functional dependency, there is an evaluation of the need for constant personal attendance. Here a distinction is drawn between the need for continual or partial attendance. The need for partial attendance is already built into the functional section of the dependency test, and is expressed in points which are scored for the need of prompting.

There is no mandatory connection between functional level and the need for constant attendance, and need here appertains to the state in which the applicant cannot remain alone, whether the basis is physical, mental, or cognitive. This condition may be summarized as one in which the applicant, if not supervised, might harm himself or others. This need is determined through behavioral observations by the nurse during the course of her visit (usually lasting at least an hour), and directed questions. In forming a conclusion, the nurse also draws on all other relevant evidence available to her.

Eligibility is approved or rejected through a two-step process. In the first step conditions of entitlement are examined, while the second step determines level of dependency. The latter is based on the total points accumulated in the dependency test and in the evaluation of the need for constant personal attendance. Those who are in need of constant attendance receive the highest benefit level. Those who live alone and have a cumulative score of 2 points or more receive an additional 2 points to their final score.

Minimal eligibility is established by the accumulation of a minimal score of 2.5 points. There are four essential paths to accumulating at least 2.5 points. These are:

1. A score of at least 2.5 on the dependency test.

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1. See Table 7 below for range of scoring for each ADL.

2. A score of 2 on the dependency test, and 2 additional points for living alone.
3. A score of at least 2.5 on the dependency test, and a need for constant attendance.
4. A score of less than 2.5 on the dependency test, but a need for constant attendance.

Two benefit levels of eligibility have been set, a lower level (equal to 10 hours of weekly help) and a higher level (equal to 15 hours of weekly help). In terms of the cumulative score, the higher level is set at 6.5 points or higher. The total possible score is 14.5 points.

Table 4 shows the distribution of determinant conditions according to which applicants were found eligible in the period 1988-1992 (Baich and Zipkin, 1991). In the first year of the implementation of Long-Term Care Insurance, 1988-89, 75% of beneficiaries were found eligible on the basis of the dependency test alone, that is a score of 2.5 or more. For another 7%, eligibility was approved on the basis of an additional 2 points received for living alone; that is, their score on ADL was exactly 2 points. The need for constant personal attendance accounted for fully 18% of those eligible in 1988-89. Of this group, 22% (4% of the total eligible), qualified solely on the basis of the need for constant personal attendance, while the remaining 78% would have qualified on their ADL scores alone (if not at the higher benefit level). During the period covered, the proportion of those newly qualified solely due to their need for constant personal attendance declined from 14% to 6%. This sharp decrease can be attributed to the changing functional profile of the applicants, which in the first year of the law's implementation reflected a relatively high proportion of severely dependent elderly.

Table 4. Determinant Conditions of Eligibility for Long-Term Care, 1988-1992

Total			Determinant Condition			
Year	Number	Percent	At Least 2.5 Pts on Dependency *Test*	2.0 Pts On Dependency *Test, 2.0 Pts for* Living Alone	At least 2.5 Pts on Dependency *Test, 6.5 Pts for* Constant Attendance	6.5 Pts for Constant Attendance
1988/89	20,966	100	75	7	14	4
1989/90	16,514	100	79	9	9	3
1990/91	14,279	100	81	9	7	3
1992	20,371	100	83	9	6	3

In contrast to some other tests (Rojas-Pakes, 1981) which denote the absence or presence of a dependency, that of the National Insurance Institute countenances intermediate functioning levels. This allows a more precise assessment of dependency, matching ADL score with number of hours of assistance needed (Habib et al, 1988). This match assists in designing the personal care plan for those eligible.

Patterns of Dependency and Eligibility Levels

This discussion focusses on the relationship between the patterns of ADL dependencies and eligibility level. The principal question raised here is the extent to which patterns of dependencies are identified which discriminate between those eligible for long-term care and those who are rejected, beyond a simple scoring. This is of particular relevance for borderline case discrimination. Table 5 shows the score distribution of the various ADL functions for all applications in the four-month period from October 1992 until January 1993. The most common activity in which there was any dependency was bathing, 81% of all applicants, while the dependency found least frequently was in mobility, 27%. This distribution confirms again the hierarchical pattern of ADL functions, where assistance in bathing is the earliest incidental dependency.

Almost a third of the applications(30%) had either one or no dependency, another third were dependent in two to three items, while the remainder were dependent in four to five items. Table 6 clarifies the relationship between each area of dependency and the likelihood of being

Table 5. Scoring Distribution for Each ADL Function, Applications from Period October 1992-January 1993

			Points						
ADL Item	Number	Percent	0.0	0.5	1.0	1.5	2.0	3.0	Percentage Receiving Any Points on the ADL Item
Mobility	12,660	100.0	73	18	9				27
Dressing	12,660	100.0	33	18	49				67
Bathing	12,660	100.0	19	22	44	15			81
Eating	12,660	100.0	42	50	5	3			58
Incontinence	12,660	100.0	59	17	6	3	5	7	41

Table 6. Rate of Eligibility for applicants by ADL Function (Percent), October 1992 - January 1993

ADL Item	Among Those Receiving Any points	Among Those Receiving No Points
Mobility	98	39
Dressing	81	3
Bathing	67	2
Eating	85	13
Incontinence	95	27

eligible for long-term care. For example, 98% of those who had a dependency in mobility were eligible for long-term care services; among those who were incontinent, the likelihood was nearly as high, 95%. Of course, those who had either a dependency in mobility or were incontinent, also had other dependencies which, cumulatively scored, made them eligible. The predictive ability for those having a dependency in bathing was the lowest of all five ADL's - only 67% of those with a dependency in this area were eligible.

On the other hand, only 3% and 2%, respectively, of those who scored zero in dressing and bathing were eligible, compared to 39% and 27% of those who scored zero in mobility and continence. It would seem, therefore, that a score in mobility or continence is a good positive predictor for eligibility while no score in dressing or bathing is a good predictor for non-eligibility.

In Table 7 a more detailed analysis is presented of the relationship between ADL score in individual functions and the likelihood of being

Table 7. Rate of Eligibility for applicants by Score in Each ADL Function, October 1992- January, 1993 *

	Points					
ADL Item	0:0	0.5	1.0	1.5	2.0	3.0
Mobility	39	97	99			
Dressing	3	42	95			
Bathing	2	14	83	100		
Eating	13	82	100	100		
Incontinence	27	89	99	99	99	99

* Percentage represent the eligibility rate of each score in each ADL item. E.g., 39% of all those with 0 points for mobility were eligible for long-term care benefits.

eligible for long-term care. In general, a scoring of 0.5 points signifies the need for prompting or slight assistance in that activity, where a scoring of 1.0 or more points indicates the need for full, active assistance. The table demonstrates the interdependence of most of the ADL items assessed. In four out of the five ADL's, a score of 1.0 shows a high rate of eligibility. Bathing is the ADL which shows the lowest association: of those applicants with 1.0 points, "only" 83% were found eligible.

Dependency Profiles

Looking at profiles of scores in individual ADL functions is an alternate approach to examining the relation between dependency patterns and eligibility level (Baich-Moray, Zipkin, and Morginstin, 1993). Two profile typologies were examined: the first (see Table 8), describes the grouping of ADL functional dependencies and the relation to eligibility for those applicants who had at least one severe dependency, a score of 1.0 points or more. The second profile typology (Table 8) is a similar grouping of those applicants who had at least a minimal dependency, a score of 0.5 points or higher. Presentation of the two profile types combines an analysis of the association between ADL dependencies, their severity and eligibility. This approach represents a sequential path in the decline of physical functioning. Due to technical limitations at the time, the data set used for these two tables was collected from individual files, and dates from the period 1988/89.

Of those applicants with at least one severe dependency and not eligible (see Table 8), the dependency was almost always that in bathing. There were a significant number of applicants (1% of all applicants) who had severe dependencies in both bathing and dressing (2.0 points) and were not eligible.[2] In contrast, among those eligible at the lower level (100%), a large portion of them (29% of lower benefit beneficiaries) had a severe dependency in bathing, while any other recorded dependencies had a score of no more than 0.5 points. Ten percent of all applicants fit this eligibility pattern of at least one point in bathing and lower scores in other ADL functions. The remainder of those eligible at the lower level had at least two severe dependencies, with 12% (4% of total applicants) of these level beneficiaries being severely dependent in three or four functions. At the higher eligibility level, more than three-quarters of those eligible (77%) had

2. A combination of dependencies was included only if it amounted to 1% or more of the total number of applicants.

Table 8. Profiles of Applicants with Severe Dependency in ADL Functions, by Eligibility Level* (1988/89)

Eligibility Level	Mobility	Dressing	Bathing	Eating	Incontinence	Frequency Percentage
Ineligible	-	-	-	-	-	33
Ineligible	-	-	+	-	-	11
Ineligible	-	+	+	-	-	1
100%	-	-	+	-	-	10**
100%	-	-	+	-	+	12
100%	-	+	+	-	-	8
100%	-	-	+	+	+	2
100%	+	+	+	-	+	2
150%	-	-	+	-	-	2***
150%	-	+	+	-	-	1***
150%	-	+	+	-	+	2
150%	-	+	+	+	+	1
150%	+	+	+	-	+	2
150%	+	+	+	+	+	5

Note: Dependency profiles are only presented here which comprised 1% of more of total applications. The total, therefore, amounts to less than 100%.

* The sign "+" represents a score of at least 1.0 points in that dependency.

** This profile describes those applicants who received a score of at least 1.0 in bathing, and additionally received a score of less than one point in the other ADL items.

*** Eligible for the higher benefit level due to the need for constant personal attendance.

at least three severe dependencies. It is noted that there remains a small group of applicants with only one or two severe dependencies, yet who qualified for the higher level due to the need for constant personal attendance.

Using the second profile type to analyze eligibility, the presence of a dependency at any score, a high proportion of all applicants (19%) who had a dependency in one or two items were not eligible (see Table 9).[3] Being dependent in three ADL functions, albeit not necessarily severely so, nevertheless proved a significant threshold; only 2% of the total applicants who had three or more dependencies at any level did not qualify for long-term care. Conversely, eligibility was correlated with the presence of at least three dependencies. Eighty percent of those eligible for the lower benefit had four dependencies or more, and 51% were dependent in all five items. Using this criterion of any dependency, 35% of all applicants were eligible at the lower level. Of those eligible at the increased benefit level, 77% (10% of all applicants) had five dependencies.

3. See Note 2.

Table 9. Profiles of Applicants with Any Dependency, by Eligibility Level* (1988/89)

Eligibility Level	Mobility	Dressing	Bathing	Eating	Incontinence	Frequency Percentage
Ineligible	-	-	-	-	-	18
Ineligible	-	-	-	+	-	3
Ineligible	-	-	+	-	-	7
Ineligible	-	-	+	-	+	1
Ineligible	-	-	+	+	-	2
Ineligible	-	+	+	-	-	6
Ineligible	-	+	+	+	-	2
100%	-	+	+	-	+	2
100%	-	+	+	+	-	5
100%	-	+	+	+	+	7
100%	+	-	+	+	+	1
100%	+	+	+	-	+	1
100%	+	+	+	+	-	1
100%	+	+	+	+	+	18
150%	-	+	+	+	+	3
150%	+	+	+	+	+	10

Note: Dependencies profiles are only presented here which comprised 1% of more of total applications. The total, therefore, amounts to less than 100%.

These profile typologies demonstrate that eligibility for the lower benefit level is frequently based on only one severe dependency or some combination of several mild dependencies. As noted above, a dependency in mobility appears only among those who are eligible, while all other dependencies are found among the rejectees as well as beneficiaries.

The two tables together establish a sequential hierarchy encapsulated in the dependency test which closely follows functional deterioration. A dependency in bathing is quite frequent among rejectees, and is indicative of initial loss of functioning. A loss in mobility is indicative of much greater overall dependency, while the three remaining ADL functional items evidence intermediate eligibility.

Reliability of Dependency Tests

Qualification for Long-Term Care Insurance benefits is based on the principles of universality and uniformity of application. Test reliability is of

prime importance in maintaining these principles. This includes both reliability among public health nurses who undertake the testing, and within the population tested of each individual nurse. The issue concerns the equality of opportunity in eligibility for long-term care.

Checking reliability among and within tests by nurses is complex due to the numerous public health nurses utilized for this purpose, distributed throughout 15 local health districts in the country. These health districts are highly differentiated by population size, age structure, and density.

Examining test reliability according to health district makes the assumption that the work of nurses within an individual health district can be characterized by the same procedural and evaluative guidelines. Our aim was to research the role of the local health office as a contributory factor to test variation, after the data had been adjusted for population mix, including age, gender, and living arrangements. A general linear model was fitted to the data set of all applicants for long-term care between October, 1992 and January, 1993. The following were including as dependent variables:

1. Total number of points in ADL (from 0 to 8).
2. The points given in each area of ADL, which are: eating, mobility, washing, dressing, and continence .
3. The presence or absence of the need for constant personal attendance.

Independent variables in the model were gender, age group (groupings of every 5 years past 59 until age 85), living arrangements (alone or with others), and the particular local health district (of a total of 15 at the time).

The model examined the contribution of each independent variable to the need for constant personal attendance, as well as to the score in each ADL area. The results indeed verified that all demographic variables were significant contributors to explaining variations both in the total ADL score and in the need for constant personal attendance ($p < .001$). Local health district was also significant in explaining test variation.

Controlling for demographic variables only, there were a number of local health districts which showed significant variation from the average scores in individual ADL functions (Student's t value, $p < 0.05$). This ranged from four to five local districts (see Table 10). In the total ADL score, however, there were only two health offices whose adjusted scores varied from the overall average. In these two districts, Nazareth and Beersheba, the scores in individual ADL functions also varied significantly from the mean, in four

Table 10. Average Adjusted ADL Scores, by Local Health District, October, 1992- January, 1993

Health District	No. of Depen-d-ency Tests	Mobility	Dressing	Bathing	Eating	Inconti-nence	Total ADL Score
National	12,600	0.19	0.58	0.77	0.35	0.53	2.24
Jerusalem	792	0.18	0.54*	0.78	0.36	0.62*	2.49
Safad	185	0.19	0.55	0.71	0.40	0.57	2.44
Tiberias	134	0.20	0.63	0.74	0.39	0.67	2.64
Afula	533	0.22*	0.62	0.79	0.40	0.63*	2.67
Akko	570	0.19	0.45*	0.72*	0.35	0.59	2.33
Nazareth	143	0.16	0.43*	0.50*	0.30*	0.37*	1.90*
Haifa	1,576	0.18	0.56	0.74*	0.33*	0.53	2.37
Hadera	476	0.25*	0.60	0.75	0.37	0.53	2.50
Netanya	742	0.21*	0.62*	0.82*	0.37	0.54	2.58
Petach-Tikva	859	0.18	0.55*	0.77	0.36	0.54	2.62
Ramle	323	0.21	0.62	0.78	0.41*	0.62	2.65
Rechovot	842	0.18	0.61	0.80	0.38	0.52	2.51
Tel-Aviv	3,757	0.17*	0.60	0.78	0.34	0.49*	2.40
Ashkelon	814	0.16	0.57	0.77	0.33*	0.47*	2.32
Beer-Sheba	832	0.22*	0.57	0.80	0.33*	0.69*	2.63*

* $p < 0.05$.

items for the former and in three items for the latter. In only one other health district was there a deviancy in more than two ADL items.

By individual ADL functions, the ability to bathe oneself showed the least variation: only four health districts differed statistically from the average. In the area of incontinence, there were six health districts whose average scores differed significantly from the national average. For each of the other ADL functions, there were five health districts whose averages differed from that of the national one.

Similarly, assessment scores of the need for constant personal attendance are presented in Table 11. Here, the scores are converted to rates, since only two options were available- either the condition presented itself, or it did not. This area of testing proved a more problematic one than was ADL functions. Nine out of fifteen local health districts varied from the national average, after controlling for the demographic variables of gender, age, and living arrangements. Overall, 4.6% of all applicants were assessed to require constant personal attendance. It is noted that of these nine health districts, six had rates significantly lower than the average, and three had rates significantly higher than the average.

Table 11. Adjusted Rates of the Need for Constant Personal Attendance, by Local Health District, Oct. 1992-Jan.1993

Health District	*Number of* Dependency Tests	*Percent of Applicants* in Need of Constant Attendance
National	12,650	5
Jerusalem	792	2*
Safad	185	3
Tiberias	134	1*
Afula	533	2*
Akko	570	2*
Nazareth	143	1*
Haifa	1,576	4
Hadera	476	4
Netanya	742	7*
Petach-Tikva	859	4
Ramle	323	4
Rechovot	842	3
Tel-Aviv	3,754	7*
Ashkelon	814	3*
Beer-Sheba	832	2*

* $p < 0.05$.

A note of methodological circumspection needs to be addressed. There are several obvious limitations in the methods used here. In the first place, the number of dependency tests carried out in several of the local health offices was too low in the defined period to draw any definitive conclusions, particularly in the area of evaluating the need for constant personal attendance. It is unclear if repeated data sets will duplicate the results. Secondly, it is essential that the data be examined on the individual level of the nurse, as the variation within local health office might approximate or surpass that between local health offices. Nonetheless, as one of an array of tools in a system of quality control, this methodology appears promising.

Summary and Conclusions

The use of dependency tests in establishing eligibility for long-term care is part of a decision-making process in which the law is transformed into normative procedures. This goal can only be achieved if correct targeting delivers services to those most in need, according to the conditions set in

law. This, in turn, can only be achieved if the principle of universality is upheld, that those in equal functioning condition receive equal benefits.

In order to examine the extent to which the dependency tests currently in use fulfill these aims, this article has examined the test results and has attempted to answer the following questions: who comprises the eligible population, what are its patterns of dependencies, what are the relations between the eligibility levels and dependency patterns, and what are the connections among the individual ADL dependencies. The distribution of scores of individual ADL functions establishes a hierarchy betwen dependency incidence and eligibility. Approximately 80% of the applicants were dependent in bathing themselves. About two-thirds were dependent in dressing, with slightly less than this in eating and incontinence. Less than a third of all applicants were dependent in mobility.

As expected, a more advanced age, being male, and living with others are significantly correlated with a more severe level of dependency. The data also showed being dependent in either incontinence and mobility was a good indication of being eligible, whereas *not* having a dependency in bathing was a good indication for being noneligible.

Analysis of the patterns of dependency in the individual ADLs for all applicants showed that most rejectees have no dependencies (16% of applicants), or have no more than one or at most two dependencies. The general pattern of those eligible for the lower benefit level is either a severe dependency in bathing together with a more severe dependency in one or more items, or a mild dependency in four or five ADLs. Eligibility for the increased benefit is generally due to a severe dependency in a minimum of four ADL functions.

Even in situations where the instruments used to test dependency are structured, there is variation in the results. Controlling for demographic variability in the populations of local health offices, the evidence points to idiosyncratic influence of the specific health office on tests results. This seems particularly applicable in assessing need for constant personal attendance, where the rates of 60% of the local offices were significantly different than the national average.

In general, the research results support the effectiveness of implementation of the present dependency test in identifying the targeted population, with a degree of uniformity of scores between the local health offices who are assigned this task. The findings that the dependency tests in a majority of sites were carried out uniformly on average reinforces the claim to equity in eligibility. Assessing the need for constant personal attendance appears to

be less satisfactory in claiming equity of implementation. Further serious examination is required in this area, both in the area of the unstructured nature of the assessment instrument, and in the amount of discretion assigned to the public health nurses. A decision protocol clearly might contribute to this complex issue.

In the area of dependency patterns, the data demonstrated that fewer dependencies might be required to establish the same eligibility level. This finding is based on the ample experience acquired over the years in using this dependency test, and should prove valuable in creating standards for quality control.

One of the more problematic issues in the findings concerns the appropriate match of needs and benefits. This is highlighted most explicitly in beneficiaries with two dependencies receiving the same scope of services as those with four or more dependencies. There would appear to be an imperative requirement to achieve a better match between needs and resources. One appropriate means would be the adjustment of additional benefit levels to dependency test scores.

Bibliography

Baich-Moray, S., Zipkin, A. (1989-1992), "The Implementation of the Long-Term Care Insurance Law", National Insurance Institute, Survey Numbers 80, 90, 108 (in Hebrew).

Baich-Moray, S., Zipkin, A., and Morginstin, B. (1993), "Dependency Assessment Under Long-Term Care Insurance", National Insurance Institute, Survey Number 112 (in Hebrew).

Cohen, A., Ginsburg, G. and Stesseman, Y. (1991), "Assessment of Eligibility for Receiving Long-Term Care Services Utilizing the Dependency Test of the National Insurance Institute and Additional Tests", Jerusalem Institute for Gerontological Research, (Unpublished paper. In Hebrew).

