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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: Toward the 21st Century • Private Finance, "Supplementary Insurance" and Reform of Israel's Health System: Perils and Prospects • Private-Public Mix in Government Acute-Care Hospitals in Israel: An Assessment of the Present Status and Future Developments • *Halakha* and Patriarchal Motherhood: An Anatomy of the New Israeli Surrogacy Law • Early Childhood: A Psychological Perspective on Israeli Policy • Universality vs. Selectivity in Child Allowances and Limits of Implementation • "New Careers for the Poor": A Review of the Career of an Innovative Idea • The Development of Welfare Services for the Mentally Handicapped in Israel

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All correspondence, enquiries and orders concerning *Social Security*, should be addressed to:

Social Security, Journal of Welfare and Social Security Studies
Research and Planning Administration
The National Insurance Institute
13 Weizman Ave.
Jerusalem 91909, Israel

CONTENTS

FORWORD

The National Insurance Institute is happy to present to the professional community and to its regular readers issue No. 5 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. 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 was written by Abraham Doron with the intent to mark the publication of the 50th issue of *Bitachon Sotziali-Social Security*. Since the appearance of the first issue in 1971, there have been major changes in context and content of social policy both here in Israel and abroad. The major goal of the Journal was, as perceived by its founders, to serve as a forum to clarify current social issues, especially those of poverty and social inequality, in order to gain a better understanding of them and enable the formulation of innovative and practical social policies. The public agenda on these issues has remained practically unchanged in the last 25 years.

In the published 50 issues the Journal has reflected the collective experience with regard to social welfare policies and social protection in Israel and in cross-national comparative perspective. The main thrust of the paper is, however, not to dwell on the achievements of the past, but to look forward at the social problems facing Israeli society toward the next millennium. It seems, that the main difficulty in this respect is the prevailing mood of pessimism and deep apprehension about the future prospects of social policy.

The main attempt of the paper is therefore to look into some of the main issues affecting our lives at present, and in the years to come, and the challenge they present to the making of social policies. The issues are: the intractable "social question", the meaning of the "social", the welfare state and the notion of social citizenship, the welfare regimes in capitalist societies, the rise of a "new class", globalization, and the manner in which all these are influencing the role of the welfare states in contemporary societies.

The Israeli National Health Insurance Law enacted on January 1, 1996,

stipulates that sick funds which are responsible for the provision of the universal entitlement under public finance, can offer "supplementary insurance" (SI) and provide services for extra billing (EB). This option - new in Israel for most practical purposes, and yet to be well regulated and fully implemented - poses some grave risks to the reform objectives in the Israeli health system: cost control and efficiency, equity, and client satisfaction. At the same time, this option also presents opportunities, if SI, EB and private finance in general, are appropriately regulated to promote reform efforts.

Dov Chernichovsky analyzes Privately-financed, health services and insurance risks and opportunities related to health system reform in Israel. At the outset, Israel starts with adverse circumstances from the perspective of SI and EB managed by the same sick funds and providers who organize, manage, and provide care under public contracts. It has high health expenditure, as percentage of GDP and per capita. Its share of private finance is also relatively high. Exceptionally high ratio of physicians per capita, and a high propensity to adopt modern technology, will have an effective outlet through SI and EB, further increasing national expenditure. This without any scope of improving the health status of the population that is already high. This drive will be particularly powerful, because sick funds are budgeted on a capitation basis, most medical staff are wage-earning employees, and almost all medical institutions are, by and large, centrally budgeted.

Moreover, other reform objectives, equity and client satisfaction are also likely to be in jeopardy in part because with the SI and EB options, both sick funds and providers have less of an incentive than without this option to improve services under public finance as intended through the newly established capitation system.

The author believes that it would be advisable to institute in Israel a Canadian-style system whereby providers and, in the Israeli case, sick funds which operate under public contracts, cannot operate under private contracts.

Alternatively, if SI and EB are condoned in conjunction with public contracts, they should be enacted in a way, akin to the Australian system that would promote the objectives of principles of public finance.

An insurance system as suggested here, can be used to insure "copayments", should they be instituted in Israel as a viable source of private finance for the public-based system. The levels of co-payment and rates of insurance would then depend on the relative importance of government objectives: raising private funds, or curtailing demands and use of services.

An additional SI package (SI2) can be available to those who so desire, but

completely separate from public finance and from the SI along the principles just stipulated.