Factor, H. and Primak, H. (1990), "Disability Among the Elderly in Israel", Brookdale Institute of Gerontology, Discussion Paper 180-90, Jerusalem (in Hebrew).

Habib, J., Factor, H. and Shmueli, A. (1987), "The Need for Community Services and Their Costs", Brookdale Institute of Gerontology, Discussion Paper 142-87, Jerusalem (in Hebrew).

Habib, J. et al. (1988), "Disabled Elderly in the Community: Developing Adequate Community-Based Services and Their Implications for the Need for Institutional Placement", Brookdale Institute of Gerontology, Discussion Paper 160-88, Jerusalem (in Hebrew).

Morginstin, B. (1984), "Personal Care and Home Assistance: Needs and Service Provision by Family and Community", National Insurance Institute, Experimental Projects Series Number 19 (in Hebrew).

Morginstin, B. (1985), "Measuring Functional Disability - Attendance Allowance", Experimental Projects Series Number 20 (in Hebrew).

Naon, D. (1991), "Development of an Instrument for the Classification of Disabled Elderly", Brookdale Institute of Gerontology, Discussion Paper 158-91, Jerusalem (in Hebrew).

Rojas-Parkes, J. and Bar-Giora, M. (1981), "Assessment for Long-Term Care: A Review of Selected Instruments", Brookdale Institute of Gerontology, Jerusalem.

Spector, W. (1991), "Cognitive Impairment and Disruptive Behaviors among Community-Based Elderly Persons: Implications for Targeting Long-Term Care", The Gerontologist, 31, Number 1.

Stone, R. and Murtaugh, C. (1990), "The Elderly Population with Chronic Functional Disability: Implications for Home Care Eligibility", The Gerontologist, 30, Number 4.

Zilberstein, J. (1981), "Functionally Disabled Aged in Bnei Brak - The Need for Additional Services and their Cost", National Insurance Institute, Experimental Projects Series Number 13 (in Hebrew).

EVALUATION OF COMMUNITY-BASED RESIDENCES FOR PERSONS WITH MENTAL RETARDATION

by Prof. Arie Rimmerman* and Dr. Chaya Schwartz**

Introduction

During the last two decades, Israel, as other countries in the west, has developed community-based programs for persons with developmental disabilities (Schwartz, 1993). The community-based program is an alternative setting to both the family and the institution. It exists as a separate residence (and not as part of an institution of foster care).

Although the developments of community residences for adults with mental retardation are described as universal, there is a significant difference between the United States and Israel. In the United States, the development of community programs and residences was influenced by the institutionalization movement followed by federal legislation and social and political reform (Baker, Seltzer and Seltzer, 1977). In Israel, the lack of specific ideology and reform was a feature of the service delivery system. The Ministry of Labor and Welfare allocates most of the budget in this area to out-of-home placement and, in particular, to institutions. Nevertheless, during the last fifteen years the number of community residences, such as group homes and apartments, increased dramatically; ninety percent of the community residences have been opened since 1980 (Schwartz, 1993).

Historically, the movement from institutional to community care took place in the United States in the early 70s. Wolfensberger (1972), an advocate for community living, viewed institutional care as islands of neglect and dehumanization. The protest of leaders of the reinstitutionalization movement in conjunction with parent advocacy groups exerted pressure on the federal government to change its policy toward the development of community residences, particularly in group homes and

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congregate care facilities (Conroy and Bradely, 1985; Vitelo and Soskin, 1985). In Israel, the early residential programs were group homes because they were constructed as an alternative to institutions rather than to fit the varying needs of adults with mental retardation (Schwartz, 1993).

In recent years there has been a professional trend to shift the focus of attention from the need for placement to models of care for adults with mental retardation. Instead of providing our congregate care model such as the hostel, the effort is toward matching different kinds of environments to persons with different needs. In their research, Larson and Lakin (1989) demonstrated the fact that persons with mental retardation who moved to community residences significantly increased their instrumental and social skills

The development of community residences for adults with mental retardation in Israel was not carried out with proper documentation, research and evaluation. There is a growing interest in research and its contribution to policy, planning and decision-making in this area.

The Role of Evaluation

Community residential programs should be considered as service provision organizations. Program evaluation is important in the task of improving and enhancing the process of decision-making in these organizations.

Evaluation of any residential facility should have the following goals: the impact on the social and educational program on the residents' well-being; the effectiveness and efficacy of different service models, identifying program components and their relationship to outcome measures, and the provision of a budgeting mechanism for a given program (Jacobson and Regula, 1988). It can be carried out by professionals from within the residential facility or by external professionals. Both directions have shortcomings. Internal evaluation may be based on better understanding of the organization leading to easier implementation. However, an external evaluation is more objective and may provide specific information and expertise. It is often the case that a decision to adopt internal or external evaluation is associated with political and ecological considerations within the organization.

This article describes three areas of evaluation of residential facilities: (a) evaluation of residents' advancement within the residential program; (b) evaluation of ecological harmony of the residential facility; (c) systematic-organizational evaluation. In each category we describe the recommended instrumentation used.

Evaluation of Residents' Advancement

One of the central measures in residential facilities is the evaluation of residents' advancement within the program (Bellamy, Newton, LeBaron and Horner, 1990; Conroy, Efthimiou and Lemanowicz, 1982). There are different methods of evaluating the resident's advancement in a given facility. The common method is to evaluate overall changes in the resident's functioning or personal condition. The evaluation can be multidimensional and examine changes in several functioning areas, or predict the resident's level of functioning within and outside the residence. In this context, Seltzer et al. (1981) suggest that the resident's level of adjustment is the critical component in determining his/her well-being.

The method and statistics are crucial in measuring small residential programs. The evaluation has to be independent and free of any bias, including the impact of the baseline measurement. The measurement has been standardized with two evaluators. The total score for each item should be the mean score between the two. To avoid bias, the evaluators must have similar exposure to the resident or residential facility.

A central goal of community-based residences is to enhance the resident's adaptive behavior by reducing maladaptive behavior. Adaptive behavior is measured by the person's compliance to standards of personal independence and social responsibility and it is age- and culture-related (Ehlers, Prothero, and Langone, 1982). Therefore the recommended instruments to measure the resident's personal advancement are the adaptive behavior scales. Because these scales are long and time consuming, shorter and easier to use versions have been developed. These versions are presented in Table 1.

Three measures are widely used for adaptive behavior: (a) The short version of the Minnesota Developmental Programming System Behavior Scales (MDPS-AF). This instrument describes and provides scores for eight areas of motor functioning and daily instrumental activities (Joiner and Krantz, 1978); (b) The short version of the Behavior Developmental Survey (BDS). This is the short version of the Adaptive Behavior Scale constructed by the American Association on Mental Deficiency (AAMD) in 1979, based on the earlier work of Nihira, Foster, Shellhaus and Leland (1974). The instrument provides information in five areas: Self-care, Community Adjustment; Personal and Social Responsibility, Social Adaptation, and Personal Adjustment. These areas are frequently used in the assessment of community programs (Conroy st al., 1982). The third instrument used to

measure adaptive behavior among low functioning individuals is the Camelot Behavioral Checklist (1974). It measures five areas of functioning: Self Care, Physical Development, Vocational Ability, Numeric Ability and Communication.

Table 1. Scales to Measure the Resident's Personal Advancement

Authors	Scales	Variables
Adaptive Behavior Scales		
Joiner and Krantz (1978)	Minnesota Developmental Programming System Behavioral Scales (MDPS-AF)	Gross motor, Eating, Hygiene, Dress and grooming, Communication, Writing and reading, Math skills, Independent living skills
Individual Data Base (1979)	Behavior Development Survey (BDS)	Self Care, Avidity to live in the community, Personal and social responsibility, Social Adjustment, Personal adjustment
Foster (1974)	Camelot Behavioral Checklist (CBC)	Self Care, physical development, Vocational ability, Ability to use numbers, Communication
Maladaptive Behavior Scales		
Quay and Peterson (1984)	Revised Behavior Problem Checklist (RBPC)	Control disorders, Aggressiveness, Attention deficits, Anxiety, Psychotic behavior, Hypertonic
Silverstein Olvera, Schalock and Bock (1984)	Revised Behavior Impediments Scale (RBIS)	24 behaviors listed according to severity, Maladaptive behavior (general)
Bruininks, Woodcock, Weatherman and Hill (1985)	Scales of Independent Behavior-Problems Behavior Scale (SIB/PBS)	Maladaptive behavior (internal), Asocial behavior, Maladaptive behavior (external)
Integrative Scales		
Bruininks, Hill, Weatherman and Woodcock (1986)	Inventory of Client and Agency Planning (ICAP)	Adaptive behavior using four measures: Social skills, Self help skills, Community skills. Maladaptive behavior: Eight categories of problematic behavior with frequency and severity

When the evaluation is focused on behavioral problems that prevent the person from adjusting to his environment, it is common to use maladjustment scales. These scales are also presented in Table 1 as follow: (a) The Revised Behavior Problems Checklist (RBPC), constructed by Quay and Peterson (1984); (b) Revised Behavior Impediments Scale (RBIS) developed by Silverstein, Olvera, Schalock and Bock (1984); (c) In the University of Minnesota, Bruininks and his associates (1985) developed the Scales of Independent Behavior-Problems of Behavior Scale (SIB/PBS). In addition, they constructed the Inventory of Client and Agency Planning (ICAP), a very popular scale to measure adaptive and maladaptive behavior. All the instruments listed in Table 1 can be used with all disability groups, including individuals with psychiatric disabilities.

In general, instruments that test maladaptive behavior are statistically less reliable than instruments that measure adaptive behavior, although their reliability scores are within the acceptable psychometric range. The analysis and evaluation of the behavioral advancement of the residents should be carried out three times a year by using specific items in the scale, because, in longitudinal assessment, residents with polarized scores move toward the group average. It is also recommended to evaluate the group of residents as part of a program of evaluation.

The evaluation is reflected not only in the changes in his/her skills but also of his/her activities in the community. One of the most accepted measures of assessing community integration is the Rehabilitation Indicators (Brown et al., 1980). This instrument describes the resident's capacity and type of integrative behavior within the community. There are additional means of assessing community integration (Crapps, Langone and Swaim, 1985; Hill et al, 1989).

During the last decade there has been an inclination among researchers in the area of developmental disabilities to use subjective measures to assess the residents' quality of life and the satisfaction they derive from it. There are a few questionnaires mentioned in the literature such as Heal and Chadsey-Rusch Satisfaction Questionnaire (1985) or others, such as Schalock et al. (1990) or Rosen et al. (1985), that evaluate the person's quality of life.

Evaluation of Ecological Harmony of the Residential Facility

Evaluation of the ecological harmony of the residential facility is critical for his/her well-being (Intagliata and Willer, 1982). In evaluating the

environment there are physical and social components to be considered. The latter include characteristics of the social climate such as patterns of relationship of the staff, residents, neighbors, and friends in daily living. The evaluation should examine the effect of ecological characteristics on the resident's social adaptation through observation techniques (Romer and Heller, 1984). Due to the high cost of observation and its methodological limitations researchers looked for objective measures. The three common objective instruments used are listed in Table 2.

Table 2. Scales to Measure Ecological Harmony

Authors	Scales	Varables
Moose and Lemke (1980)	Multiphasic Environmental Assessment Procedure (MEAP)	Physical Resources, Resources related to policy and program, Resources related to resident and staff
Pratt, Luszcz and Brown (1980)	Group Home Management Schedule (GHMS)	Rigidity and routine, Depersonalization, Social distance.
Wolfensberger and Glenn (1975)	Program Analysis of Service System III (PASS III)	Normalization program, Normalization setting, Management, Distance and accessibility

Moose and Lemke (1980) developed the Multiphasic Mental Assessment procedure (MEAP) to evaluate aging residents in congregate care facilities. The instrument measures four factors: Physical, programmatic, supports and social climate. Each factor is measured separately in a checklist. Wandersman and Moos (1981) claimed that although the instrument was not designed specifically for persons with developmental disabilities, it was capable of evaluating their residential environment. In this context, it is worth mentioning an earlier version of Moos (1972), the Program Environment Scales-COPES, which relates to social climate only.

An additional scale is the Group Home Management Schedule (GHMS) constructed by Pratt and his associates (1980). The scale evaluates the variance in the person's day to day activities and among residents. It examines the level of involvement of the staff, parents and friends in the group home and whether the patterns in the residents' behavior are individually or group related. The most common instrument to measure normalization is the Program Analysis of Services System (PASS III),

constructed by Wolfensberger and Glenn in 1975. This semi-objective or subjective scale is unique since it assesses normalization in a given facility or program. It evaluates the following dimensions: (1) age appropriate activities, individualization and the use of general as opposed to specific resources; (2) physical planning; (3) management and original initiations by staff and accountability; and (4) location and accessibility to physical and cultural resources. The PASS III is evaluated by five professionals trained for this job. There is a shorter version that may be used in one-day evaluation (Flynn, 1980).

Despite the significance of the assessment of ecological harmony, the contribution should be taken with some reservation. The scales do not take the given habilitation practice or the provision of services into consideration. These scales are useful when comparing different facilities or when assessing the same facility longitudinally to verify changes in environmental harmony.

Systematic-Organizational Evaluation

Systematic-Organizational Evaluation is used to examine the effect of the economic-administrative inputs on residential outcomes. The most common evaluation in this area is assessing the dynamic of the facility (or organization), assessing patterns of staff and cost-benefit. Assessing the dynamic of the residence focuses mainly on the effect of its structural patterns on residents' advancement. Specifically, should the program be centralized or decentralized? Is it preferable to offer an autonomous management for each residence? Such evaluation affects the functioning of the staff and the quality of life of the residents.

Evaluation of the staff is central to the quality of the residence. One of the most frequent questions asked by service providers is about the most efficient ratio between staff and number of residents. The common knowledge is that staff efficiency in small residences is associated with quality, the model of residence (group home or apartment) and the residents' level of functioning.

The quality of staff in residential facilities is related to other organizational aspects, such as: the structuring of job patterns, the chain of command in the organization, and the satisfaction of the staff, all of which are measurable.

A visible evaluation model is the cost-benefit, that matches clients' optimal benefits with minimal cost. This is not an easy task, as parts of the benefits are quite difficult to translate into objective measures. Despite this

difficulty, the use of this model of evaluation is recommended (Schalock and Thornton, 1984; Yates, 1985).

Implications

The development of community residences for individuals with developmental disabilities in Israel requires systematic evaluation using instrumentation reviewed here. The end product of the evaluation will improve the quality of residential services provided for the population above.

On the macro level, there is a need to clarify the policy of residential care for persons with mental retardation, including the definition of goals and the activities necessary to attain them. It is quite difficult to construct evaluation at the micro level without responding to the question of how the specific program relates to the macro policy. The lack of a data base on persons with mental retardation is an obstacle to the formulation of policy regarding residential services.

The need for evaluation is important for the public because the allocation of resources for the development of residential services should reflect the demand for it. It is recommended that service providers of residential services be required to evaluate their programs. The use of evaluation research may improve the quality of existing services and the planning of new services. For example, the evaluation of residents' level of progress may give a clue to the question of how urgent the need is to transit them to a higher level. Furthermore, ongoing evaluation of the residents may help service providers plan special services for an aging population. In addition, the evaluation of physical and social ecology of the residence may provide answers to questions regarding the need to enhance normalization and integration of the residents, such as: What are the preferable environments in which to open community residences? How many residents should live in residential facilities to ensure ecological harmony?

Systematic-organizational evaluation is critical to determine standards. What should be the resources needed to ensure quality of services for each residential model? The Ministry of Labor and Welfare should adopt such type of evaluation and, in particular, cost-benefit analysis. Such analysis may help determine the standards and the costs of all community residential programs. In addition, systematic-organizational evaluation may help the Ministry of Labor and Welfare in supervision and control.

Evaluation at the micro level can be helpful in running an individual facility. It is important that the social worker in charge, along with the director, periodically evaluate the progress of each resident and develop

individual programs for each resident. In addition, each director may assess the ecological harmony of the residences and learn what changes are needed in respect to budgeting, staff and management.

It is equally important to evaluate the residential unit in terms of budget and organization. The provider should know whether the program operates in deficit and if so, what steps are needed to improve it. It is our belief that proper evaluation will provide the key for rational planning and required change.

The use of evaluation methods and instrumentation needs experience and guidance. It is necessary that at the initial phase the evaluation be carried out by professionals or academics. There is also a need to standardize the measures presented here and adapt them to Israel. It is our assumption that policy makers as well as administrators of residential facilities will adopt evaluation because of its merits.

Bibliography

Baker, B., Seltzer, G. and Seltzer, M, (1977), *As Close as Possible: Community Residences for Retarded Adults,* Boston: Little Brown.

Bellamy, G.Y., Newton, J.S., LeBaron, N. and Horner, R.H. (1990), "Quality of life and lifestyle outcomes: A challenge for residential programs", in: R. Schalock (ed.), *Quality of life: Perspectives and Issues,* Washington: DC: American Association on Mental Deficiency, pp. 127-137.

Brown, M., Diller, L., Fordyce, W., Jacobs, D. and Gordon, W. (1980), "Rehabilitation indicators: Their nature and uses for assessment", in: B. Bolton and D.W. Cook (eds.), *Rehabilitation Client Assessment,* Baltimore: University Park Press, pp. 102-117.

Bruininks, R.H., Hill, B.K., Weatherman, R.F. and Woodcock, R.W. (1986), *Inventory for Client and Agency Planning (ICAP),* Texas: DLM Teaching Resources.

Bruininks, R.H., Woodcock, R.W., Weatherman, R.F. and Hill, B.K. (1985), *Development and Standardization of the Scale of Independent Behavior,* Allen, TX: DLM Teaching Resources.

Conroy, J.W., Bradley, V.J. (1985), *The Penhurst Longitudinal Study: A Report of Five Years of Research and Analysis,* Philadelphia, Temple University Developmental Disabilities Center and Boston Human Services Research Institute.

Conroy, J.,W., Efthimiou, J. and Lemanowicz, J. (1982), "A matched comparison of developmental growth of institutionalized and deinstitutionalized mentally retarded clients", *American Journal of Mental Deficiency,* 86: 581-587.

Crapps, J.M., Longone, J. and Swaim, S. (1985), "Quality of participation in community environments by mentally retarded adults", *Education and Training of the Mentally Retarded,* 20: 123-129.

Ehler, W.H., Prothero, J.C. and Longone, J. (1982), *Mental Retardation and Other Developmental Disabilities: A Programmed Introduction,* Columbus, Ohio Charles E. Merril Publishing Company.

Flynn, R.J. (1980), "Normalization, PASS, and service quality assessment: How normalizing are current human services?" in: R.J. Flynn and K.E. Nitsch (eds.), *Normalization, Social Integration and Community Services,* Baltimore: University Park Press, pp. 323-359.

Hill, B.K., Lakin, K.C. Bruininks, H.R., Anderson, D.J. and Copher, J.I. (1989), *Living in the Community: A Comparative Study of Foster Homes and Small Group Homes for People Who are Mentally Retarded,* MN: University of Minnesota.

Heal, L.W. and Chadsey-Rusch, J. (1985), "The lifestyle satisfaction scale (SLL). Assessing individuals' satisfaction with residence, community setting, and associated services", *Applies Research in Mental Retardation,* 6: 475-490.

Individual Data Base, (1979), *Behavior Development Survey User's Manual,* Panama, CA: UCLA Neuropsychiatric Institute Research Group at Lanterman State Hospital.

Intagliata, J. and Willer, B. (1982), "Reinstitutionalization of mentally retarded persons successfully placed into family care and group homes", *American Journal of Mental Deficiency,* 87: 34-39.

Jacobson, J.W. and Regula, C.E. (1988), "Program evaluation in community residential setting. in: Janicki., M.P.. Krauss, M.W. and Mailick-Seltzer, M. (eds.), *Community Residences for Persons with Developmental Disabilities: Here to Stay,* Paul H. Brookes Publishing Co.

Joiner, L.M. and Krantz, G.C. (eds.) (1978), *Assessment of Behavioral Competence of Developmentally Disabled Individuals: The MDPS,* Minneapolis: University of Minnesota.

Moos, R. (1972), Assessment of psychosocial environments of community oriented psychiatric treatment programs", *Journal of Abnormal Psychology,* 79:9-18.

Moos, R. and Lemke, S. (1980), "Assessing the physical and architectural features of sheltered care setting", *Journal of Gerontology,* 35:571-583.

Nihira, K., Foster, R., Shellhaus, M. and Leland, H. (1974), *AAMD Adoptive Behavior Scale, 1974, Revision,* Washington, DC: American Association on Mental Deficiency.

Pratt, M.W., Luszcz, M.A. and Brown, M.E. (1980), "Measuring dimensions of the quality of care in small community residences" *American Journal of Mental Deficiency,* 85:188-194.

Quay, H.C. and Peterson, D.R. (1984), *Revised Problem Behavior Checklist,* Coral Gables, FL: University of Miami.

Romer, D. and Heller, T. (1984), "Importance of peer relations in community setting for mentally retarded adults"; in: J.M. Berg (ed.), *Perspectives and Progress in Mental Retardation,* Vol. I:*Social, Psychological and Educational Aspects,* Baltimore: University Park Press, pp. 99-107.

Rosen, M. Simon, E.W. and McKinsey, L. (1985), "Subjective measure of quality of life", *Mental Retardation,* 33:31-34.

Schalock, R.L., Keith, K.D. and Hoffman, K. (1990), *The 1990 Quality of Life Questionnaire Standardization Manual,* Hasting, NE: Hastings College, Department of Psychology.

Schalock, R.L. and Thornton, C.V.D. (1984), *Benefit-cost Analysis and Program Evaluation,* Paper presented at the Annual Convention of the American Association on Mental Deficiency, Minneapolis.

Schwartz, C. (1993), "Models of community residences for adults with mental retardation", *Society and Welfare,* 13 pp. 195-209 (in Hebrew).

Schwartz, C. (1993), "Residents of community residents and their community integration", in: c. Schwartz (ed.), *Community Residents to Adults with Mental Retardation: National Survey and Data base,* Jerusalem: Joint-Brookdale.

Seltzer, M.M., Sherwood, C.C., Seltzer, G.B. and Sherwood, S. (1981), "Community adaptation and the impact of institutionalization", in: Bruininks, R.H., Meyers, C.E., Sigford, B.B. and Lakin, K.C. (eds.), *Deinstitutionalization and Community Adjustment of Mentally Retarded People,* Washington D.C: American Association on Mental Deficiency, pp. 82-88.

Silverstein, B., Olvera, D., Schalock, R and Bock, W.B. (1984), *Allocating Direct Care*

Resources for Treatment of Maladaptive Behavior: The Staff Intensity Scale, Paper presented at the 108th Annual Convention of the American Association on Mental Deficiency, Minneapolis.

Vitelo, S.J., and Soskin, R.M. (1985), *Mental Retardation: It's Social and Legal Context,* Englewood Cliff, NJ: Prentice Hall.

Wandersman, A. and Moos, R.H. (1980), "Assessing and evaluating residential environments: A sheltered living environments model", *Environment and Behavior,* 13:481-508.

Wolfensberger, W. (1972), *The Principle of Normalization in Human Services,* Toronto: National Institute on Mental Retardation.

Wolfensberger, W. and Glenn, L. (1975), *PASS III: A Method for the Quantitative Assessment of Human Services,* Toronto: National Institute on Mental Retardation.

Yates, B.T. (1985), "Cost-effectiveness analysis and cost-benefit analysis: An introduction", *Behavioral Assessment,* 7:207-234.

THE POWER OF PHYSICIANS IN THE WELFARE STATE: ANALYTIC FRAMEWORK AND ISRAEL CASE STUDY

by Prof. Yael Yishai*

Introduction

Health, everyone's hearts desire, has been expropriated from the domain of the individual and become a public commodity, one of the responsibilities of the welfare state. The planning and provision of health services reflect political preferences and ideological leanings (Maynard, 1993). Some countries (such as Britain) have assumed direct responsibility for the provision of health services; others (like Germany) transferred the major responsibility to health funds; and yet others (like Switzerland) adapted a narrower definition of social solidarity, with considerable reliance on private medicine (Immergut, 1991). At the same time, there is today widespread consensus in all industrialized democracies that the health of their citizens should not be left to the market alone (Chernichovsky, 1993). Within this consensual framework, every country aspires to realize its particular preferences and to organize its health services in a manner which will reduce costs, increase social justice, and maximize its citizens' satisfaction. To what extent will doctors - the major suppliers of health services - be likely to thwart or advance the realization of these aspirations? An answer to this question requires prior discussion of the components, dimensions, resources, sources, and limitations of the power of the physicians.

Physicians have always been regarded with a mixture of respect and suspicion. For historical, psychological, and sociological reasons, doctors were perceived as emissaries of God, deliverers and saviors, angels in white uniforms (Jonsen, 1991). Rabbi Elazar advised his pupils: "Respect your doctor, but it's better not to need him" (Ta'anit, 3,5,6). Modern researchers have been concerned with the "tyranny of experts" (Lieberman, 1970) that physicians can exercise to prevent the state from advancing the public interest. The universality of the medical profession and the extensive

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literature that deals with the power of doctors make it possible to discuss the problem in a broad theoretical framework. The uniqueness of Israeli politics requires discussing the subject in light of local reality. This paper focuses on both these dimensions, beginning with a general discussion of the power of physicians and then reviewing the case of Israel.

The Power of Doctors: Definitions

Welfare states allocate a substantial portion of their national income to health care, ranging in the common market countries from about 6% (Denmark) to 10% (in Finland). Both in Israel and elsewhere, the issue of health is almost perpetually on the political agenda. No country resembles any other in its method of providing health services. Moreover, endless disputes about the patterns and prices of the services have created a dynamic, constantly changing system. In the 1980's many countries, among them Australia, Spain, Italy and Germany instituted basic reforms in their health systems (Rodwin, 1989). In Britain, Holland, New Zealand, Israel, and even in the United States, reforms were proposed which are in one or another stage of implementation. Despite, or because of the frequent changes, doctors hold a key position, which enables them to influence health policy in the welfare state.

Power is one of the most basic concepts in social science. Yet no method that is both theoretically pure and empirically precise has been found for measuring it. According to Max Weber's classic definition, a holder of power can change the behavior of another against the latter's will. This definition is too inclusive and does not distinguish between the ownership of power resources and their utilization - that is between power as a resource and the power that is acquired as a result of the use of the resource. The empirical and psychological difficulties involved in measuring power also make defining it difficult (Dahl, 1963). As Dahl asserted, "Even more than with power terms themselves, notions of 'more' or 'less' power were in classical theory left to the realm of common sense and intuition (Dahl, 1968:413). With regard to doctors, the research literature has distinguished between three major measures of power:

a) Professional power: One of the fundamental principles of professionalism, to which doctors also subscribe, is public service based on a sense of calling and mission (Freidson, 1986; Wilding, 1984). Because of doctors' (assumed) commitment to the public well being, society has given them a great deal of power within the confines of their professional work: control of licensing and of the granting of specialist status; supervision of the

training of medical manpower and of the contents of medical work (Bjorkman, 1982); The right to set professional standards which dictate the patterns of medical diagnosis and treatment; supervision of medical ethics (Elston, 1977); control of other health care workers; and power over the behavior of consumers - the patients.

b) Economic power: Some scholars regard doctors as an "economic class", which, like every other class, attempts to promote its own interest and preserve its material attainments (Weber, 1968). Their economic power is manifested in their ability to determine their income and its components and to influence the size and allocation of the national or regional medical budget. Doctors are also "gate keepers" who determine when a person is entitled to benefits or compensation for illness or disability (Stone, 1979). The degree to which they use their position affects how much power they possess in the allocation of national resources.

c) Political power: As a strong pressure group, doctors may also acquire political power - that is, they may determine how the health services are organized and run them in practice (Elston, 1991). Among many other things, the say in "organization" includes deciding on the composition of patient entitlements from the various health services.

From the three types of power named here, we can derive the three facets of health policy which doctors may influence: the professional facet - which entails the regulation and circumscription of the medical profession; the economic facet - which involves the budgetal aspects of the health sector; and the political facet - which involves ideological and, especially, political decisions on the structure of the health services. These components of physicians' power do not stand alone, but have a reciprocal impact on one another. Political power can lead to the transfer of considerable authority to physicians and even to the improvement of their economic status. Doctors' control of the economic junctures of the health services can affect how much political and professional power they amass.

With regard to the use of power, doctors are like all other organized social groups in democratic societies. They can allow public medicine by supporting or assisting it by their performance, knowledge, or participation in the decision making process. Or they can exert their influence by obstructing, that is by thwarting the intentions of the policy makers. In both cases, the use of power is necessary. The components and limitations of doctors' power are the subject of this discussion.

Sources of Physicians' Power in the Health Sector

The power of physicians derives, among other things, from their involvement in the various arenas of the health sector (Bjorkman, 1989). As noted above, health is not simply another personal problem, but a public issue which has high priority on the political agenda of the welfare state. An array of legislatures, governments, and investigative committees in the western world pay attention to health related issues. Four major arenas in the health sector of democratic countries can be distinguished: the political, the bureaucratic, the public, and the professional.

A. The Political Arena

In the past, medicine was a personal matter between the patient and doctor. The politicization of health services has turned health into a public commodity and increased the involvement of politicians in the provision of the service (Starr and Immergut, 1989). Welfare states allocate enormous sums to health. Most of them have a specific ministry that deals with health. Britain and Sweden represent extreme cases of the involvement of politicians in the provision of health care. In 1946, the British government passed a national health insurance law, which gave the state a key role in health care. Sweden followed suit when in 1974 it turned a system of voluntary insurance into one of obligatory insurance which encompassed the entire population. France (Wilsford, 1991), Germany (Altenstetter, 1989), and Holland (Baakman, et al., 1989) also considered introducing health service reforms which would require considerable involvement by politicians in the health policy making process. The influence of politicians on the health sector is especially felt in times of change. Since, as noted above, in most countries the health sector is generally subject to frequent changes, politicians' influence on the making of health policy has increased. Politicians set objectives for health systems and bestow legitimacy on their services. They mobilize human and material resources which compete with resources for other sectors in the welfare state and allocate them to the health sector. Politicians can act to promote change or to prevent change proposed by their opponents.

B. The Arena of the Senior Bureaucracy

When the state assumes responsibility for the provision of health services, it generally establishes an administrative authority which supervises the

provision of services and/or actually provides them. Sweden, for example, decided to decentralize the provision of services and delegated authority to local authorities to directly operate health services through regional councils. These councils are staffed mostly by bureaucrats. In the modern state, the power of the senior bureaucracy has greatly increased. The "mandarins" (Dogan, 1968) not only carry out the policies of politicians but also have considerable influence of their own on policy making and implementation. The expertise they acquire, based on their experience and seniority in the public service, their connections with interested parties, and their ability to delay or speed up the implementation of political decisions have given them enormous power, which has become a thorn in the side of those who favor representational democracy (Mosher, 1968).

C. The Public Arena

The center of gravity of representational democracy lies in the elites who are elected to govern by legal and authorized procedures. In the last two decades, there have been calls for a return to participatory democracy, which gives a great deal of weight to the public and especially to citizens who are directly concerned with the political issue under consideration. Although everyone requires health services in the course of their lives (at least at birth), the major players in the public arena are the patients who come into direct contact with the service providers. Patients' organizations are not to be found. Illness is a transient or exhausting phenomenon, which does not permit public activity, The expression "sick fund" is merely intended to sound good, since the fund does not belong to those who are ill; at best, it is only on their behalf. At the same time, the aggrandizement of participatory democracy has been accompanied by greater attention to consumer needs, even when they were not clearly formulated by the mediation of an organized interest group. For example, the people who planned the health care reforms in the state of Oregon based their list of entitlements on citizens' preferences, as expressed in public opinion surveys and at local meetings (Dougherty, 1991). Although most patients are not organized, there are two types of voluntary organizations that operate on their behalf: One consists of organizations of people who suffer from relatively non-severe chronic illnesses (i. e., diabetes), who work together to further their aims. The other are organizations whose activists are not necessarily patients, but rather persons who come together to promote a public objective (i.e., Israel Cancer Society and Enosh, which helps the mentally ill). All of these - the unorganized public, organized patients, and

groups that work on behalf of patients - act in a political-cultural context which assigns differential weight to health and illness. This context creates the framework for the activities of the authorities on health policy issues. The rise in the status of the organized associations that fight the battle of AIDS sufferers in the U.S. is an instructive example of the impact of values on the public arena of the health sector.

D. The Arena of Professional Expertise

The experts are the actual suppliers of health services. They hold the keys to the provision of these services. The more that coping is based on professional knowledge, specific training, and expertise, the greater the power of the professionals. From this standpoint, doctors enjoy a clear advantage, since not all health suppliers are "professionals" in the full sense of the word. Nurses and other supporting workers, administrative and maintenance staff, and workers in the diagnostic services (technicians and laboratory assistants) are less "professional" than their physician colleagues in the sense that it is easier to replace them. Nonetheless, they too have aspirations for professional status and the remuneration that goes with it; they also have unmediated connection with the patients, which can be exploited to influence the health system; and they too can impose sanctions which bring home their power and the dependence of the politicians on their services.

The degree of influence that doctors have depends on their ability to make alliances and rally support in each of the four sectors: the elected governmental, the bureaucratic, the public, and the professional. In several countries, the minister of health is expected to be a physician. Even if the health ministry itself is not staffed by people who specialized in medicine, anyone who holds the degree of Doctor of Medicine and is also a member of parliament (there is hardly a parliament in the modern world that does not have several MDs as members) is expected to contribute his/her expertise to the formation of health policy. Doctors regularly serve in key positions in the upper echelons of government offices that deal with health, whether health is the office's only concern or one of several matters, as in a general ministry of social welfare. Doctors serve on public committees whose function is to inspect or operate health services. Specialist physicians contribute to the design of specific policies in the area of health services (for example, policies for the prevention of cardiac illness). They head voluntary organizations that deal with health, and they take advantage of their social connections, status, and power of expression to promote their personal and

public objectives. In short, the expertise and social status of physicians has led to the fact that every arena where the political game is played in the field of health is open to them, though to different degrees (Bjorkman, 1989).

The status of doctors in the professional arena is more complex. Only rarely have they made an effort to form a united front with other groups of health care employees. The education, specialization and prestige that go with the medical degree set doctors apart from other workers whose contribution may be less vital to society and its patients. This distinction is both a source of power, for doctors control the professional arena, and of weakness, for they are enclosed in their small professional shell and do not make alliances with other interested parties in the health care field.

Environmental Conditions

The degree of doctors' influence is the subject of many studies (i.e., Eckstein, 1960; Safran, 1967; Stone, 1980; Freddi and Bjorkman 1989; Wilsford, 1991; Immergut 1992). Their conclusions can be summed up in three major categories: Doctors' power is an outcome of (a) the structure of the political system and the relationships among its components; (b) the health market sector, and (c) the resources of the doctors themselves.

A. Structure of the Political System

How much influence doctors have depends on what the research literature calls the "political opportunities structure" (Kitschelt, 1986). This term refers to the degree of openness of the political system, as measured by various criteria, and the division of power among its components. Reflection on the ability of doctors to veto political decisions has led to the conclusion that the components of the political system contribute more to their power than do their own economic and organizational resources. Immergut (1991, 1992) found that there is little manifestation of doctors' power in a parliamentary regime resting on an absolute majority and reinforced by comprehensive consensus. Sweden is a classical example of such a regime. Although the country has a system of proportional elections, Swedish political culture condemns discordant differences of opinion and discourages militant opposition of organized groups to official policy. Even issues that are highly controversial in other welfare states (such as monetary policy) are resolved by means of negotiations and compromise. There is thus relatively little disagreement around them in the Swedish political system. This constellation leaves doctors only limited room for exerting

pressure on decision makers. The failure of Swedish doctors to thwart reform (the "seven crowns reform") instituted in 1969, which sharply cut into their income and autonomy, is evidence of their relative weakness (Carder and Klingberg, 1980; Heidenheimer and Johansen, 1985).

In contrast, in a decentralized political system, where political power is divided among many different factors, doctors have splendid opportunities to influence and to accumulate power. Switzerland and the United States illustrate this principle, In Switzerland, doctors exploit referendums to promote their interests. Such referendums enable an organized group to formulate policy in accord with its preferences. In the United States, where power is divided horizontally among three federal authorities (the president, the congress, and the courts) and vertically (between the central government in Washington and the governments of 50 states), doctors have many channels through which to influence health policy (Yishai, 1992).

The theory of the political structure opportunities assumes that there is a distinction between the state and its institutions (the government), on the one hand, and society and its components (i.e., doctors' organizations), on the other. Within the parameters of "corporatism", which is a concept that is relaxant to assessing the power of doctors, the state and social organizations are partners. Corporatism is an institutional arrangement by means of which a structured partnership between public organizations (mostly economic or professional ones) and the state authorities is formed (Schmitter, 1979; Williamson, 1989). The corportatistic principles are applied through councils or committees that are made up of representatives of both the state and of public organizations, who have the authority to formulate and implement policy. The partnership between the state and interest groups is based on exchange relations: the state delegates authority to a social group in exchange for its representa-tives' agreement to waive their opposition to government proposals. Corporatism serves as an instrument for simultaneously curbing and furthering demands. Its existence depends on the readiness of the state to share its power with "outsiders" who are not an integral part of the government. At the same time, corporatistic arrangements protect the state against shocks and give it a wide range of control. This partnership also contributes to the well being of interest groups. It grants them direct and institutionalized access to important decision making centers, access which does not depend on the caprices of whoever happens to be in charge. A comparative study of doctors' power found that corporatist patterns create an atmosphere highly conducive to influence (Godt, 1987). In a country which has a tradition of

partnership between doctors and the authorities, such as West Germany, doctors are given the opportunity to influence health policy directly (Stone, 1980). Corporatist arrangements encourage the establishment of doctors' bureaus (on the model of the Bureau of Advocates in Israel). A bureau is not a voluntary body, but an organization whose establishment and operation are anchored in the law of the state. The law requires all doctors to belong to the bureau, to pay its fees, and to submit to judgment by its institutions for violations of medical ethics. The doctors' bureau has formal status in everything concerning medical legislation (which is more limited than health legislation). Those in charge have considerable authority in matters of licensing and specialization. Two western countries have such bureaus (Germany has its Arztekammer and Britain - its General Medical Council), which bestow on doctors great power over their members and, to some extent, over the government as well (Moran and Wood, 1993). At the same time, it should be pointed out that such bureaus limit the freedom of maneuver of doctors employed in the public health sector in their struggle over wages. As a result, even in countries where there is a bureau, doctors form professional associations which represent their economic interests (for example, the British Medical Association).

B. The Health Sector Market

This category consists of institutional arrangements for the allocation of health services, the values that guide these arrangements (Webber, 1991), and the economic and human resources available to them. Three major arrangements can be distinguished: (a) those whereby health services are controlled by the state or a state agency (Britain); (b) those whereby health services are supplied mainly by the private sector (the U.S.); and (c) those which combine state and public services (Holland). The particular arrangement is the outcome of the balance of political power (of which the power of doctors is one of the components), of economic forces (the capital market and technology), and of cultural and historical factors, such as the importance attributed to human life and the expected level of health care (Field, 1989). A comparative study of the power of doctors in various countries found that the doctors' organization in the U.S. (the AMA) had more power than corresponding organizations in other countries (Bjorkman, 1985). But it is not clear whether this influence is the product of the division of political power (enabling doctors to influence congressional representatives) or of the structure of the market. It seems reasonable to suppose that doctors would have more influence in countries where public

medicine is prominent, since political commitment to the provision of health services increases the state's dependence on the service providers. On the other hand, one would expect doctors' power to decrease under conditions of swelling costs and surplus medical personnel. A study of the health system in Holland found that the more technical and the less based on principles the administration's output was, the more influence doctors had (Cox, 1992). The cultural explanation adds a dimension to the power of doctors. It seems that their influence increases as health becomes a more important personal and public resource (Yishai, 1992).

C. Doctors' Resources

Discussion of doctors' resources runs the risk of being tautological. For resources not only help to create influence but are also the product of influence. This circularity is one of the impediments to establishing precise criteria for "power". The resources relevant to this discussion are the scope and quality of the medical professionals' organizations.