The objective of the study by Arie Shirom and Zippi Amit was to assess proposals to introduce privately-financed inpatient services into government accute care hospitals in Israel. The issue of public-private mix in government hospitals is discussed (a) in the broader social and economic context of the Israeli system of health care, (b) in terms of the gradual development of the private sector within government hospitals in Israel, and (c) as representing an attempt to partially commercialize acute care hospitals. The authors summarize some of the experience gained in advanced market economies and then present the lessons gained in the few not-for-profit acute care hospitals that have already introduced privately-financed inpatient services. They conclude by surveying the advantages and disadvantages of these proposals..

Carmel Shalev examines the differences between the recommendations of a public-professional commission regarding legislation in the matter of surrogate motherhood (the Aloni Commission), and the statute actually passed by the Knesset (Israel's Parliament) in March 1996. The author describes the content of the new statute, which is unique in its regulation of surrogacy arrangements through the mechanism of approval by a statutory committee. She posits that the prior conditions for such approval, as set down in the statute, were dictated by political-religious considerations. The analysis is embedded in feminist theory and reaches the conclusion that the result of the legislation is to reinforce patriarchal norms of reproductive relations and motherhood.

Charles Greenbaum describes the need for an early childhood policy in Israel, outlines the assumptions derived from a knowledge of child development which could support such a policy and makes specific suggestions for needed programs.

The author points to the need for an early childhood (ages 0-6) policy on theoretical grounds in contrast to competing views that oppose any social policy. He suggests that early childhood has special features since policy must be integrated across the usual frameworks of health, education and welfare. He then reviews recent data indicating that while there has been some improvement in investment in early education relative to the number of pupils, it is difficult to determine whether adequate investment has been made in needy sectors of the population.

Greenbaum presents assumptions derived from research in developmental psychology and the rights of the child concerning the needs of young children and the environments that could meet those needs.

Finally, he suggests an integrated, egalitarian policy providing specific

programs for young children and for families in Israel based on these assumptions. These programs emphasize prevention, beginning with education for parenthood, and provision of effective support for families with young children at risk.

The advantages of universality in child allowances over the introduction of selectivity based on means testing are examined by Dalia Gordon and Tammy Eliav. Their paper presents the advantage of the universal system currently used, which achieves good progressivity even without means testing, and also reviews the implications of the administrative constraints which dictated the method of implementing income tests for family benefits during the years 1985-1992. The criterion for receipt of benefits at the time was the income of the main breadwinner only. The theoretical alternative is one in which the family income is the criterion for payment of family benefits, the main argument here being that the income test in use was inequitable, creating inequality in the receipt of benefits among families of similar income but different in the distribution of these incomes among the earners.

Joseph Katan deals with non-professional employment - an idea that was suggested about 30 years ago in the US, spread to other countries and brought a new message to the established Human Service Organizations (HSO's), and their professional workers. The main point of the message is that clients of HSO's such as poor people, residents of distressed communities, ex-mental health patients, and mothers with a large number of children - should be employed in these organizations in significant roles.

The paper reviews the development of the implementation of the idea, and analyzes the reasons for its partial implementation in Israel and in other western countries.

Meir Hovav and Avi Ramot review the development of Israel's system of care for the retarded from the founding of the state until the present day, Over the years there were changes in underlying conceptions as well as in the characteristics of the services delivered.

The entire period can be divided into four sub-periods, each of which is marked by different organizational and service delivery conceptions:

- Period I (1948-1961): Early organizational efforts and separation of care for the retarded from other services.

Period II (1962-1976): Establishment of special services and broadening of existing care frameworks (boarding schools; day care; sheltered workshops) as well as introduction of new legislation.

Period III (1977-1985): Ideological development, investment in planning,

training, research, and evaluation. The organizational level was raised to a high-level department which is also responsible for budgets and personnel.

Period IV (1968-1995): Intensification of care and broadening of frameworks dealing with married couples, diagnosis and re-diagnosis, support for the family, and inclusion of parents.

Over the years, the importance of care for the retarded individuals has risen in the eyes of the Ministry of Labor and Social Affairs, and this issue now has the highest priority. An emphasis has been placed on the relations with parents and joint activities. State custody is provided for those receiving care who are without parents. Public and private frameworks are relatively smaller, fewer services are directly provided by the state; there has been an expansion of sheltered housing as an alternative to boarding schools; and there has been an acceptance of new approaches to integrating the retarded individual into the community, and in normative frameworks.

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 the editor, Mr. Raphael Julius and to all the authors who agreed to have their articles published in the present issue of the journal, thereby contributing greatly to the Israeli experience in the fields under discussion.