Doctors' associations have deep roots. Although for hundreds of years doctors were not organized and their only responsibility and affiliation were vis a vis their patients, the first organization of doctors in the world, the Royal College of Physicians, was established in England as early as the beginning of the sixteenth century, in 1518 (Berlant, 1975, p. 154). Within a short while, this organization acquired the right to grant licenses to practice medicine and to punish those who did so without authorization. In the United States, doctors organizations were formed quite close to the declaration of independence (Berlant, 1975, pp. 191-217). Three types of doctors' organizations can be distinguished. The first type is a voluntary organization whose members join it in order to promote their professional interest, to form social ties, and to attain certain benefits, such as inexpensive insurance or professional congresses. The doctors organization in the U.S. (the AMA) is a classical example of this type. It is open to all licensed physicians and there is no obligation to join or sanctions for leaving. The second type is an organization where membership is required by law, as noted above. The physicians bureaus in Britain and Germany are of this type. There is obviously no obligation to practice medicine, but anyone who wants to do so is required by law to belong to and pay dues to the doctors' professional chamber. The third type is the professional union. When doctors organize in the framework of a professional union (France provides a salient example), such unions represent all or part of the professionals employed in the public sector. A doctors' union may be all-

encompassing, embracing doctors of all specialization (general practitioners versus hospital physicians, as in Britain) or professional rank (senior versus junior). The medical unions in France and Denmark illustrate the division into sectors.

Doctors everywhere enjoy considerable prestige. The white uniform they wear bestows on them a special aura which distinguishes them from other mortals. Given this reality, doctors' organizations might be expected to translate the prestige of the profession to organizational power. At the same time, their actual power, like that of organizations in every other field, may be assessed by two major measures: their resources (members, finance, institutionalization) and their organizational cohesion (Wilsford, 1987). The control that professional associations have over their members is a major component of organizational power. The greater the organization's assets and the more cohesive it is, the greater its ability to utilize the resources of its membership to influence. In contrast, decentralization, divisiveness, and competition among doctor's associations detract from the power they can acquire and exercise in affecting public policy.

Limits on Doctors' Power

The assumption that health is not simply an individual problem but has far reaching public implications has contributed to the power of the experts charged with supplying medical services. At the same time, certain conditions developed in the welfare state that reined in the doctors' organizational power. Ten major factors that have eroded the power of experts can be discerned: a new definition of "health"; the development of alternative medicine, medical consumerism, the rising cost of medical services, the decreasing return on investments in the health system, the surplus of medical labor power, the proletarization of the profession, the bureaucratization of the profession, the development of information systems, and the standardization of medical treatment.

A. New Definition of Health

Everyone wants good health. But what good health means is different at the end of twentieth century than in the past. In modern countries, there is increasing realization that conservative medical treatment is not the only answer to health problems. To be healthy today means not only not to be sick, but also to be able to enjoy physical and psychological quality of life. This ability entails non-medical activities. Health today is predicated more

on a way of life than on laboratory findings. Preventive medicine, quite neglected by modern medicine, has acquired a central place in the health consciousness of the citizens of the welfare state. A "healthy" lifestyle is not necessarily within the compass of physicians, many of whom prefer to provide medical treatments and services which reward them with homage and monetary remuneration (Moses, 1988, p. 161). Moreover, studies have proven that changes in environment and way of life do more for health than medical treatment (Contandriopulos, 1991). Progress in the two most deadly illnesses - hearty disease and cancer - has been more related to changing the environmental conditions (reducing the level of fat and cholesterol in the blood and not smoking) than to healing methods.

B. Alternative Medicine

In the wake of the above, a network of alternative medicine (sometimes called complementary medicine) has developed in the western world, against which doctors have declared total war. Precise research findings on the scope of what is derogatively called "quack medicine" are still lacking, but in western countries alternative medicine facilities that treat specific organs (such as chiropractics) or the entire body (holistic medicine) have sprung up like mushrooms after rain. The degree of legitimization that alternative medicine enjoys varies from country to country. In Britain, for example, doctors fiercely guard their monopoly; in contrast, in the United States, several alternative medical professions (especially chiropractic) are legally recognized (Moran and Wood, 1993).

C. Medical Consumerism

Wide dispersal of medical knowledge has contributed to reducing the faith that patients once had in doctors. The stripping of the aura of mystery from the profession has resulted in a wave of legal suits for "medical negligence". Their acknowledgement of the public's right to know and their fear of such suits have led doctors to strive to defend themselves from their patients rather than to wield power over them. Moreover, for a diversity of reasons, various organized groups tend to be hostile to the medical establishment. The consumer movement, for example, is critical of the commercialization of medicine and the supposed greed of those who deal in it. The civil rights movement denounces the monopoly of doctors in the area of medical decisions and demands that patients be allowed to exercise "informed consent" based on knowledge. Doctors themselves have added their voices

to the arraignment, pointing out improper professional conduct, such as unnecessary hospitalizations (Epstein, et. al., 1987). The feminist movement condemns the humiliating treatment by "male" doctors of "female" patients (Ehrenreich and English, 1978). In his book, *Limits to Medicine*, (1978), Ivan Ilych, one of the sharpest critics of the medical establishment, goes so far as to assert that doctors have begun to greatly endanger health.

D. Rising Cost of Medical Services

In most, though not all, welfare states public expenditure on health care has risen. This growth draws resources from other social services. The United States provides the clearest example of the dramatic rise in health care expenditure (which in 1991 reached more than 11% of the GDP) alongside increasing unemployment and deepening pockets of poverty and personal misery. Since the doctors are the major producers of health services, this public expenditure is blamed on them. Although the United State is not regarded as classic welfare state, it does not totally divest itself of its responsibility for the health of its citizens.

E Decreasing Marginal Profit

The swelling costs notwithstanding, there is no statistical link between national per capita expenditure on health services and the major measure of the efficiency of these services - life expectancy. In England, for example, where per capita health expenditure is among the lowest in Europe, life expectancy is higher than in Ireland, which spends much more on medicine. Moreover, even when more is spent on health services (often without any real improvement in the health of the population), this does not guarantee consumer satisfaction (Chernichovsky, 1993, p. 12). To this should be added the increasing doubts with regard to the results. Despite evidence that survival rates with different types of treatment are similar, doctors continue to claim that only their treatment is effective, and thereby expose the imprecision of the art of medicine (Maynard, 1993).

F. The Proletarization of Medicine

Not only are there today more doctors than in the past, but many of them are wage earners, subject to the commands of those in charge. The thesis of the "proletarization" of medicine (McKinley and Arches, 1985) holds that today's doctors are employees on a production line and that this has affected their autonomy and power. They have lost their ability to control

their means of production (treatment methods) and income (which is subject to collective agreements).

G. Bureaucratization of Medicine

The doctor is not only an employee. He is also a small cog in a giant bureaucratic machine, over which he has little influence. Alongside the private medical services traditionally given to patients in the doctor's office, the modern state has seen the emergence of professionally managed medical corporations and institutes, which impose "external" controls on doctors. Researchers have concluded that doctors are not suited to management (Duran-Arenas and Kennedy, 1991; Hunter, 1992; Duran-Arenas, et al., 1992). They generally lack the professional training and the orientation required for filling senior managerial positions. The control by professional managers on giant medical corporations reduces the power of doctors.

H. Increasing Dependency on Information Systems

The age of computers has not passed over the health sector. Syndromes, diagnoses, and treatment methods are today based on advanced medical techniques supported by sophisticated computers. Increasing professional specialization and the need to huge masses of medical knowledge within a limited period of time prevent doctors from acquiring thorough knowledge in computer science as well. Doctors are thus often dependent on computer specialists. This dependency impairs their power.

I. Standardization of Medical Treatment

Finally, the type of treatment that doctors give their patients has changed. In the past, treatment was a product of judgment, born of doctors' personal acquaintance with their patients and of the professional knowledge that they amassed in their years of practice. Diagnosis and choice of treatment still rest on doctors' personal decisions, whether made individually or in a team, and this places considerable responsibility on physicians. But here too there has been a dramatic change. The need to contain costs, the accumulation of medical knowledge, and doctors' desire to avoid conflict with their patients and the law have resulted in the adoption of standard treatments, which somewhat undermine the role of doctor's judgment. The method of budgeting developed in the U.S. (DRG, Diagnostic Related Groupings) reflects the replacement of personal evaluation by a standard framework. This process, which has been termed the "deprofessionaliza-

tion" of medicine (Starr, 1982) has contributed to a reduction in the authority of doctors both as individuals and as an organized group.

Doctors' Power: An Israeli Case Study

Examination of the three types of power - professional, economic, and political - does not produce a uniform picture of the power of doctors in Israel, since in each area weaknesses and strengths coexist. Nonetheless, it seems that the doctors' greatest power is in the professional arena, while the translation of this power to economic and political terms is only partial.

A. Professional Power

Doctors can be expected to be a strong pressure group able to terrorize patients, bureaucrats, and politicians alike. A precise look at the components of doctors' professional power in Israel lends considerable support to this view, but it also reveals points of weakness. The weak points in the power of the doctors in Israel are in the control of medical education and medical ethics.

The first medical school in Israel was established in 1949 in the Hebrew University of Jerusalem. In the course of the following twenty years, three other medical schools were opened up, in Tel Aviv University, the Haifa Technion, and Ben Gurion University of the Negev. These schools were largely the product of pressure by local doctors who wanted to be associated with an institution of higher education. Various arguments were raised by those who urged the opening of additional medical schools, among them the great pressure of medical school applicants and the dearth of general practitioners who were ready to work in the outlying areas. It was also argued that a surplus of doctors was a blessing to those in the profession, who would be able to devote themselves to their patients and have time for research and advanced training (Yishai, 1990, p. 137). The Israel Medical Association (IMA) was not involved in the details of the planning and implementation of the medical training. Moreover, the curricula were set autonomously by the faculties of the various universities, which were subject to the rigid rules of the National Council of Higher Education. This council even determines - by means of its allocation of positions and other resources - the scope of the school and the number of its students.

Nor have Israeli doctors attained much control over medical ethics. The apportionment of authority between the Ministry of Health and the doctors

is not clearly set out. The Ministry handles problems of improper conduct by means of committees that are established by order of the doctors and that are made of a representative of the government's legal advisor, the person in charge of the medical professions in the Ministry of Health, and a representative of the IMA. According to the state comptroller's testimony, the level of functioning of these committees is very low. At the end of the 1980's the comptroller asserted that "complaint files were closed without any discussion at all, because of a lack of treatment for years; directives of the Director General of the Ministry regarding the preparation of the necessary orders to punish medical professionals who were found guilty and even orders signed by the Minister were not obeyed, and thus the punishment was not imposed" (State Comptroller, 1988, p. 297). It is not clear whether this impaired functioning was the result of administrative impotence or reflected the opposition of the doctors to legal procedures against their colleagues. In any case, IMA itself did not succeed in calling its members to order and imposing on them the rules of medical ethics.

The IMA has a Supreme Ethics Committee (whose chairperson and sixteen members are elected by the representatives in its general assembly), but the committee has not been effective, for two reasons: First, the committee is authorized to discuss only complaints that do not involve a criminal offense and not issues of negligence or malpractice. Secondly, the committee has the authority to lodge an official complaint against an offending doctor to the Ministry of Health; but if it does so, it would not be able to continue its own discussion of the case, since the principle of sub judice disallows simultaneously dealing with the same issue in more than one forum. Thus far, the Ethics Committee has avoided imposing severe sanctions, even within areas of its authority. Only most rarely has the IMA published a guilty verdict against a doctor in its monthly *Member's Letter.* Internal pressures and substantive reservations prevented dealing effectively with complaints against doctors. Along with this, the IMA was given a say in procedures designed to take away (or suspend) doctors' licenses. After a long struggle in which the IMA strongly protested efforts to take away its right to be involved in the trial and judgment of doctors, the legislature established a special committee, consisting of a representative of the Director of the Ministry of Health, a representative of the Legal Advisor to the government, and a representative of the IMA to hear and judge such cases. This struggle intensified the opposition of interests between the state and the doctors. The state claimed that the doctors' judgment, which was guided by the interests of their professional monopoly, could not be relied

on; the doctors claimed that the judgment of the bureaucrats, who were not "experts", could not be relied on (Yishai, 1990, pp. 103-104).

One area in which the doctors could not control their colleagues was in medical advertising. Both the Doctors' Ordinance and the IMA's rules of ethics forbid doctors to advertise their qualifications, abilities, or other virtues; except on a plaque whose dimensions and contents are precisely stipulated. Despite this prohibition, many doctors make use of the media to publicly announce activities of achievements that they believe will enhance their reputation. The IMA strongly disapproves of such behavior but has thus far not succeeded in uprooting it.

A review of the remaining components of professional power, however, indicates that doctors do have considerable power in those areas. The Doctors' Ordinance (new version, 1976) and its regulations govern the constitutional aspect of the doctors' power. The license to practice medicine in Israel is granted by the General Director of the Ministry of Health on the basis of the recommendations of an advisory committee consisting of three doctors: one a representative of the Ministry of Health and the other two doctors who are appointed by the Minister of Health from a list drawn up by the IMA. Licensing doctors in Israel is most simple. According to the law, a license to practice medicine is given to anyone who meets three requirements: he or she is an honorable person, has a medical education, and is a citizen or permanent resident of Israel. Till 1987, for the purpose of licensing, someone with a medical education was broadly defined to encompass everyone to whom an institution of higher education in Israel gave a degree (subject to the recognition of the Council for Higher Education of the same institution) as well as anyone who had studied medicine in a medical school abroad that was recognized by the General Director of the Ministry of Health on the basis of an authorized list drawn up by the World Health Organization. The ethos of immigrant absorption led to making the licensing requirements in Israel more liberal than those in any other developed country. This was corrected in 1987, with the institution of licensing tests (nostrification). The new law granted a committee of nine doctors, consisting of four representatives of the IMA's Scientific Council (recommended by its chairperson), four representatives of Israeli medical schools (recommended by the dean), and a single (MD) representative of the Ministry of Health, the authority to draw up and check the examinations. For all practical purposes, this arrangement deposited the entire subject of licensing persons who did their medical training abroad in the hands of the doctors themselves.

The matter of medical specialization is controlled solely by the doctors. The first regulations regarding medical specialization in Israel were passed in May 1960, when the Ministry of Health published subsidiary regulations (ordinances added to the Mandatory Order dealing with medicine) stipulating how and when a doctor could be granted a "specialist" degree in one of the branches of medicine. Although the initiative for these ordinances came from the Ministry of Health, they were consistent with the Scientific Council's Specialization Ordinance. Indeed, the ordinances explicitly named the Scientific Council: the Council's recommendations were to serve the General Director of the Ministry of Health as the basis for granting a qualified doctor a "specialist" degree. Over the years, more and more regulations dealing with specialization were passed. New regulations added recognized specializations to the list, set the length of study for the specializations, and gradually institutionalized the training for the "specialist" degree. In 1976, passing a specialist examination became a requirement for the "specialist" degree. This requirement gave enormous power to the Scientific Council and established its status among the public. Its power further increased in the 1990's when the doctors who had immigrated from the previous U.S.S.R. strove to join Israel's medical establishment.

The doctors' monopolistic control of the entrance into and specialization in the profession also had informal ramifications. Immigrant doctors who met the criteria that were set (20 years prior work in clinical medicine, which the Knesset's Labor and Welfare Committee reduced to 14 years) were granted a license and recognition of their specialization following their "observation" in a hospital department of ambulatory clinic for six months. The authorization of the head of the department thus had a critical impact on their professional future. In the vast majority of cases (94% of 890 doctors between 1989-1991), the immigrant doctors received licenses to practice (Nirel et al., 1993).

Doctors also have considerable, though not total, control over determining the kinds of medical diagnosis and treatment that are available. Since medicine in Israel is largely public, the employer (in cooperation with doctors) sets the medications that doctors can prescribe. Thus, for example, patients suffering from gaucher accused the managers of the health funds of getting together as a cartel to draw up uniform criteria for their authorization of a new drug to treat the illness. Even though the Ministry of Health authorized the new drug, only half of the patients with gaucher were able to get the medication through their health funds. On the other

hand, Israeli physicians are not subject to tight constraints on the treatment of their patients. They are permitted to exercise judgment based on professional criteria without being subject to administrative sanctions. The supervision of doctors who diverge unreasonably from the norms and send their patients for superfluous tests is medical rather than administrative. Moreover, the Israeli doctor determines almost unilaterally the right to life or death. Doctors staff the committees that authorize abortions and, in the absence of formal laws, it is doctors who decide on a person's right to die. The doctors claim that they are under no authority other than that of the profession. In the ongoing dispute over the patient's right to refuse medical treatment, one doctor wrote: "The considerations are medical and there is no room for other factors" (Ravid, 1993).

The power of the doctors is also evident in their control over their profession. Israeli law circumscribes the practice of medicine and restricts it, to a great extent, to doctors. This restriction also applies to the doctors themselves: "A licensed doctor may not engage in any other trade, commerce, or commercial enterprise" (Doctors' Ordinance, Chapter 2, par. 10). On the other hand, persons who are not licensed physicians may not practice medicine or represent themselves, either explicitly or implicitly, as a medical practitioner. Only doctors may write prescriptions; only licensed doctors may engage in known medical activities. Regulations of the Minister of Health that were made after consultation with the IMA (and authorized by the Labor and Welfare Committee) stipulate special activities of medical practices that only authorized doctors, with pre-determined qualifications, are entitled to carry out. Thus, for example, only doctors with a specialist degree in surgery may carry out intrusive procedures.

Doctors' control of other medical professions is weaker. The Israeli legislature passed detailed regulations concerning nursing and did not place nurses under the authority of doctors. Along with this, the law explicitly stipulates that doctors are entitled to employ nurses, orderlies, and assistants under their personal supervision in connection with their professional practice. This explains the doctor's known power in the professional arena.

In summary, it seems that doctors in Israel, like their colleagues in other western countries, have considerable control over the professional side of their work. They control the licensing, specialization, and definition of their work, in practice if not in theory. The gap between theory and practice derives from the law that requires authorization by the Director General of the Ministry of Health (and in some cases also by a Knesset committee) for

activities involving the medical profession. The state apparently decided to give the Ministry of Health the last word. This phenomenon is especially striking in everything that concerns the preservation of professional integrity. The fact that the Ministry of Health has the final word before the courts on issues of medical ethics testifies to the well known lack of faith in the professional specialists. As one of the senior officials in the Ministry of Health put it: "I do not find it acceptable for the cat to guard the cream".

B. Economic Power

According to the testimony of Israeli doctors, their income is extremely low in comparison to that of their colleagues in the west. Testifying to a government investigative committee (Natanyahu Committee), Dr. Ram Ishay, the then Chairman of the IMA, presented a slew of data to document the terrible financial condition of Israel's doctors in comparison to that of both doctors in other countries and of persons in the free professions in Israel. Doctors contend that their salaries do not include special supplements for their profession of realistic reimbursement for their work related expenditures and that their wages are reasonable only because they work overtime. As a result, they claim, their income falls drastically when they retire, go on vacation, or become ill. This contention has not been unequivocally confirmed by non-doctor researchers, who point out that the data on doctors' wages in public institutions do not include income from other sources, such as private practice or additional work in the public sector (Rosen, 1989, p. 565). A different view of the matter is that the problem of doctors' earnings lies not in the doctors' relative deprivation but in the internal division of income in the doctors' community. The professional elite exercises very tight control of the promotion, work conditions, financial rewards, and training of junior physicians (Sussman and Zakai, 1991). This view is reinforced by Doron's (1992) assertion that "for years now doctors are one of the highest paid group of workers in Israel". Indeed, the public image of doctors is one of material well being, not hardship.

Although most of Israel's doctors are wage earners, it is an open secret that they have other sources of income outside the framework of the collective wage agreements. A good portion of doctors who are employed in hospitals engage in "black" medicine - giving paid, private treatment within the public institution where they are employed. Although there are no precise figures as to the scope of the phenomenon, it is evidently very common (State Comptroller, 1988, p. 247). The legal right to practice

private medicine within the public hospitals was one of the conditions that the (state employed) doctors set for their support of Minister of Health Ulmert's 1991 proposal to incorporate the hospitals (Yishai, 1994). Moreover, the practice, which is highly prevalent in U.S., of doctors referring their patients to diagnostic or treatment services in which they have a financial stake is also beginning to show up in Israel.

Have doctors translated their economic status to influence over the allocation of health resources? Health resources in Israel are allocated by the Finance Ministry, which has acquired a great deal of power in overseeing overall public expenditures. In the past, ministers of health have complained that, although it is they who are responsible for health in the country, they are rarely consulted on the health budget (Yishai, 1990, p. 51-53). If the bureaucrats in the Health Ministry have little influence on allocation, then certainly the doctors, who are not asked and do not respond, have no formal say. Along with this, doctors influence the apportionment of health resources by means of their salary demands. The strikes, sanctions, and work conflicts in which the IMA has engaged in the past have led to substantial wage increases (which, according to its leaders, are soon eroded). Another type of influence is that which involves the purchase of medical equipment. For instance, doctors had a great deal of influence on the opening of cardiac bypass institutes in hospitals, even when there was no material justification (Yishai, 1991).

In Israel, as in other countries, doctors make specific decisions which have broad ranging economic implications. When they determine disability percentages and entitlements to compensation, they create economic facts at the national level. In the absence of data, the economic impact of medical decisions on the economy cannot be assessed.

In short, doctors have economic power, which is anchored mainly in matters pertaining to their professional status. Though not all doctors agree, they seem to be able to affect their level of income. In the allocation of health resources, their involvement is less direct and their impact weaker.

C. Political Power

The participation of doctors in the making of Israel's health policy is also a mixed matter. The history of health policy making in Israel is riddled with abortive attempts at health legislation, some of which failed because of doctors' opposition. In 1973, a health insurance bill was presented to the Knesset. Doctors did not participate in the proposal and were not involved in formulating it. The then chairman of the IMA, Dr. Noah Kaplinsky,

sarcastically declared "health is too serious to be given over to doctors" (Yishai, 1990, 193). Things reached the point where IMA representatives had to plead with the Chairman of the Knesset committee that was discussing the bill to invite them to committee meetings. The process was controlled entirely by the political system, which allowed only a narrow crack for the medical professionals. Complaining about the political parties' enormous influence over health policy, the Chairman of the IMA, asserted that, "a non-partisan voluntary organization like the Medical Association has zero influence. This is the situation even when the law is meant to designate the entire way that doctors work in the future" (Ishay, 1976).

In 1981, the Knesset discussed another national health insurance proposal. Although the Minister of Health (Eliezer Shostak) promised that no bill would be formulated, devised, or completed without continuous consultation with "the interested parties", the IMA was again forced to look for opportunities to express its opinions on a matter "which will have a direct impact on the doctors as individuals and on the entire image of medicine" (Ishay, 1981).

In both cases, it was known that the IMA opposed the Minister of Health's proposals. In both cases, it remained outside the decision making clique. On the other hand, the IMA did succeed in thwarting the passage of the first two versions of the health insurance bill. For this purpose, it was assisted by parties whose support was essential to the survival of the government coalition (Yishai, 1990).

While this paper was in the writing (1993), the Knesset passed the first reading of the third version of the national health insurance bill. This bill too was drafted without the participation of the IMA. This time, however, the channels of discourse between the doctors and the Ministry of Health were considerably widened - among other reasons because there was no disagreement on principle between the Minister and the IMA.

A similar dialogue occurred when the issue of the incorporation of the hospitals was on the Ministry of Health's agenda. One of the major conclusions of the Natanyahu Committee was that the hospitals in Israel should be no longer managed by the state or the General Sick Fund but be granted administrative autonomy. Since the first stage of the plan involved only five government hospitals, the Ministry of Health conducted negotiations with the state-employed physicians (which is a branch of the IMA). The cooperation between the two bodies - the Ministry of Health and the doctors' organization - was greater than in the past, mainly because

they managed to draw up a framework of mutual advantages that were consistent with the interests of both sides.

In summary, it seems that the political influence of doctors in Israel is not institutionalized and is not anchored in permanent arrangements. While the channels of dialogue between the doctors and the state authorities have been widened in recent years, it is not clear whether or not this dialogue indicates an increase in the doctors' influence. Nor is it clear whether the change in the pattern of interaction is the product of (chance) agreement on principles, of successful negotiations based on give and take, or of the politicians' recognition of the doctors' power.

Components of Israeli Doctors' Power

A. The Arena

In general, Israeli doctors do not get involved in party politics. Thus far, only one doctor has been a cabinet minister. Up through the 12th Knesset, the number of Knesset members who had a medical degree could be counted on the fingers of one hand (Dr. Moshe Sneh, Dr. Ben Zion Harel, Dr. Shimshon Unitchman, and Dr. Haim Kanovitch). The number rose sharply in the 13th Knesset, where three doctors (Dr. Gonen Segev, Dr. Yoram Lass, and Dr. Ephraim Sneh) were members. Although not all the Knesset members who are doctors deal with health, some of them are active in this area. The issue of the representation of doctors in the senior bureaucracy is more complex. Israeli law requires that the Director General of the Ministry of Health and the medical administrators of the government hospitals be medical doctors. Moreover, doctors serve on the important investigative committees that made recommendations on health matters. On the other hand, these appointments have not necessarily been made on the recommendation of the IMA. The doctors who served in the senior bureaucracy (or as members in important committees) were chosen on a personal basis and not on an organizational group basis. Their selection does not necessarily reflect the "power" of the doctors as a group, but rather the skills, experience, and opinions of the individual physicians.

Do doctors enjoy the support of public opinion in Israel? This question does not have an unequivocal answer. The fact that the IMA utilizes the services of a large public relations firm and publishes huge newspaper ads when there are labor disputes testifies to its desire to win wide public support. But in the absence of public opinion surveys querying patients'

confidence in their doctors and people's support for doctors' actions, it is difficult to know how much support they actually enjoy.

B. Environmental Conditions

Israel has a centralized government and powerful political parties. The parties staff public offices with their people and have considerable influence on the making of public policy. The IMA, which is apolitical, finds it difficult to integrate into the foci of power. The pattern of territorial democracy is developing slowly (one of its signs is the push for electoral reform to place representation on a narrower regional basis); but there is not yet any demand for functional democracy which enables persons with professional expertise to be partners in the policy making process. The structure of the government in Israel thus works against the doctors.

Several characteristic signs of corporatism can be found in Israel. Israel's interest groups are centralized and monopolistic (there is only one manufacturer's association and only one labor federation), well organized, and powerful. At the same time, Israel lacks the institutional arrangements for state cooperation with voluntary organizations, and lacks too any readiness to share its power with "outsiders" (Yishai, 1991a). All the IMA's demands to establish a doctors' bureau (which have lately been made more softly) have met with failure. Only lawyers have received the special status of a statutory "bureau" which enjoys institutionalized cooperation with the state. Moreover, particularistic demands still tend to be delegitimized in Israel, though less than in the past. When teachers strike, they try to avoid "harming the educational system in Israel" (from a newspaper ad published in April 1993 during a teachers' strike); when doctors strike they express anxiety about the level of health.

Although "public" phraseology is also prevalent in other countries, in Israel, where collective values still hold, it is more common and considered more legitimate. This public ethos militates against the exertion of power by a group even if the group represents those who are considered a social and professional elite.

C. The Health Sector Market

Israel's health system is one of the political islands that survived after the parties abandoned their social functions. At least until quite recently, decisions and arrangements involving health care were guided by party considerations. The fact that the largest health insurer in Israel - the

General Sick Fund - was in practice an organizational arm of a political party has left its imprint on the country's health sector market. It has naturally blocked channels of influence for doctors, who are not considered an electoral group whose support must be courted.

Another factor that has undermined doctors' power is the surplus of doctors in the work force. Israel has always had a surplus of doctors. The last official census of doctors, published in the 1983 Statistical Yearbook, counted 11,895 doctors. According to international data, Israel has one of the highest proportions of doctors in the population - and did even before it was inundated by the recent wave of immigrants from the former Soviet Russia (World Development, 1991, p. 259). The percentage of doctors among the immigrants (2.5%) is much higher than their percentage in the veteran population (0.35%). Between September 1989 and July 1992, 10,450 persons who declared themselves doctors arrived in Israel from the former U.S.S.R. By the end of 1992, only about 2,900 doctors had received permits to practice in Israel (Nirel et al., 1993). Yet despite the difficulties, many of them have been absorbed in the labor market. According to IMA's Scientific Council figures, more than half the immigrant doctors have passed the licensing exams (Schenker, 1993). Others are still waiting in line for a place of observation or are still taking preparatory courses (funded by the state) leading to a relatively high percentage of students who pass the exam. These figures indicate that Israel is inundated by doctors, without either the state or the IMA doing anything to stem the flood. This inundation contrasts sharply with the trend in most western countries to limit the number of doctors by reducing the size of medical schools and imposing strict restrictions on the immigration of doctors (Moran and Wood, 1993). In theory, the surplus should reduce the power of the doctors in Israel. In the meantime, however, it has not. The disparity between the prestige and reputation of the doctors who graduated from medical schools in Israel (or a western country) and those from the Soviet Federation has simply left the former in complete control of the profession.

If the over-supply has not detracted from the doctors' power, the norms within which they operate are less cozy. Although Jewish tradition regards life as holy ("he who saves one soul saves the whole world") and Israelis according to public opinion surveys ascribe great importance to good health, health as a political resource is not at the top of the agenda. Israeli politics is dominated by the issue of security. A cursory analysis of the contents of the written and electronic media points to the salience of this subject. From time to time, when a minister with initiative takes office,

there are also extended discussions of health. But such discussions are also overshadowed by problems of security and the peace process. Some ministers of health have been more involved with foreign policy than medical problems; others have looked for chances to move to a more "important" and less complex ministry. Moreover, health was not perceived in the past as a goal in and of itself, but rather as a means of building and settling the country. The General Sick Fund was founded to provide mutual insurance and to enable the Jews in Palestine to actively participate in conquering the desert and making it bloom. This picture is totally different from the state of affairs in the U.S., where health has become a personal cult which requires a large investment of time and resources.

Doctors' Resources

The IMA is one of the oldest and best established organizations in Israel. At its inception in 1912, its founders debated whether it should be an organization of doctors who joined together to promote their economic and professional interests or a medical organization occupied chiefly with medicine. In the end, they decided to adapt both aims. The IMA is the representative organization of Israeli doctors both in law and in actuality. This fact has become a thorn in the side of the General Federation of Labor, which is displeased that doctors are represented by a body of their own. Even though the IMA does not have the status of a bureau, the state authorities recognize it as the doctors' sole representative. The Scientific Council, one of the IMA's most prestigious institutions, is in charge of preserving the level of medicine in Israel. Its representatives are members of licensing committees, prepare the specialization exams, and set restrictions in practicing in the profession.

The IMA is extremely "dense" in terms of the ratio of actual members to those who are eligible for membership. Not much under a hundred percent of those who are eligible for membership actually belong to the organization. There are various reasons for joining, including to get a doctor's parking sticker, to participate in tenders, and to receive information about conferences and advanced training, and, above all, for the feeling of belonging to the medical community. At the same time, membership also has an involuntary basis. Since it is the doctors' recognized representative, its dues are automatically deducted from salaried doctors' wages (who make up most of the membership). It has a centralized organizational structure. The branches have no influence on the administration or decisions of the organization. Its regulations (which were

changed several years ago, see Yishai, 1987) set out the rights and duties of the members, the structure and functioning of the elected institutions, and the status of the secondary units. The IMA has several organs that are distributed to the members.

Its size and scope are the IMA's Achilles heel. In its organizational life, the IMA illustrates the curse of abundance. It encompasses all the doctors in Israel, in all specialties, places of work, and ranks. Despite the fact that most doctors in Israel are employed in public institutions, there are great differentiations based on disparate and sometimes conflicting interests. This fact creates strong internal tensions. The major split in the organization is on the basis of place of work rather than specific occupation. It would seem that the greatest conflict of interest should be between the clinic doctors (family medicine) and the hospital doctors. But in fact, the widest organizational gap is between the doctors who work for the General Sick Fund (about 43% of the members) and those employed by the state (about 35% of the members). Despite the fact that some Sick Fund doctors are hospital doctors, the sectoral interests related to place of work are stronger than the professional interests related to medical occupation.

The internal split in the IMA led to its changing its regulations so as to reflect the rising power of the "organizations", as its sub-units are called. The new regulations (adopted in 1985) gave the sub-organizations considerable autonomy. They collect dues and are entitled to decide on the method of election to their institutions. They are also entitled to conduct separate negotiations with employers when the matter concerns only them. (The negotiations on the incorporation of the hospitals that were conducted between the Ministry of Health and the State-Employed Doctors Organization are an excellent example). The power of the organizations is manifested mainly in the composition of the IMA's institutions, especially its Central Committee. Although the regulations stipulate that a committee member "is not subject to any authority other than his conscience, the rules of ethics, and the laws of the state", and members are elected by the General Assembly, the Central Committee's composition is determined "on the basis of an agreed-upon key which takes into account the relative number of the representatives who were elected by the organization in relation to the number of members of the central committee" (IMA Regulations). Another paragraph in the regulations deals with the conflicts of interests in the IMA. It stipulates that in the event of a dispute between the organization and an IMA institution, the organization is entitled to act independently only if it gets a special majority of 80% of the Central Committee.

Although the IMA tries to maintain a united front, it has difficulty in rallying the support of its members on many matters, especially those that involve health policy principles. Many of its decisions are thus compromises that lack teeth, which express wide consensus that cannot be translated into operational terms. Israel's doctors prefer a loose, federated framework to give them the benefits of unity. The price they pay for this framework is organizational weakness. In one area, however, the IMA has managed to form a united front: work conflicts with the public employers. During its lifetime, the IMA has been involved in more than twenty strikes, among them the large 1983 strike, whose history and course have been the subject of many studies (for example, Ishay, 1986). All in all, there were very few strike violations. Although decisions on work stoppages are generally made in the Central Committee, the rank and file have generally carried out its directives. In the matter of labor conflicts, the IMA had managed to show cohesion, which results in "power".

Limits of Doctors' Power in Israel

How extensive are the limitations on the power of doctors in Israel? Examination of the criteria presented above shows that the various components of doctors' power have eroded less in Israel than in other western countries.

Israeli citizens are not as absorbed in the cult of health as others in the west, even though they visit doctors relatively often.[1] Most have not adopted the principles of preventive medicine that are accepted in other industrialized countries. The percentage of smokers in Israel is among the highest in the world (Yishai, 1991, p. 135). The public parks in the large cities are not filled with joggers worshiping the cult of physical fitness. In the main, Israelis try to keep health with the help of prescription drugs (in enormous quantities) and not by changing their lifestyles. The "new definition" of health has not significantly changed Israelis' lifestyles.

Alternative medicine is gradually spreading in Israel, but much more slowly than in the rest of the western world. In the absence of research that documents the scope of alternative medicine, this assertion is based only on impression. Nonetheless, a look at the *Yellow Pages* indicates that in Haifa,

1. The average per capita number of doctor's visits in Israel is 8/4 a year, in comparison to 4/8 in the U.S., 3.6 in Canada, and 3.2 in Holland (*Medical Service in Israel*, 1988, p. 63).

a city of a quarter of a million people, there are only five "natural" food stores and only six homeopaths. These figures, which provide only a gross indication, show that alternative medicine although on the rise, is still quite thinly dispersed.

By the same token, medical consumerism is developing at a very measured pace in Israel. Although the number of lawsuits for medical negligence has risen in recent years (there are no precise figures), they are not the plague that they are in the U.S., and they do not impose a heavy economic burden on the health institutions. Here and there one hears grumblings about medical ethics in Israel (especially noteworthy are the books by Dr. Nudelman, 1985, 1986; see also the *State Comptroller's Report* cites above). But there is no movement whose major aim is to criticize doctors and their activities. The relative lack of public activism is not unique to the health sector. The consumer movement, the feminist movement, and the environmental movement in Israel all suffer from chronic weakness. The known passivity of the Israeli citizen, the control by the state (and political parties) of political and social life, and the salience of the issue of security have led to the marginalization of issues related to the quality of life or to their being handled by the long, conspicuous arm that stretches from the halls of government in Jerusalem.

The cost of medical services in Israel in 1991 was 7.9% of GDP. Compared to costs in Europe, this sum is higher only than Denmark's (5.6% of GDP in 1987) and Britain's (6.1% of GDP in 1984) (*The Health System*, 1986, p. 62). Although Israel's national expenditure on health has risen both in absolute and relative terms, the situation does not evoke concern. Moreover, according to data by the Center for Social Policy Research in Israel, the government's share in the production of health services has dropped significantly while that of the private sector has risen. The greatest decline was in two major components of government expenditure on health: general subsidies for non-governmental health facilities and allocations for general hospitalization (Weinblat and Blankett, 1993, p. 45). It thus appears that cutting public costs of health services is not a cardinal, high priority objective.

The decline in health sector costs has not affected the quality of medicine, whose major test is life expectancy. Israeli citizens enjoy a long life expectance, especially men.[2] This is an impressive fact given the special

2. Male life expectancy in 1985 - 73.1 - was higher than in any European country. Female life expectancy - 76.6 - was lower than in most European countries.

problems of the Israeli population, which has a high proportion of Holocaust and war refugees and of immigrants from countries (such as Ethiopia) with particularly low levels of health and shaky security situations. Israel's demographic achievements are to the credit of the health system in general and the doctors in particular, and have bolstered their prestige.

As already indicated, one of the main sources of weakness of the doctors in Israel is their surplus, unparalleled in any western country. This surplus, however, has not overburdened the system, for three reasons: Firstly, the increase in the number of doctors has been matched by an increase in the number of patients. A known economic fact is that the medical market creates itself and adjusts the demand to the supply. Secondly, the doctors themselves control the health market, since, as explained above, the legislator deposited in their hands the keys to licensing. Thirdly, the labor market has not responded positively to the addition of doctors. Even when the immigrant doctors succeed in passing the exam, the road to getting a job is still long. For these reasons, the surplus manpower has not caused a serious decline in doctors' power.

The above description of the proletarization of medicine is quite germane to Israeli doctors, a large proportion of whom are employed as wage earners in public institutions. Yet here too a reservation stemming from the changing reality may be added. Figures indicate an impressive rise in private medicine. Between 1978 and 1986, the number of admissions to private hospitals increased by 9.4% a year, while the rate of admissions to all the general hospitals in Israel rose only by 3.7% annually (Health Ministry, 1988)). There has also been an (undocumented) increase in the number of doctors who are involved in group practices. Thus, while the status of Israeli doctors is low insofar as they are wage earners in public institutions, more and more of them have private practices where they work as free professionals.

The fact that a large proportion of Israel's doctors are employed in public institutions means that they are subject to a management that is not always medical. Although the heads of hospitals and clinics are doctors, doctors do not always play key roles in decision making, as this is the province of the political leadership. On the other hand, most Israeli doctors are subject to a medical, not a managerial, hierarchy. Department heads in Israel's hospitals serve for an unlimited term and cannot be dislodged. In a letter published (anonymously) in the IMA monthly, *Members' Letter,* a doctor complained of the "god syndrome" of the department head, whose decisions cannot be

appealed, whose actions cannot be criticized, and whose major feature is the feeling that "there is no limit to the ability to rule" (Anonymous, 1986). In short, it seems that it is not bureaucratization that sullies doctors' prestige, but the differences in authority within their own community.

In Israel, as in other western countries, computers and data systems are widespread. But in Israel the split between doctors and patients is caused not by the computer but by the medical system. One of the major complaints about the Israeli medical system is that patients have only very limited freedom of choice. Until quite recently, they were not allowed to chose their doctor, treatment facility, or treatment method. The patronizing attitude towards the citizen that characterized the state authorities was also evident in the medical sector. In the framework of discussions on reforming Israel's health system, there had been talk of emphasizing freedom of choice, which is regarded as essential to the building of trust between patients and those who treat them. The anonymity that typified the medical process, it was claimed, does injustice to both doctor and patient. In any event, this anonymity is not the outcome of the introduction of computerization into the health sector but rather of basic norms whose source is in the early years of Jewish settlement in Israel. It has now been eroded by the introduction of the National Health Insurance Law that enables a free choice of sick fund to every Israeli citizen.

The standardization of medical treatment (DRG) was also discussed in the context of the recent efforts to change in the health system. In the meantime, however, this is largely a vision of things to come. It does not seem that standardization constitutes a present danger to the power of Israel's doctors.

Conclusions

The above discussion focuses on two main questions: 1. How much power do doctors have in the welfare state in general and in Israel in particular? 2. What are the sources and limitations of this power? The answer to the first question (how much?) entails both empirical and normative dimensions: Do doctors have power? And is it a good thing for doctors to be able to influence the making of health policy? The examination of the power of Israel's doctors in the context of the general analytic framework leads to three sets of conclusions regarding the nature and sources of their power.

A) The doctors' power is manifested mainly in the professional arena. Doctors have monopolistic control of the entrance to the profession and of its boundaries. As in Europe (but not the United States), this control is

centralized and in the hands of a single body. On the other hand, in contrast to many European countries, Israel's government has not entirely removed itself from the management of professional matters relating to doctors. To date, the authorities have obdurately refused to grant the IMA the status of a bureau or exclusive control over licensing and specialization. This refusal may stem from a long governmental tradition of concentrating authority in the state itself and not delegating it to other bodies. Alternatively, it may be that, in practice, the Ministry of Health plays only a formal role in these matters, which has no meaning in the decisions that are actually taken. The doctors' control of professional matters may not be total from a legal point of view, but in real terms it is alive and well.