Prof. Johanan Stessman
Director General
The National Insurance Institute of Israel

THE WELFARE STATE TOWARD THE 21ST CENTURY: THE NEW OLD ISSUES ON THE AGENDA

by Abraham Doron*

Introduction

This article, in its Hebrew version, was written to celebrate the appearance of the 50th issue of *Social Security, Journal of Welfare and Social Security Studies*, whose first issue appeared over half a century ago, in February 1971. Among the goals of the journal, according to its founders, was "to serve as a forum for clarifying questions with which social thought in our society is preoccupied" (p. 2). The main issue voiced in this context was "the problem of poverty protruding against the background of the welfare state", and within this, "poverty patterns and income distribution in Israel". It was further stated that Israeli society should be studied and explored in order to "objectively examine its weaknesses and problems, and to break out of the circle of acceptance of whatever exists in society" (ibid.). The Minister of Labor at the time, Yosef Almogi, agreed with these aims, and hoped that the new journal would "contribute to the understanding of the social, economic and technological changes and issues which shape our lives, and help direct our social policy in the right direction" (ibid., p. 4).

Looking back, one can state that these aims still remain of utmost importance in our society in the 1990s. Furthermore, they are given added significance in wake of the rapid changes taking place in Israel and in the world, bringing us towards the year 2000. Since the 1970s, these changes have been characterized by the sharp turn in the attitude towards problems of inequality, poverty and the welfare state in most developed countries on both sides of the Atlantic. Economic, political and social forces combined to erode the social security and social protection systems which had been built up in the post Second World War period, and led to new patterns of expanding inequality. The erosion of social security pushed large population groups to the margins of society and brought about the formation of new patterns of stratification,

* The Paul Baerwald School of Social Work, The Hebrew University of Jerusalem, Jerusalem, Israel.

sharply differentiating between the opportunities of the weaker groups in the population and those of the stronger groups (Lawson and Wilson).

The issues of *Social Security* reflect to a large extent the nature and strength of collective experience on the topic of welfare in Israeli society, as expressed during the half century that has elapsed since the journal first appeared. The dozens of articles that have been published in the fifty issues of *Social Security* endeavored to confront, each in its own way, the various problems of the welfare state, social security and social protection, with which the State of Israel has been dealing over the years. A perusal of these articles gives a comprehensive picture of the research findings, ideas and arguments, pro and con, regarding the different aspects of the welfare state and social security which were on the public agenda at the time. A notable share of the articles even opens a window to the world of welfare and social security abroad, thus enabling cross-national learning and comparisons which enriched social thought here in Israel.

With all the importance of the achievements of the 50 issues which have appeared so far, this does not mean that we can rest on the laurels of the past. The great changes that have taken place in our world and those that await us in the coming years set the journal with an old-new challenge of how to confront - and even more important, how to comprehend - the same problems faced by its founders: the same need "to clarify problems with which social thought in our society is preoccupied" (p. 2); the problems of poverty are more predominant than ever in our society of abundance; the poor and the needy have not yet disappeared from among us. Therefore, the challenge is in the need to search for solutions to the old-new social problems which continue to trouble us.

In the present article I shall attempt to sketch some of the main issues which will preoccupy us in the coming years, and for which we will have to search for answers. The challenge which *Social Security* will have to meet is, to what extent can it indeed continue to serve as a forum for new ideas and to present new and creative solutions to old problems in general, and in Israel in particular.

In the current era of the seemingly triumphant capitalist order, and the rush to return to unrestrained free market economies, there are some outstanding issues in the political discourse regarding the welfare state. The contemporary discourse is marked by a social and economic individualism bent on relinquishing the universalistic welfare state and its caring, protecting and empowering elements. The roots of this mode of thinking can be found in both traditional conservatism and in the more contemporary neo-conservatism. This thinking has nowadays been embraced by the traditionally left of center social

democratic labor parties, and thus left the political arena open to an onslaught of a combination of forces seeking to dismantle the welfare state.

The aim of these forces is to drastically reduce welfare expenditure, to replace the existing universal welfare state institutions with residual lower cost forms of welfare, to fragment opposition and to undermine sources of resistance to these policy trends. Though these policies are supposed to achieve an improvement in a country's competitiveness in the global economy by reducing labor costs, lowering taxes, and encouraging a return to the traditional virtues of individual responsibility, hard work and family cohesiveness, they also lead to the weakening of the sense of social solidarity, an increase in economic inequality, and a further degradation of the weak and poor population groups (Leonard, 1997).