On the other hand, the above analysis points to the doctors' apparent political weakness, marked by their very marginal involvement in the making of health policy. This does not mean that the doctors have not succeeded in obstructing policies to which they objected, but rather that their success was out of the ordinary and would not have occurred without the substantial involvement of some of the political parties. Despite their political weakness, the doctors managed to thwart the state's first two efforts to pass a national health insurance law. The IMA's influence was limited, however, to frustrating government intentions. The government never availed itself of its members' expertise to formulate a more rational and efficient policy.

With regard to the economic aspect of the doctors' power, here too the picture is mixed. Doctors are subject to country-wide wage agreements and do not directly influence the allocation of health resources. On the other hand, they have considerable indirect influence (as individuals more than as an organization) on the way these resources are apportioned after their sum is set by the Finance Ministry. Moreover, although doctors complain about their low wages and low status compared to other doctors in the west (which indicates low influence), the increased legitimization for combining private practice with public employment and the expansion of private medicine dwarf the significance of this weak spot in the doctors' power.

B) Examination of the components of the doctors' power shows a complex picture. Doctors tend to enclose themselves within the walls of their profession and to remain aloof from the other arenas of the health system. They tend not to get involved in politics and rarely appear on public forums unrelated to their professions or express opinion on problems that have "political" overtones. In recent years, a group of doctors founded an organization of doctors aimed at improving the health services in the

territories (Association of Israeli and Palestinian Physicians), but this body has no impact on the status of doctors in Israel. Moreover, when doctors serve in the medical bureaucracy, they generally adopt a "public" approach which is not necessarily consistent with their own particular interests.

Nor have political conditions in Israel been kind to doctors. Israel's political system is not marked by any excessive openness and does not tend to share its powers or authorities with outside bodies. This government culture is not confined to the health sector. Doctors, like other experts, are not natural partners in public policy making. Israel's political tradition regards professionals not as experts entitled to take an active interest in areas concerning their own interests, but rather as "agents" of the society whose function is to see to the realization of national goals. Even though many features of this tradition no longer hold, it is still too deeply rooted to be totally extirpated. Israel's political system is centralized, rigid, and difficult to change.

C) A detailed look at the factors that have led to the erosion of doctors' power in the west has failed to find many parallels in Israel. On the contrary: In Israel, the conservative definition of medicine is still quite prevalent; there is no real protest on the part of ecological, consumer, and other organizations; and alternative medicine is spreading very slowly. Nor are the economic dimensions of the erosion always relevant to Israel. Although Israel is inundated by doctors, the number of applicants to medical school is still very large and the profession still has considerable prestige. Moreover, several Israeli universities now have programs for training professional in medical administration and the Scientific Council recognizes administration as a medical specialization - factors which have contributed to blurring the boundaries between medicine and administration.

Thus, the main conclusion that emerges is that, despite the fact that Israeli doctors have considerable control over the professional arena, and even though the worldwide developments that have led to the erosion of the status of doctors are less relevant to Israel than other western countries, the only area in which Israel's doctors have managed to translate their power to real influence is in matters related to the regulation of their profession and that they have been much less successful in matters related to health policy. Moreover, the economic power of Israel's doctors is confined to a relatively limited portion of the medical community, and has not been translated to influence in the allocation of health resources. The doctors' lack of political power has three main drawbacks: it frustrates the doctors, it impedes (or

has impeded) the state's making changes in the health sector, and it deprives the public of the benefit entailed in policy making based on cooperation with experts. These conclusions suggest the normative approach to the problem of the power of the doctors. The need for doctors' participation in the making of health policy derives not only from their control of knowledge but also from the democratic assumption that every person who is affected by government decisions has the right to take part in making them. This generalization is particularly pertinent to experts whose contribution of knowledge and support is so vital to running the state. This does not mean that the state should give doctors, who were never elected and are not accountable to the voter, the power of decision. There is always the concern expressed by Titmus many years ago, that professionals will not show the public responsibility that is required by their control of the service or that they will focus first and foremost on furthering their own interests (Titmus, 1958). This concern, however, should not prevent the development of reciprocal relations between the state and doctors, which will make it possible to integrate expertise with an understanding of social priorities in accord with the principles of the welfare state.

Bibliography

Altenstetter, C. (1989), "Hospital planners and medical professionals in the Federal Republic of Germany". in: G. Freddi and J.W. Bjorkman (eds.), *Controlling Medical Professionals. The Comparative Politics of Health Governance,* London: Sage.

Altenstetter, C. and Haywood, S.C. (eds.) (1991), *Comparative Health Policy and the New Right. From Rhetoric to Reality,* London: Macmillan.

Anonymous (1986), *A Letter to the Member,* September (in Hebrew).

Aridor, E. (1993), "Cure by Monopoly", *Haaretz,* May 4 (in Hebrew).

Bakkman, N., Van der Made, J. and Veeman, I.M. (1989), "Controlling dutch health care", in: Freddi and Bjorkman, *op. cit.*

Berlant, J.L. (1975), *Professions and Monopoly,* Berkeley: University of California Press.

Bjorkman, J.W. (1982), "Professionalism in the Welfare State: Sociological savior of political pariah?", *European Journal of Political Research, 10*:407-428.

Bjorkman, J.W. (1985), "Who governs the health sector? Comparative European and American experiences with representation, participation and decentralization", *Comparative Politics,* 17: 399-420.

Bjorkman, J.W. (1989), "Politicizing medicine and medicalizing politics: Physician power in the United States", in Freddi and Bjorkman, *op. cit.*

Carder, M. and Klingberg, B. (1980), "Toward a salaried medical profession: How 'Swedish' was the Seven Crowns Reform", in: A.J. Heidenheimer and N. Elvander (eds.), *The Shaping of the Swedish Health System,* London: Croom Helm.

Chernichovsky, D. (1993), "Health system reforms in industrialized democracies: An emerging paradigm", *Social Security,* 39: 5-38 (in Hebrew).

Contandriopoulos, A.P. (1991), "Regulation and performance of health systems", in: World

Health Organization, *Organization and Financing of Health Care Reform in Countries of Central and Eastern Europe*, Report on a meeting held by WHO, Geneva, 22-26 April.
Cox, R.H. (1992), "After corporatism. A comparison of the role of medical professionals and social workers in the Dutch welfare state", *Comparative Political Studies*, 24: 532-552.
Dahl, R.A. (1963), *Modern Political Analysis*, Englewood Cliffs, N.J.: Prentice Hall.
Dahl, R.A. (1968), "Power", *International Encyclopedia of Social Sciences*, 12: 405-414.
Dogan, M. (ed.) (1975), *The Mandarins of Western Europe The Political Role of the Top Civil Servants*, New York: Halstead.
Doron, A. (1992), "The health service in Israel: The prospects for the 1990s", *Social Security*, 38: 5-26 (Hebrew).
Dougherty, C.J. (1991), "Setting health care priorities, Oregon's next steps", *Hastings Center Report*, May-June.
Duran-Arenas, L. and Kennedy, M. (1991), "The constitution of physicians' power: A theoretical framework for comparative analysis", *Social Science and Medicine, 35: 643-648.*
Duran-Arenas, L., Asfura, M.B. and Moran, J.F. (1992), "The role of doctors as health care managers: An international perspective", *Social Science and Medicine*, 35: 549-555.
Eckstein, H. (1960), *Pressure Group Politics: The Case of the EMA*, Stanford: SUP.
Ehrenreich, B. and English, D. (1978), *For Her Own Good*, New York: Doubleday.
Elston, M.A. (1991), "The politics of professional power: Medicine in a changing health", in: J. Cabe, M. Calnan and Bury M. (eds.) *The Sociology of the Health Service*, London: Routledge.
Epstein, L., Rishpon, S. Renart, G. (1987), *Unjustified Hospitalization in General Hospitals*, Jerusalem: Jerusalem Institute for Israel Studies, no. 23 (in Hebrew).
Field, M.G. (1989), "Introduction", in: M. Field (ed.), *Success and Crisis in National Health Systems. A Comparative Approach*, New York: Routledge.
Freddi, G. and Bjorkman, J.W. (eds.) (1989), *Controlling Medical Professionals. The Comparative Politics of Health Governance*, London: Sage.
Freidson, E. (1986), *Professional Powers: A Study of the Institutionalization of Formal Knowledge*, Chicago: University of Chicago Press.
Godt, P.J. (1987), "Confrontation, consent and corporatism: State strategies and the medical profession in France, Great Britain and West Germany", *Journal of Health Policy, Politics and Law*, 10: 459-497.
Groenewegen, P.P. Jouke van der Zee, and Van Haaften, R. (1991), *Remunerating General Practitioners in Western Europe*, Aldershot: Averbury.
Health Ministry (1988), *Health System in Israel: Facts and Trends*, presented to the National Committee on Health Services. Jerusalem (Hebrew).
Health Ministry (1988), *Hospitalization and Day Care Institutions in Israel*, Jerusalem. (in Hebrew).
Heidenheimer, A.J. and Johansen, L.N. (1985), "Organized Medicine and Scandinavian professional unionism: Hospital policies and exit options in Denmark and Sweden", *Journal of Health Policy, Politics and Law*, 10: 347-370.
Hunter, D.J. (1992), "Doctors as managers: Poachers turned gamekeepers?", *Social Science and Medicine*, 35: 557-566.
Illich, I. (1976), *Medical Nemesis*, Toronto: Bantam Books.
Immergut, E.M. (1991), "Institutions, veto points, and policy results: A comparative analysis of health care", *Journal of Public Policy*, 10: 391-416.
Immergut, E.M. (1992), *Health Politics. Interest and Institutions in Western Europe*, Cambridge: Cambridge University Press.

Ishay, R. (1976), A letter to the Chair of the Knesset Committee on public services, March 9, (in Hebrew).
Ishay, R. (1981), A letter to H. Korfu, February 26 (in Hebrew).
Ishay, R. (1986), *A Doctors' Strike* Tel Aviv: Zmora Bitan (in Hebrew).
Ishay , R. (1988), *Health Service in Israel*, Presented to the National Committee on Health Services. December.
Jonsen, A.R. (1990), *The New Medicine and The Old Ethics*, Cambridge: Harvard University Press.
Kingdon, J.W., *Agendas, Alternatives and Public Policies*, Boston: Little, Brown.
Kitschelt, H. (1986), "Political opprtunity structure and political protest: Antinuclear movements in four democracies", *British Journal of Political Science*, 16: 58-95.
Lieberman, J.K. (1970), *The Tyranny of Experts: How Professionals are Closing the Open Society*, New York: Walker.
Maynard. A. (1993), "Health care for whom? Operationalyzing public preferences", *Social Security*, 39: 39-50 (in Hebrew).
McMinlay, J. and Arches, K. (1985), "Towards the proletarianization of physicians", *International Journal of Health Services*, 15: 161-195.
Moran, M. and Wood, B. (1993), *States, Regulation and the Medical Profession*, Buckingham: Open University Press.
Mosher, F. (1968), *Democracy and the Public Service*, New York: New York University Press.
Mozes, B. (1988), *Modern Medicine. Decision Making in Uncertainty*, Tel Aviv: Am Oved. (in Hebrew).
Nirel, N. Rosen, B. Ben-Nun, G. Shemesh, A, Vardi, P. (1993), "Stages in the licensing process for immigrant physicians in Israel", *Harefua*, 125: 19-22 (in Hebrew).
Nudelman, Y. (1985), *Killing in Medicine*, Beer Sheba: Hanegev (in Hebrew).
Nudelman, Y. (1986), *Without Anesthesia*, Beer Sheba: Hanegev (in Hebrew).
Ravid, M. (1993), "Doctor's Duty", *Haaretz*, April 20 (in Hebrew).
Rodwin, V.G. (1987), "American exceptionalism in the health sector, The advantages of backwardness' in learning from abroad", *Medical Care Review*, 44: 119-154.
Rosen, B. (1989), *The Public-Private Mix in Israeli Health Care*, Jerusalem: JDC.
Safran, W. (1967), *Veto-Group Politics: The Case of Health Insurance Reform in West Germany*, San Francisco: Chandler.
Schenker, J.G. (1993), "Results of medical licensing examinations 1988-1991", *Harefua*, 124: 638-640 (in Hebrew).
Schmitter, P.C. (1974), "Still a century of corporatism?" *Review of Politics*, 36: 85-131.
Starr, P. (1982), *The Social Transformation of American Medicine*, New York: Basic Books.
Starr, P. and Immergut, E. (1989), "Health care and the boundaries of politics", in: C.S. Maier (ed.), *Changing Boundaries of the Political*, Cambridge: Cambridge University Press.
State Comptroller (1988), *Annual Report for the Fiscal Year 1987*, No. 38, Jerusalem.
Stone, D.A. (1979), "Physicians as gatekeepers: Illness certification as a rationing device", *Public Policy*, 27: 227-254.
Stone, D.A. (1980), *The Limits of Professional Power: National Health Care in the Federal Republic of Germany*, Chicago: University of Chicago Press.
Sussman, Z. and Zakai, D. (1992), "Wage gaps between senior and junior physicians and crises in public health in Israel 1974-1990", *Bank of Israel*, Discussion Paper Series 92.03, Jerusalem. February.
Titmus, R.M. (1958), *Essays on the Welfare State*, London: Unwin University Books.
Webber, D. (1991), "Health policy and the Christian-Liberal Coalition in West Germany:

The conflicts over the Health Insurance Reform, 1987-1988", in: Altenstetter and Haywood, *op. cit.*

Weber, M. (1968), *Economy and Society* (G. Roth and C. Wittich, eds.), New York: Bedminster.

Weinblat, J., and Blankett, J. (1993), *Government Expenditure on Social Services*, The Center of Israel Social Policy Research, Jerusalem: March.

Wilding, P. (1984), *Professional Power and Social Welfare*, London: Routledge and Kegan Paul.

Williamson, P.J. (1989), *Corporatism in Perspective. An Introductory Guide to Corporatist Theory*, London: Sage.

Wilsford, D. (1987), "The cohesion and fragmentation of organized medicine in France and the United States", *Journal of Health Politics, Policy and Law*, 12: 481-503.

Wilsford, D. (1991), *Doctors and the State. The Politics of Health Care in France and the Unites States*, Durham: Duke University Press.

World Development Report (1991), *The Challenge of Development*, Oxford: Oxford University Press.

Yishai, Y. (1987), *Interest Groups in Israel*, Tel-Aviv: Am Oved (in Hebrew).

Yishai, Y. (1990), *The Power of Expertise. The Israel Medical Association*, Jerusalem: Jerusalem Institute for Israel Studies (Hebrew).

Yishai, Y. (1991a), "Heart disease in Israel", Curative or preventive policy?", in: Altenstetter and Haywood, *op. cit.*

Yishai, Y. (1991b), *Land of Paradoxes. Interest Politics in Israel*, Albany: SUNY.

Yishai, Y. (1992), "Physicians and the State in the U.S.A. and Israel", *Social Science and Medicine*, 34: 129-139.

Yishai, Y. (1993), *State and Physicians: Hospital Privatization in Israel*, Jerusalem: The Jerusalem Institute for Israel Studies.

THE HEALTH INSURANCE LAW: BACKGROUND, PRINCIPLES AND IMPLEMENTATION

by Shlomo Cohen* and Reuben Steiner**

A. Introduction

Untill the end of 1994, most residents of the State of Israel were insured voluntarily in four sick funds which provided medical services to 95% of the population, each fund having its own particular conditions of coverage. About 200,000-300,000 persons were not insured in any of these funds, some of them of their own free will, preferring a private medical service, and others due to their inability to afford the monthly payment. In addition to these four funds, there were voluntary medical services available for the needy, both in the Jewish sector, mainly in ultra-orthodox circles, and in the non-Jewish sector, in charity organizations run by the various churches. The extent and quality of the service varied from fund to fund. The baskets of services were not defined and not entirely clear, and some services were provided only after application of personal pressure, intervention of appeals committees, etc., although under the influence of the discussions on the national Health Insurance Law, the services to which the members of funds were entitled began to be registered and more clearly defined.

In January 1995 the national Health Insurance Law came into effect. The law introduced far-reaching changes in the health system of Israel, defining the rights and obligations of the insured persons as well as the areas of responsibility of all state and public bodies partner to the law's implementation. This chapter presents in brief the central principles of the law and its significance from the point of view of the insured resident. Particular emphasis is placed on the role of the National Insurance Institute

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in the collection of the taxes targeted at financing the health system - both in policy and practice.

B. Indicators of the Extent of National Expenditure in Health

The financial framework of the health system will be presented, with emphasis on the main developments and trends which took place in this system over the years. The data are based mainly on the calculations of the Central Bureau of Statistics[1] and the Ministry of Health.[2]

Table 1. National Expenditure of Health - Total, as Percentage of GNP and Per Capita, 1984-1993

	Total expenditure				Expenditure per capita (1990 prices)	
	Current prices		1990 prices		NIS	% of change
Year	Million NIS	% of GNP	Million NIS	% of change	NIS	% of change
1984/85	800	7.5	6,379	-	1,534	-
1985/86	2,236	6.8	6,379	0.0	1,507	-1.7
1986/87	3,224	7.0	6,634	4.0	1,543	2.4
1987/88	4,306	7.3	7,098	7.0	1,625	5.3
1988/89	5,427	7.6	7,311	3.0	1,646	1.3
1989/90	6,955	7.9	7,823	7.0	1,731	5.2
1990/91	8,510	7.8	8,136	4.0	1,746	0.8
1991	10,041	7.6	8,374	3.0	1,692	-3.1
1992	12,520	8.0	8,779	5.0	1,713	1.3
1993	14,913	8.2	9,286	6.0	1,765	3.0

NIS = New Israeli Shekels

The national expenditure on health is generally measured as a percentage of the GNP and as the average expenditure per capita. An examination of data from the past ten years in Israel shows that the pace of annual growth of national expenditure on health ranges from 3% to 7% when calculated in set prices. The average annual growth is about 4.5%, as compared to an average annual growth of about only 2.6% of the total population of the country. According to the average national expenditure per capita in set

1. Supplement to the monthly Industrial Bulletin of Israel, no. 5, 1995
2. Gaby Ben-Nun, Danny Ben-Uri: Trends in the National Expenditure on Health, 1984-1993, Jerusalem, June 1995.

prices (1990 prices), the growth rate is more moderate. In certain years the percentage of growth was even negative.

The national expenditure on health as a percentage of the GNP during these ten years grew gradually, from 7% in the mid 1980's to 8.2% in 1993. A comparison with other countries was conducted in order to estimate the average weight of the expenditure on health in Israel.

Table 2. National Expenditure on Health, as Percentage of GNP, in Selected Countries - 1982, 1992

Country	1982	1992
USA	10.3	14.0
Canada	9.4	10.1
France	8.0	9.4
Finland	6.8	9.4
Germany	8.6	8.7
Holland	8.4	8.6
Italy	6.9	8.5
Norway	6.8	8.3
Belgium	7.4	8.2
Sweden	9.6	7.9
Israel	**7.2**	**7.8**
New Zealand	6.9	7.7
Britain	5.9	7.1
Spain	6.0	7.0
Japan	6.8	6.9
Denmark	6.8	6.5
Greece	4.4	5.4

The national expenditure on health as a percentage of the GNP grew from 1982 to 1992 in most countries (except Sweden and Denmark). At the top of the list, from the point of view of this percentage, are the United States and Canada. In 1992 Israel allotted to health a similar percentage to that allotted by Sweden and New Zealand, and higher than that allotted by developed countries such as Britain, Japan and Denmark.

Tables 3 and 4 present the share of the various sectors in the financing of the health system and in the provision of medical services, respectively. The data show that the share of the government in the financing of health decreased substantially, from 54% in 1985 to 44% in 1995, and that as a result of the rise in the share of the membership dues paid to the sick funds, the burden on households increased in parallel from 39% to 52%, respectively.

Table 3. Expenditure on Health, by Source of Financing (percentages), 1985/6, 1993

		Government and Local Authorities				Households			
Year	Total	Total	Parallel Tax	Other Subsi-dies	Supply of Ser-vices	Total	Mem-b-ership Dues to Funds	Pay-m-ent for Services	Other and not Known
1985/6	100	54	27	7	20	39	14	25	7
1993	100	44	24	3	17	52	25	27	4

Table 4. National Expenditure on Health by Body Implementing (percentages) 1985/6, 1993

Year	Total	Government and Local Authorities	Sick Funds	Other Non-Profit Organizations	Other
1985/6	100	24	43	12	21
1993	100	20	44	12	24

No significant changes have occurred over the past ten years in the respective shares of the various sectors providing medical services, although the government's share did go down from 24% to 20%, with a parallel increase in the share of the sick funds, private bodies and households.

Finally, when the number of employees in the health system in 1984 (79,500, constituting 5.8% of all employees) is compared with the parallel number for 1993 (about 100,000 employees, constituting 5.7% of all employees), we can see that this system retains its relative share in occupation, and that it adapted itself to the large waves of immigration of recent years.

C. Factors Which Influence the Introduction of the Health Insurance Law

Attempts to legislate a national health insurance law in the Knesset (Israeli parliament) have been carried out for decades. Various public committees were set up[3] and most political parties even made explicit promises to complete the legislation in this area. The main reasons why the question of

3. The last and most important committee, which was of considerable influence, was that of the Judge S. Netanyahu, who published the comprehensive report, "The National Investigation Committee for Examining the Role and Effectiveness of the Health System in Israel", Jerusalem, 1990.

national health insurance remained on the social agenda up until the time that the law was actually passed, will be reviewed below.

- About 300,000 persons in Israel, including about 90,000 children, were not insured, and their difficult situation was again and again brought to the attention of the public at large.
- Medical services were provided non-equitably to members of the different sick funds, and sometimes even to members of the same fund. A comparison of the types of services provided in the different funds at the end of 1994 shows that the Clalit Sick Fund and the Leumit Sick Fund provided more or less the same extent of services, while the Maccabi and Meuhedet Sick Funds provided additional services, mainly in the areas of heart diseases transplants artificial insemination and others.
- Each sick fund had the right to choose its own members, that is, to select the type of insurees it preferred. As a result there were cases of refusals on the part of certain funds to accept persons who were elderly or seriously ill, preferring young, high-wage earners, and tending to develop services in urban regions at the expense of the periphery.
- There was no logical or acceptable connection between the expenses of the sick funds and their income. This led to a constant feeling of impending crisis, and to the fear that the system of health services was about to collapse. The financial deficits which characterized some of the funds usually required government intervention and a massive flow of cash from the State Treasury.
- The sick funds introduced differential membership dues, which varied not only from fund to fund but sometimes even from member to member in the same fund. The system of collection was a very regressive one, since low-income members paid from 5%-6% of their wages, while those having high incomes paid only about 4%; moreover, the maximum income for payment of membership dues was not very high.
- There were funds that operated in the framework of a labor union, which influenced the insurance rules and the system of collection, since these funds also collected the taxes used for funding the activities of the labor union. As a result, in funding policy factors came into play which had little to do with the activities or with the financial stability of the health system.

This situation was reflected in the number of persons insured in the different funds and in their characteristics, as presented in Table 5.

Table 5. Distribution of Members Among Different Sick Funds and Selected Characteristics, end of 1994

Sick Fund	% of Fund Members out of Total Members of all Funds	% of Fund Members out of Total (weighted) Members*	% of Aged 65+ in Fund out of Total Members of Fund	Average Monthly Income of Fund Members in 1993 (NIS)	Distribution of Non-Jewish Members Among Funds
Total	100.0	100.0	10.2	2,975	100.0
Clalit	63.5	68.4	13.1	2,825	81.4
Leumit	9.0	8.3	7.3	2,772	10.2
Maccabi	18.8	16.1	4.9	3,663	4.4
Meuhedet	8.7	7.2	4.1	3,396	3.9

* The data in this column were calculated taking into account the relative weight of each age group (see further on, in chap. G, section 2).

The table shows that the Clalit Sick Fund insured about 63.5% of the total population of the State of Israel, but after weighting the number of persons by age (see below under "capitation"), the share of this fund grew to 68.4%, mainly due to the large percentage of elderly members, higher than that in the other funds. The average income of members of the Clalit Sick Fund is lower in than that of members of the Maccabi and Leumit funds. Furthermore, the high rate of non-Jews insured in the Clalit Sick Fund also strained the fund's finances, since these are on the whole a low-income population. At the end of 1994 over 80% of the total non-Jewish population in Israel were insured in the Clalit Sick Fund, as compared to about 64% only of the overall insured population in Israel.

D. Principles of the New Law

Following lengthy discussions on various state and public levels, as well as in a special Parliamentary committee, which included the Financial Committee and the Committee of Labor and Social Affairs, the final drafting of the bill was formulated. It was ratified on the second and third reading on July 26, 1994 and thereby enacted into law. The central principles are as follows:

- obligating every resident of Israel to insure himself in health insurance. The definition of "resident" in this context is the one used in the National Insurance Institute.
- clearly defining the "basket of services", uniform for all residents, based

mainly on the services provided by the Clalit Sick Fund at the time of the law's ratification. (The law determined rules for possible changes in the composition of the basket and in the manner of updating the costs of its various components).

- placing responsibility on the government for coverage of the "basket of services" as determined in the law - that is, if the defined sources of financing (parallel tax, health insurance dues, the share of the Ministry of Health, the self-participation of the insurees, etc.) are not sufficient, the State Treasury is committed to cover the difference.
- granting every resident the freedom to choose the fund he prefers (there are clear rules regarding how to move from one fund to another) and forbidding the sick funds to refuse to accept a person who desires to join that particular fund.
- canceling the connection between membership in the sick funds and membership in a labor union.
- entrusting the National Insurance Institute with the task of collecting the health insurance contributions, meaning that the connection between the system of collection and the medical service providers was broken, in order to reduce the weight of financial considerations in the fund's provision of medical services.
- distributing the monies collected by the NII among the funds according to a capitation formula, based on the ages of the persons to whom each fund provides services. According to this formula, the higher the age of the person insured, the higher the sum paid to the fund. This system allows for a fair return on the fund's investment on services to all its members.
- forbidding workplaces to make membership in a certain sick fund a condition for employment of workers.
- determining rates of health insurance contributions or premiums by means of a system which is more progressive than it was in the past, according to the rules already operating in the National Insurance Institute (under law, disabled persons, elderly and other low-income population groups are entitled to substantial discounts in insurance contributions).
- thorough and comprehensive government supervision, particularly that of the Ministry of Health, over the sick funds.

E. Significance of the Law from the Point of View of the Individual Insured

The importance of the law lies in its clear and open definition of the role of every party to its implementation. Unlike in the previous voluntary insurance arrangement, the rights and obligations of the individual are

anchored now in the law, and the individual is thus entitled to demand his full rights if he feels that one or more of the bodies responsible for the law's implementation has not fulfilled its obligations towards him.

The sick funds too act to fulfill their role as defined by the law, and they are not allowed to deviate from this role. On the other hand, they are entitled to receive the resources required for them to carry out their task, since the State is responsible for the funding. Due to the fact that the State, by means of the relevant authorities - the Ministry of Finance, the Ministry of Health, the National Insurance Institute - is the one responsible for the funding of the health system, it also bears overall responsibility for guaranteeing the proper implementation of the law, with each authority responsible for a defined area. The success of the law actually depends on maintaining the delicate balance among the three major bodies partner to its implementation: the insured person, the sick funds and the State - including the National Insurance Institute. Taking strict care that every one of these bodies carries out its role properly is an essential condition for the operation of the law according to its guiding principles.

The significance of the law from the point of view of the individual insured may be summed up in the following points:

- Since the basic principle of the law is that every resident of the State is obligated to be insured in one of the recognized sick funds, and since his right to choose the fund he prefers is guaranteed, a far-reaching change in his situation has occurred. In the past, the freedom of choice had been in the hands of the sick funds, who could accept or reject members according to their own - manly economic - considerations. The new law transfers this freedom of choice from the fund to the resident. The resident is now the one who chooses the fund, with the funds competing among themselves to "attract'" members.
- An additional important point from the point of view of the insured person is his right to receive a defined "basket of services" as laid down in the law. The basket is uniform for every resident and includes a variety of medical services and procedures which, as mentioned, were guaranteed in the Clalit Sick Fund's basket of services on the eve of the law's implementation. Since the basket is open and detailed in the law, not hazy or hidden as in the past, it is now possible for the insured person to examine exactly what his rights are. Although full details about the basket of services are not yet available, and there is still a lack of clarity regarding some of the services included in the basket, this is still a significant change for the better.
- A person who wishes to be insured over and beyond what is provided by

the basic basket may arrange for additional (supplementary) insurance by means of programs offered by the sick funds and authorized by the Ministry of Health and by the supervisor of insurance in the Ministry of Finance. The operation of the supplementary insurance programs must be closely followed and supervised by the State authorities in order to ensure that the services included therein are indeed provided *in addition* to the basic basket - and not *instead* of them.

- The legal status of the insured person - that is, the fact of his rights and obligations being anchored in law and particularly of his rights being defended by the authorities - allows him to demand the take-up of these rights in court. Every sick fund is obliged under law to appoint a person responsible for examining members' complaints, and the Minister of Health is obliged to appoint a commissioner whose task it is to investigate complaints of the public. Any resident who feels discriminated against in the matter of membership in a sick fund may complain to the Director General of the Ministry of Health, and is always free to turn to the labor court if he thinks he has been wronged by one of the funds or authorities.

- With the implementation of the law it became necessary to arrange for the registration of members, a matter which had been previously flexible even to the extent of disorder. Under the Health Insurance Law, a resident may not be registered in more than one fund. The previous phenomenon of membership in two funds often stemmed from various constraints and was even sometimes forced, but we may assume that at times it reflected the insured person's wish. For practical reasons, a resident who, with the coming into force of the law, was insured in more than one fund is considered to be a member of the last fund in which he registered. This arbitrary decision doubtlessly hurt some people, and efforts are being made to correct the distortions insofar as possible.

- In the area of registration of members, there are two more matters worthy of note. The first - a certain limitation of the possibilities of transfer from fund to fund. Despite the basic right to choose whichever fund one prefers, this option may be taken advantage of, under the law, only once a year. This decision stemmed mainly from administrative considerations and from a concern for the stability of the health system and for a continuity in the provision of services, but it did cause a certain restriction of the resident's freedom of choice.

The second - the registration of children in sick funds. The law determined that the registration of a child in a fund must be carried out by his parents, and that a child cannot by registered in two funds. When both

parents are insured in the same fund, no problem arises regarding the registration of the children. However, when the two parents are insured in two different funds, the question of where to register the children arises. In order to solve this problem, the regulations determined that the children be registered in the fund in which the parent who receives the children's allowance is registered. However, it is allowed to register the child in the fund in which the parent who does not receive the allowance is registered, if both parents agree to this, or if the child is in the custody of the parent who does not receive the allowance.

F. The Role of the National Insurance Institute in Implementing the National Health Law

As mentioned, the National Health Insurance Law defines the roles of the central bodies involved in the health system today: the sick funds, the Ministry of Health, the Ministry of Finance and the National Insurance Institute. It should be noted that the National Insurance Institute was connected with the health system even before the law came into effect, and this connection was anchored in law. The main activities of the NII in the health system in the past were as follows:

- covering of the medical expenses of work injured;
- covering the medical expenses entailed in the hospitalization of mothers giving birth;
- the participation in partial coverage of the expenses of hospitalizing chronically ill elderly;
- collection of parallel tax and its distribution among the sick funds;
- taking care of the medical insurance of the recipients of old-age and survivors' pensions (who are entitled to income supplement), general disability pension and income support benefits.

The law entrusts the National Insurance Institute with many new tasks, and in fact makes the Institute the one most important operative link in the law's operation. By force of the National Health Insurance Law the NII is responsible for the following activities:

- collecting health insurance contributions and parallel tax;
- distributing the parallel tax and health insurance contributions among the sick funds;
- continuing to cover the medical expenses of work injured by the method used today and continuing to participate in the funding of the hospitalization of chronically ill elderly. On the other hand, the medical expenses of

hospitalizing mothers giving birth are now financed by the general sources similar to the health system.
- administering the national file of persons insured in health insurance.

G. Health Insurance Contributions

Under the National Health Law every insured person is obligated to pay health insurance premiums or contributions, but a delay in payment or non payment does not rule out entitlement to medical services. The task of collecting the insurance contributions was imposed on the National insurance institute, in view of the effectiveness of its collection system which had proved itself for many years in the collection of national insurance social security) contributions and parallel tax. Taking advantage of an existing, operative collection system avoided, of course, the necessity of setting up a new system, which would have entailed high administrative costs. However, it was still necessary to adapt the collection rules of the health tax to the rules governing the NII collection system, even if these seemed not always in keeping with logic or with the original intention of the legislators. Thus far reaching changes had to be instituted in the collection patterns of the health insurance contributions previously collected directly by the sick funds.

Following are the main principles of the collection of health insurance contributions:

1. The rate of health insurance contributions paid by the working population (November 1995)

The rate of health insurance contributions is uniform - 4.8% of wages, but the rate collected from the part of wages that is up to half the average wage in the economy (today about NIS 2,100) is reduced - 3.1%. The maximum income for payment of contributions is equivalent to four times the average wage in the economy (today NIS 16,828). The minimum income for payment of contributions is equivalent to 25% of the average wage (today about NIS 1,052). This method is radically different from the one previously used. Firstly, it is much more progressive. In the past the sick funds collected a rather high payment (the Clalit Sick Fund collected NIS 99 just previous to the law), and the higher the member's income, the lower was the rate of payment - from about 5.6% at the lower incomes, down to 4.1% at the higher income levels. Secondly, in some of the funds, particularly in the Clalit Sick Fund, there was a "family insurance" plan under which an insured person whose wife did not work would pay a higher payment (in the

Clalit Sick Fund - 7.85%) because of the additional burden that the family placed on the system. Under the collection rules of the National Insurance Institute, contributions are collected from income at a uniform rate, without taking into account family composition. This constraint led to a large extent to the decision to exempt the housewife by law from payment of health insurance contributions. Thirdly, while the previous system included discounts in the payment of health insurance contributions to different professional sectors, to a working married wife and to other population groups - from economic, social and other considerations - the new collection system did not allow for any discounts. Every insured person is obligated to pay the full amount of contributions at the rates noted above. Furthermore, under law, the contributions are transferred fully and directly to the sick funds, without the intermediation of the labor unions.

Table 6 compares the parallel tax, which was paid to the tax bureau of the General Histadrut (Labor Union) just prior to the law's coming into effect, with the health insurance contributions paid by law, with the addition of the "organization tax" of 0.9% of wages.

The comparison shows that low-wage workers (earning up to half the average wage) of all family compositions were not hurt by the new law, and most even benefited from a significant reduction in the rate of health insurance contributions they pay. Secondly, a single person without a family or an individual whose wife works pays a reduced rate of health

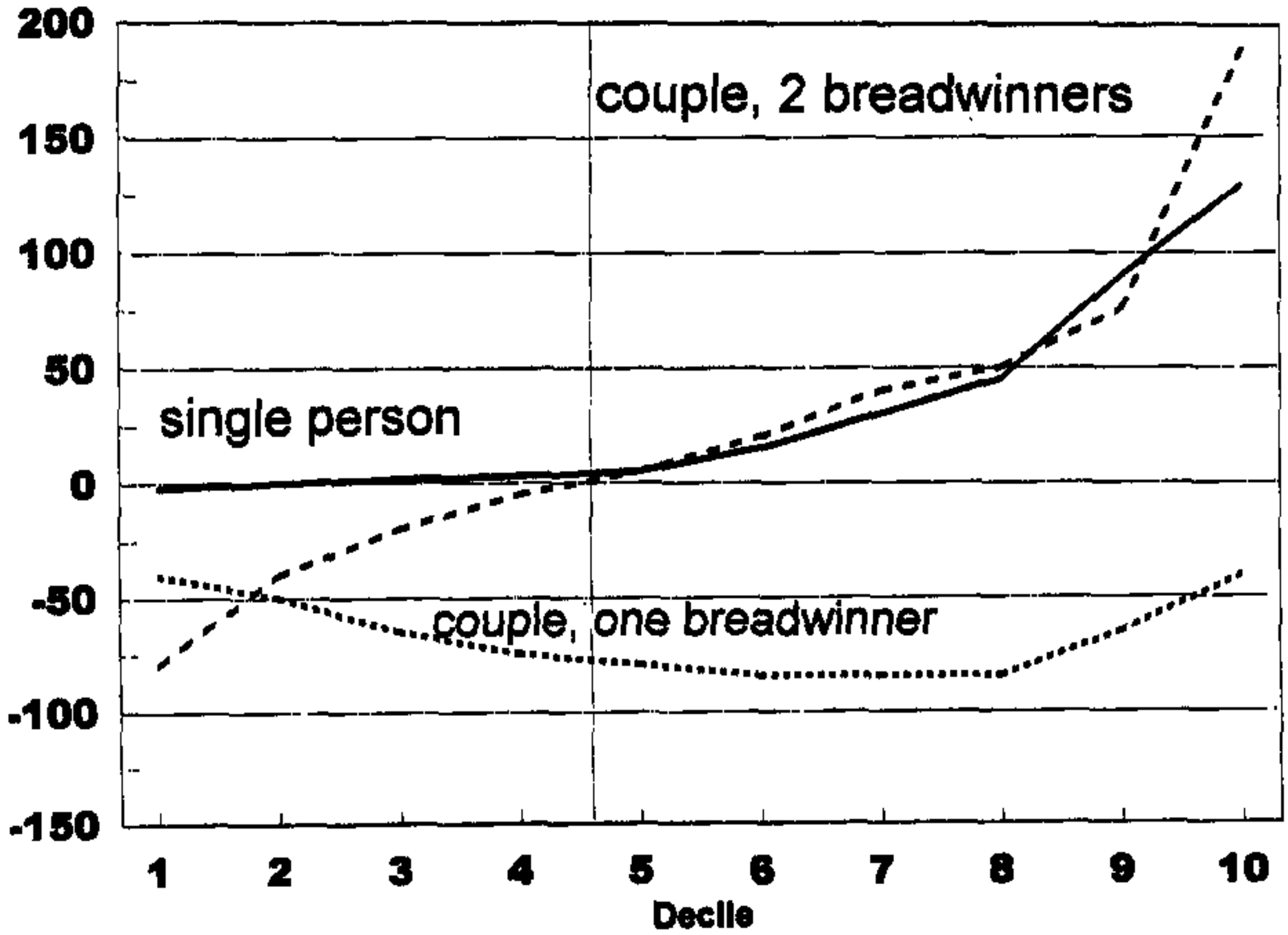
Table 6. Monthly Uniform Tax Paid to Sick Fund and Amount of Health Insurance Contributions, Under Law* (NIS), January 1995

	Single and man whose wife works		Man whose wife does not work		Working married woman	
Gross Monthly Income	Uniform Tax	Health Insurance Contributions	Uniform Tax	Health Insurance Contributions	Uniform Tax	Health Insurance Contributions
2,000	100	81	145	81	99	81
2,500	125	110	175	110	99	110
3,000	150	138	210	138	106	138
4,000	196	195	276	195	138	195
5,000	243	252	341	252	169	252
6,000	279	309	391	309	194	309
8,000	345	406	487	406	241	406
10,000	385	502	548	502	269	502
12,000	415	598	593	598	290	598
14,000	415	694	593	694	290	694
16,000	415	775	593	775	290	775

* Including organization tax at rate of 0.9%.

insurance contributions up to an income level of NIS 4,000. The higher the income level, the greater his burden of payments. Thirdly, a man whose wife does not work has a significant reduction in the monthly payment, unless his income is higher than three times the average wage. Finally, a working married woman whose husband also works pays a smaller sum when her income is not higher than half the average wage. When her income is higher then this, she pays a higher rate of health insurance contributions. In view of the significant loss of income thereby caused by the married woman, the government decided to compensate her as of January 1995 by adding a credit point for her in the income tax system. Of course, only women whose income is higher than the tax threshold benefit from this.[4]

Diagram No. 1. Impact of Health Insurance Law on Payments of Employees' Households
(back payments to family per month, in shekels)



Prepared by the Ministry of Finance and the Ministry of Health, with the cooperation of the National Insurance Institute, based on Central Bureau of Statistics data.

The overall impact of the new method on payments of households to the health system is presented in Diagram no. 1, by family deciles. All

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4. January 1996, a change will probably take place in this area.

households up to the fourth decile now pay lower sums of health insurance contributions, but the higher the decile to which the family belongs, the greater the burden of payment. The lightening of the burden on the breadwinner whose wife does not work is particularly notable. It should be noted that the diagram was prepared during the stage of preparation of the law and it does not reflect changes or adjustments which were carried out in the final phase of formulation of the system of health contributions. Thus its findings should be related to as general ones only.