The main issues addressed in the paper will be the intractable "social question", the meaning of the "social". the welfare state and the notion of social citizenship, the welfare regimes in capitalist societies, the rise of a "new Class" globalization, and the way in which these influence the role of welfare states in contemporary societies.

The Social Question

Notwithstanding the far-reaching changes our societies have witnessed since the 19th century, the "social question" has remained high on the agenda of contemporary capitalist societies. Although the "social question" is often associated with the problem of poverty, the issue is much more complicated and touches upon the very essence of contemporary society, the social integration of individuals and families within it, and the role of the state in caring for the welfare of the individual and the collective. In addition, the "social question" also relates to the ideological controversies that divide our societies.

From the end of world War II until the political and economic crises of the 1970s, it was hoped that the social question and the controversies associated with it would lose most of their meaning. It was thought that the intensive concern with these issues of the past would no longer be relevant in the welfare states established and developed during that period. In recent years, however, it has become increasingly evident that the social question is not only still relevant but it has also reemerged as a central issue in the politics of capitalist societies. If it is ignored, the social question may once again threaten established ways of life and the stability of liberal democratic societies.

In a sense, it can be argued that we have returned to the point where we started at the beginning of the 20th century. For example, when Herbert Croly, a leading spokesperson of the progressive movement in the US, defined the

social question in the first decade of this century, he did not consider it to be solely a problem of poverty. Rather, he claimed that "great inequalities of wealth are merely the most dangerous and stressing expression of fundamentalist differences among the members of society". According to Croly, the essence of the problem is "preventing such division from dissolving the society into which they enter - of keeping such a highly differentiated society fundamentally sound and whole". (Croly 1909, p. 139).

It seems that the challenge our society faces today is similar to that encountered at the beginning of the century. What characterized liberal democratic societies throughout most of the present century and especially following the great economic crisis of the 1930s and the devastation caused by World War II, was an attempt to find a solution to the social problem. The policies that evolved sought to resolve the conflict between the responsibility of individuals for their own welfare, and the collective responsibility of society for the welfare of individuals. Democratic societies responded primarily by establishing and developing the welfare state and by lending a social dimension to the status of citizenship (For a broader discussion , see: Heclo, 1995).

The Meaning of "The Social"

The challenge of the social question is related to our own perception of "the social". McDonald, for example, asserts that in contemporary societies "the meanings of "the social" are increasingly uncertain". In his view, there are clear indications that the "social connections" which molded the lifestyle of industrial societies are weakening. The leading trends are toward individualism, representing a hedonistic, narcissistic culture which rejects the deferred gratification patterns that were central earlier. In industrial culture, which supported collectivist values and the creation of institutions that contributed toward social cohesiveness, deferred gratification was a central pattern. The present uncertainty arising out of the weakening of "the social" is reflected in negation of the welfare state and the delegitimization of its redistributive dimensions. This development is underscored by "the perceived illegitimacy of the idea of redistributing wealth in any direction except towards the affluent" (McDonald, 1994).

The contemporary era is witnessing the erosion of social identities that were central to the culture of industrial society. This is evident in the decline of the labor movement and the weakening of labor unions, which are being replaced by new forms of identity based on ethnicity, individualism, and gender differences. These processes point to the end of the industrial era and its correspondence to the nation state. They have been replaced by "triumphant

economics". The language of public discourse is the language of economics and economic thinking has become a dominant factor setting the course of societal development (McDonald, 1994).

The social and cultural norms that provided the basis for social relations have been replaced by the norms of economic behavior. Market forces and their competitive features increasingly constitute the basis of social interaction. And these have resulted in the dislocation of the established social order and the erosion of the idea of society. It is however, only in the "social" that we can find the cement that can bind diverse identities such as class, nation and other identities, such as ethnicity, etc. The most powerful element integrating these different forces is still to be found in the institutions of welfare states.

The Welfare State and Social Citizenship

The Marshallian concept of social citizenship was intended to add a social dimension to the status of citizenship, above and beyond the civil and political rights that were developed in the 18th and 19th centuries. Social rights were intended to enhance the notion of citizenship. On the basis of the "social rights of citizenship" principle, the welfare state that developed after World War II reflected the desire of the liberal democratic state to assure all its citizens a certain floor of income, nutrition, medical care, housing, and social care (Wilensky, 1975).