2. Collection from pensioners and from special population groups

As mentioned, under the Health Insurance Law, every insured person, even if he does not work, is obligated to pay health insurance contributions - aside from exceptional cases in which an exemption is given. The largest group of persons exempt from payment of these insurance contributions is the housewives. Other groups include:

- new immigrants in the first six months after their arrival in the country;
- workers under the age of 18;
- workers up to age 19 who are afterwards recruited into the army;
- persons under arrest and prisoners sentenced to more than 12 months of imprisonment (the prison authority takes care of their medical needs);
- soldiers in the regular army (the army provides medical services).
- disabled persons and mentally ill persons hospitalized for long periods of time in live-in institutions under the supervision of the Health Ministry or the Ministry of Labor and Social Affairs.

A compromise was achieved regarding soldiers in the permanent army, according to which these soldiers will pay reduced rates of health insurance contributions during their military service, despite the fact that they do not use the public health system at the time of their service. The reason for this is that they join the sick funds at an older age, with their release from the army, sometimes not in the best condition of health.

It should be emphasized that the law applied only to residents, and therefore all persons not considered residents according to the criteria of the National Insurance Institute are not obligated to pay health insurance contributions, and likewise are not entitled to receive services. In the matter of determining residence under National Insurance Law, it should be mentioned that the criteria of the NII for this purpose are based mainly on court judgments passed down in the courts over the decades. The basic rule is the extent of the connection that the resident has with the State from the point of view of his living quarters (such as ownership of an apartment),

sojourn of the family in the country, registration of his children in Israeli schools, the type and character of his work, the length of time of stay in the country, payment of insurance contributions over time, etc. Therefore persons who have an identification card and who live permanently in the country are automatically considered residents (except for certain exemptions in East Jerusalem) whereas owners of passports only and persons who are away from the country for lengthy periods of time must undergo special examinations to verify their residency in order to be included in national health insurance.

The non-working population as well as insured persons who receive various benefits from the National Insurance Institute or from other State bodies enjoy special rates, in accordance with their economic situation and their capability of paying. Following are the rates of health insurance contributions for special population groups:

- the minimal rate of contributions is 4.8% of the minimum income for purposes of the National Insurance Institute; that is, a quarter of the average wage in the economy. In November 1995 the minimum sum of health insurance contributions was NIS 50. This rate applies to students, persons residing abroad, insured persons who do not work and do not have an income, etc.
- an insured person who receives an early pension from work pays 4.8% on half his pension, similarly to the rule used for the national insurance contributions paid from early pension.
- a wage-replacing benefit granted by the National Insurance Institute, such as: work injury allowance, maternity allowance, reserve service benefit and unemployment benefit, is considered as income from work and is thus liable for health insurance contributions at a rate of 3.1% on the part of the income that is up to half the average wage, and at a rate of 4.8% on the part of the income that is above this level.
- the working-age population (a woman up to age 60 and a man up to age 65) who receive any benefit from the National Insurance Institute or from any other State body (the Ministry of Defense, the Ministry of Finance, etc.) and who do not work, pay the minimum amount - today NIS 50 a month. If such a benefit recipient works, he pays the insurance contributions at the regular rates on his income from work alone. The benefit he receives is exempt from health insurance contributions.
- persons who live on their national insurance pension only - those who receive an old-age or survivors pension with income supplement, general disability pension, or income support benefit - pay the minimum sum

which, as mentioned, amounted to NIS 50 in November 1995. This sum is paid by all families no matter what the family size.

- elderly people aged 65 or over and widows aged 60 or over who receive an old-age or survivor's pension by force of the National Insurance Law now pay a uniform rate of health insurance contributions which varies only in accordance with family composition (single or couple), without regard to income level. The contributions are deducted at source from their old-age pension and the elderly pensioner is exempt from contributions on any other income he may have. This sum in November 1995 was NIS 95 for a single person and NIS 137 for a couple. Before this method was decided upon, much thought and many discussions were devoted to the subject of collecting health insurance contributions from the elderly. At first thought it may seem that determining a uniform rate without taking into account income level is not logical or fair. However, an examination of data showed that the vast majority of the elderly have low-income levels. The income of more than half the elderly is not higher than half the average wage (about NIS 2,100), while only 17% of the elderly have an income higher than the average wage. Thus the determination of a uniform rate is appropriate for the income level of most of the elderly population.

Furthermore, we have no information available on more than 100,000 elderly persons who do not receive income supplement, nor any pension from work. There is therefore a basis for the assumption that they have an income from some other source, but since there is no possibility of identifying this source, there is no way of collecting health insurance contributions from them in accordance with their income level. An examination of the income patterns of the elderly, on the one hand, and the lack of information on the income of well-off elderly, on the other hand, have therefore led us to the conclusion that there is no choice but to introduce a uniform rate of health insurance contributions. In our opinion, despite its drawback, this method is the better of the evils when compared to the alternative methods. At the same time it seems to us that in time it will be necessary to find new means and ways for a more equitable system of collection of contributions from the elderly, particularly the better-off among them. Table 7 presents the sum of health insurance contributions which the elderly are liable for, both, under law and under the previous method.

H. Distribution of Money among the Sick Funds

The law determined that the money aimed at financing the basket of

Table 7. Health Insurance Contributions of the Elderly, Under the Uniform Tax Rules of the Clalit Sick Fund and Under Law (Selected Examples), November 1995

Type of Benefit	*Uniform Tax (NIX)*	*Health Insurance Contributions (NIS)*
recipients of old-age and survivors' benefit with income supplement*		
- single	62	50
- couple	93	50
*recipients of old-age and survivors' benefit under law, with a NIS 2,000 benefit***		
- single	112	95
- couple	157	137
recipients of old-age and survivors' benefit under law, with a NIS 3,000 benefit		
- single	168	95
- couple	236	137

* In the past the National Insurance Institute collected the amount directly from the pension, under a special agreement between the government and the sick funds.

** The rate of the uniform tax was 5.6% of income for a single person and 7.85% for a couple. The old-age pension too was liable for this tax untill January 1994, when it became exempt.

services (parallel tax, health insurance contributions and State budgets) would be transferred to the various sick funds directly from the National Insurance Institute. The principle of the distribution of the money among the funds was determined in the regulations: every sick fund is entitled to receive a "piece of the cake" in accordance with its real expenditure on medical services. Since it is very difficult to accurately calculate the burden which each insured person places on the fund, it was essential to find indicators for this. Examples of such indicators are the number of insured persons in the family, age of the insured person, distance from the service centers, the level of incidence of disease, etc. A committee of experts which discussed the problem eventually reached the conclusion that the best indicator to measure the relative burden of medical expenditure is the age of the insured person, since consumption of health services grows with increasing age. It was therefore decided that the distribution of the money among the sick funds would be carried out according to a capitation method, that is, according to the number of persons insured in each fund, weighted by age. Medical expenditure according to age was determined on

the basis of data accumulated from various sources, but these were not always adequately updated. There is thus no doubt that the data which continue to accumulate in the data banks must continue to be regularly examined.

This distribution principle anchored in the National Health Law was also based on the experience recently accumulated in the National Insurance Institute in the collection of parallel tax and its distribution among the sick funds by the capitation method. This method of distribution was first introduced in 1991 following the recommendations of a professional committee headed by Prof. Jack Habib.[5] It was the accepted method untill the end of December 1994,[6] just before the coming into effect of the Health Law. The formula underlying this method is: those under 25 years old were weighted 0.6, those from age 25-65 were weighted 1.0, and those aged 65 or over were weighted 3.1.

Since this method proved to be both rational and technically applicable, it was used at the time of the legislation of the Health Insurance Law. A staff of experts headed by Mr. G. Ben-Nun, Deputy Director General for Health Economics at the Ministry of Health, was required to reexamine the formula in order to update calculations and present them in more detail. The only change introduced into the calculation was the inclusion of the hospitalization expenses of mothers giving birth in total expenditure, since the basket of services covers, as mentioned, the medical care given to mothers as well. In the past the hospitalization expenses of mothers were covered by the NII budget and the money transferred directly to the hospitals. The staff's recommendations regarding the relative weight of every age group, which were anchored in the Health Insurance Law regulations, were as follows:

Age	*Points*
up to 5	1.17
over 5 till 15	0.45
over 15 till 25	0.50
over 25 till 35	0.73
over 35 till 45	0.81
over 45 till 55	1.17
over 55 till 65	1.69
over 65 till 75	2.78
over 75	3.48

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5. See: Reuben Steiner (1992-1993), "Twenty years of implementation of parallel tax law", in: *Annual Survey of the National Insurance Institute of Israel*, Jerusalem (in Hebrew).
6. See: Report of the Committee for Examination Distribution of Parallel Tax among Sick

According to the statistical and research material available to the committee members, no justification was found for including other criteria, such as sex or distance from medical service centers or from population centers, in the calculation formula.

The source for calculating the number of persons insured in each sick fund is the national health file administered by the National Insurance Institute (described below). The law determines that the calculation of the number of persons insured in each fund shall be carried out on the first of January and on the first of July of every year, with no possibility of making corrections retroactively. That is, the transfer of the money to the sick funds during the six months following the determination of the distribution key is carried out on the basis of the number of persons weighted by age.

All the money is transferred to the sick funds by the capitation method with a few exceptions. The first - severe - diseases. The Ministry of Health transfers directly to the sick funds a certain share of the health insurance contributions collected in accordance with the number of severely ill persons in their care who demand particularly expensive medical treatment. Since the expenditure on treatment of these diseases is much higher than the usual expense predicted on the basis of the age distribution, the general capitation formula does not guarantee an adequate return to the funds for treatment of these diseases.

The second exception is the care of the mentally ill. Before the law came into effect, this care was under the responsibility of the Ministry of Health, and it is now being transferred gradually to the sick funds. The connection between expenditure on the mentally ill and the age of the insuree is a loose one. Thus a formula is presently being developed which will express the relative burden placed on the funds by the mentally ill, for purposes of a fairer distribution of the money devoted to this field.

It should be noted that since the health insurance contributions have been collected by means of the National Insurance Institute and distributed among the sick funds by the capitation method, the sums transferred to the Clalit Sick Fund and the Leumit Sick Fund, having many elderly and low-income members, have increased, while the sums transferred to the Maccabi and Meuhedet sick funds, having mainly younger and higher-income members have decreased. Table 8 presents the share of every fund in the total amount of money transferred for the financing of health expenditure in the two determining periods of time in 1995.

Table 8. Share of the Sick Funds in the Money Transferred in 1995 (percentages)

Fund	January-June 1995	July-December 1995
Total	100.00	100.00
Clalit Sick Fund	68.44	67.61
Leumit Sick Fund	8.28	8.41
Maccabi Sick Fund	16.13	16.57
Meuhedet Sick Fund	7.15	7.41

I. Administration of Health File

The National Insurance Institute administers a name file of all persons covered by health insurance. The new health file, administered as required by the Health Insurance Law, is mainly based on the parallel tax file built in 1990 by the NII for purposes of calculating the key by which the parallel tax monies were distributed among the sick funds.

The purposes and uses of the health insurance file are radically different from those of the parallel tax file. Firstly, this file must serve as the only source for the distribution of all the money targeted at financing the basket of services to the sick funds. Secondly, it must serve as the only authorized source of registration of all State residents at the sick funds. As mentioned, in the past the registration of members was conducted by each fund separately and was dependent on the payment of membership dues. The goal it is hoped to achieve is that the health file will be the only authorized source of information on where each Israeli resident belongs as far as the sick funds are concerned. In this way every resident may ascertain to what fund he belongs and may demand the full take-up of his rights from this fund. This goal shall be achieved gradually over the course of several years. In the first year many important actions were taken in order to absorb the entire population in the file, to register all the necessary details and to adapt the file to the many different demands of the law regarding membership registration. The main actions which were carried out were as follows:

- *addition of children to the health file*. In the historical file of parallel tax, the individual registration was of the adult population only, and the children were added on to each insured person as an overall number. In the health file, however, the details of each child are registered as a separate item. Almost two million new items of children were added to the file.
- *registration of residents who are not members*. Residents who were not insured in any sick fund prior to the Health Insurance Law were registered by the Ministry of Health in the various funds in the same proportion as the

existing distribution of members among the funds. A person who disagreed with the decision of the Ministry regarding in which fund to be registered is entitled to over-rule the Ministry's decision, and to register himself in the fund of his choice. The number of members who were previously uninsured and were added to the health file amount to about 200,000.

- *registration of persons residing abroad.* Under the law, a person who has been residing abroad for over two consecutive years has the right of being covered by health insurance, but he is not taken into account for purposes of the distribution of the monies among the funds. The health insurance file receives ongoing information from the border control file, in order to examine the movements of those going in and out of country. In mid-1995 there were about 75,000 residents registered in the health file whose membership was "frozen" for purposes of calculation of the distribution key on July 1, 1995.

- *prevention of double membership.* Under the Health Insurance Law, a resident is not allowed to be insured in more than one sick fund. Since this was not forbidden in the past, in the case of double membership only the registration in the fund in which the insured person last registered himself remained valid. The number of persons who had been insured in one fund, whose membership in the first fund in which they had registered was canceled, comes to about 50,000.

The health file is updated regularly on the basis of the requests of insured persons to join various sick funds - either for the first time or after moving from another fund. This request is carried out by means of a registration or transfer form signed by the resident. The funds pass these forms on to the NII, which feeds the information into the file only after conducting a series of examinations in accordance with the instructions of the law, for example: identifying the insured person on the residency register, an examination of residency, an examination of whether the person met the condition of moving from one fund to another (did twelve months elapse), an examination of the completeness and accuracy of the information on the request form, etc. After these examinations are completed and the insured person is finally registered in the health file, the sick fund is notified that he must provide this person with health services on the dates and conditions prescribed by the law and regulations.

The number of changes carried out in the file as a result of the reports of the sick funds on new members or transfers from fund to fund was about 400,000 a year in both 1994 and 1995. Table 9 presents the number of persons insured in the sick funds according to the file updated to the end of

Table 9. Number of Insured Persons in Health Insurance File, by Age Group and Sick Fund*, May 31, 1995

	Total		The Fund							
			Clalit		Leumit		Macabe		Meuhedet	
Age Group	Insured Persons	Persons Included in Capitation	Insured Persons	in Capitation Calculation	Insured Persons	in Capitation Calculation	Insured Persons	in Capitation Calculation	Insured Persons	in Capitation Calculation
Total	5,431,100	5,356,000	3,411,000	3,370,500	495,300	487,400	1,040,600	1,022,000	484,200	476,100
Up to 5	559,500	557,800	319,100	318,400	59,700	59,500	121,000	120,400	59,700	59,500
5-15	1,079,500	1,068,600	691,200	686,400	105,000	103,600	185,600	182,300	97,700	96,300
15-25	814,700	807,200	474,900	471,100	72,900	72,100	173,600	171,600	93,300	92,400
25-35	777,400	759,700	400,400	391,800	79,400	77,700	213,100	207,800	84,500	82,400
35-45	727,800	712,100	442,600	434,300	68,700	67,000	149,400	145,600	67,100	65,200
45-55	529,400	520,600	349,200	344,300	43,400	42,400	95,100	93,200	41,700	40,700
55-65	385,200	380,300	286,400	283,200	29,500	28,900	50,000	49,200	19,300	19,000
65-75	331,100	326,700	263,200	259,900	22,800	22,500	32,800	32,200	12,300	12,100
75+	226,500	223,000	184,000	181,000	13,900	13,700	20,000	19,700	8,600	8,500

* The data on the overall number of insured persons are presented in the table along with the data on the population included in the calculation of the key. The difference between these two series stems from the number of insured persons residing abroad for over two years, who are not included in the calculation key.

May 1995, which served as the basis for calculating the distribution key since the beginning of July 1995. The next updating of the file will be in November 1995, as a basis for calculating the new key to come into effect on January 1996.

The health file includes various demographic information on every insured person, in what sick fund he is a member, and the family relationships between him and other insured persons. In addition, the file has information on his income from work, based on the annual report of his employer to the income tax authorities as well as on the file of collection of insurance contributions from the self-employed, administered by the NII. The health file is the only file in Israel containing this information on the income of the individual and family from work, in the long term.

J. The Monetary System of Health Insurance

Under the law, the sources of financing the health system are as follows:
- health insurance contributions - collected by the National Insurance Institute;
- parallel tax - collected by the National Insurance Institute;
- budget for hospitalizing mothers giving birth - transfer from the collection of national insurance contributions for the Maternity branch;
- participation in the hospitalization of chronically ill elderly - transfer from the collection of national insurance contributions from the Long-Term Care branch;
- the budget of the Ministry of Health for the provision of health services;
- the budgets of Ministry of Finance for covering the medical insurance of population groups supported by the State;
- direct receipts of the sick funds for services which the law allows to collect payment for their provision, such as: medicines, visits to the doctor, etc.

The vast majority of the services is provided by the sick funds, while the minority is provided in the present interim period by the Ministry of Health but is gradually being passed on to the responsibility of the sick funds.

Following is the monetary framework of the Health Insurance Law, as estimated in early 1995, and an estimation based on data on collection and receipts in the first nine months of this year, as presented on Table 10. The overall cost of the services included in the health basket was estimated at about NIS 14.2 billion for 1995. The share of the National Insurance Institute in the financing of the health system - both through collection from the public and through transfers from its budget to the financing of the hospitalization of women giving birth and of chronically ill elderly - was

Table 10. Forecast of the Receipts of the Health System from Collection by the NII and their Corrected Estimate (NIS million), 1995

Source	Original Estimate	Corrected Estimate	Difference
Parallel Tax	5,050	4,890	160
Health Insurance Contributions	4,600	4,260*	340
Collection from Benefits	750	600**	150
Hospitalization of Mothers Giving Birth	500	500**	-
Total	10,900	10,250	650

* Collection for only 11 months, beginning in February 1995.

** Collection for 12 months. In actual fact money will probably be transferred to the funds for 11 months.

estimated on the eve of the law's implementation at about NIS 10.9 billion, constituting some 77% of all sources of financing.

In view of the sum of contributions actually collected in the first nine months of 1995, it is apparent that the early forecast was about NIS 650 million higher than the estimate of the actual annual operation cost. More accurate data on the operation for this year will be available toward mid-January 1996, and it is probable that the gap will be wider.

The explanation for the gap of NIS 650 million between the original forecast and the estimate of the operation cost for 1995 is as follows:

(1) about NIS 200 million are attributed to the fact that wage back-payments were not made. The original budget was based on the assumption that the average wage would increase by 15.8% in 1995. The corrected estimate of the wage increase in 1995 is 13.5%.

(2) about NIS 150 million of the gap are attributed to the natural delay in the collection of insurance contributions expected when a new law is implemented.

(3) NIS 150 million are the value of the corrections, discounts and reductions given the various types of pensioners and benefit recipients in the course of the discussion of the Committee of Labor and Social Affairs on the law and the regulations.

(4) The remaining NIS 150 million are attributed to the non-completion of the system of collection from certain population groups, such as students, and from various changes in the system of collection from the self-employed, which came into effect in 1995.

K. Summary

After a year of the law's implementation it is still too early to accurately measure its contribution to a change in the health system. Every new law deserves a period of "grace" untill its full maturation, even more so regarding the Health Insurance Law, which caused a revolution from the administrative, budgeting, and medical-professional points of view. At the same time, today we can already point to a few phenomena and trends, which ought to be considered.

- the integrated professional and administrative system - including the collection of insurance contributions by the NII and their distribution among the funds, the setting up of offices, the supervision and control of the Ministry of Health and the provision of medical services of the sick funds - is operating adequately and appears to be stabilizing.
- the financial sources for covering the cost of the basket of services were found to be insufficient. There was found to be a wide gap between the early forecast on the scope of receipts and actual receipts. Some of the gap, it appears, will not be covered in future and the State will be forced to allot from its budget higher sums than previously planned for the financing of the health system.
- there is no doubt that entrusting the NII with the task of collecting health insurance contributions, and dissolving the separate collection system of the sick funds, has led to a significant saving of administrative costs, estimated at about NIS 100 million annually.
- the experience accumulated in the course of the year shows that there are various problems, both in the system of rights and obligations of certain population groups and in the system of communication between the main partners to the implementation of the law. These must be improved, and made more efficient and sophisticated. Some of the improvements require legislative changes and others may be instituted by technological and administrative means. Among the issues which should be reexamined include the scope of rights of residents returning from abroad after a lengthy absence, the rates of insurance contributions imposed on special population groups, the setting of clear rules on how to act in cases of deviation from the instructions of the law or misuse of the system, the shortening of reaction time between the date of the member's registration in a fund and the day of the NII's authorization of his membership, frequency of the dates of calculation of the "distribution key", etc.

These and other questions shall be at the center of future discussions on the Health Insurance Law, with the goal of improving the system and

guaranteeing an adequate level of health as well as equitable, quality services to all residents of Israel.