Integration of the social dimension of citizenship with the civil and political dimensions derived from recognition of the close relationship between possession of social and economic resources and the ability to realize the broader concept of citizenship. The central assumption was that individual liberty and social well-being are closely linked. In a free society with a high degree of inequality, people at the lower end of the income distribution ladder, who suffer from economic hardship and poverty, are unable to realize their civil and political rights. In order for individuals to enjoy the full status and benefits of citizenship, and to participate in societal life, they must be guaranteed a certain level of social security, economic welfare, and a proper level of living in accordance with the accepted standards in the society in which they live. In Marshall's words, the goal is "a general enrichment of the concrete substance of civilized life, a general reduction of risk and insecurity, an equalization between the more and the less fortunate at all levels" (Marshall, 1963, p. 107).

In more concrete terms, the intention was to assure all citizens an universal right to social security regardless of their value in the economic market or their contribution to the economy. In this context, the social security system was to become the main core of the welfare state. In the 1950s and the 1960s, it was

commonly believed that these aspirations would soon be fulfilled. The 1990s, however, have witnessed a retreat from these aspirations. As a result, integration of social rights into the status of citizenship has only been achieved in a very partial way. Once again, emphasis is placed on market values dominance and the social dimension of citizenship has been cast aside. The concept of social rights of citizenship has been rejected to a large degree by the political forces dominant in our societies.

The political forces actively opposing the idea of social rights of citizenship draw support from the traditional themes of conservatism or from the current mode of neo-conservatism. Conservative ideologies deny the very existence of social rights flowing from the status of citizenship. The most outspoken exponent of these views, F.A. Hayek, categorically rejected the idea of social rights of citizenship, claiming them to be a manifestation of creeping socialism and a mirage of social justice (Hayek, 1960, 1976). Today, the principal advocates of these views are the extreme right wings of the Conservative Party in Great Britain and the Republican Party in America.

While the perspective of the conservative forces has gained in strength, there are diverse social and political forces still committed to the social democratic (or "liberal" in American terms) perspective, which asserts that the social dimension of citizenship is an integral part of the ongoing efforts to improve the conditions of life for the population as a whole. A wide spectrum of views exists among these forces. At one extreme, are those who claim that the idea of social rights of citizenship reflects the desire to promote social equality. B. Abel-Smith, one of the exponents of this view, argued that the main goal of social policy is to achieve more equality (Abel-Smith 1984, p. 169). Similarly, Plant views the concept of citizenship in a broad perspective and claims that it has to be conceived not only in the provision of basic welfare services but in the context of a broader program of greater social equality. The social dimension of citizenship has to reflect the distributive principle designed to obtain social justice. The value of freedom and liberties endowed to individuals as citizens must be equal in all spheres of life (Hoover and Plant, 1989).

At the other extreme are advocates of a much more limited view of the social rights of citizenship Dahrendorf (1975) argues, for example, that these rights should be regarded as a minimum level of provision for all citizens, which should serve as a "basic common status". In Dahrendorf's view, "in order to create and maintain a free society, it is in any case indispensable that every man may be a citizen in the sense of his legal rights, and can be a citizen in the sense of his social condition". Beyond the minimum floor assured to all citizens, individuals should be allowed to reach the standard of living they are willing

and able, to attain (Dahrendorl, 1975, 42-43; Espada, 1996). Beyond ensuring the minimum safety net of provision, the idea of social rights of citizenship should have no further egalitarian implications, as any broader effort to achieve equality could undermine the legitimacy of the entire stratification structure, with all of its undesirable implications.

The Welfare Regimes in Capitalist Societies

In Israel, the present democratic-capitalist regime is now accepted without reservation. Any debate regarding the nature of the regime has long disappeared from the public agenda. The collapse of Communism in the Soviet Union and its satellites at the end of the 1980s administered the final death blow to the remnants of this debate. Indeed, the capitalist system now sought in Israel is based primarily on the American model. As in many countries, Israel seeks to emulate America and follow its lead in many other spheres of life. In particular, Israel has adopted the US capitalist system with all its ramifications.

The American model of capitalism is not, however, the only existing model of a free market society. Other capitalist models include those prevalent in Europe, Japan and in other parts of the world. In its zeal to adopt the American model, Israeli society is insufficiently aware of the major differences between the American and European models. The American model has certain unique features that should be weighed carefully before they are adopted. First, it is based on a Darwinian competition for profits. By nature, the system focuses on the survival of the fittest and disregards those who lose in the struggle. This type of Darwinism clearly works to the advantage of some firms but does not necessarily benefit other members of society or the community as a whole. Prof. Y. Frankel, Governor of the Bank of Israel and the most influential advocate of this model in the country, recently claimed that it is important for entrepreneurs to know that "they are competing in an economy operating on Darwinian laws" (Quoted by Caspi, *Ha'aretz* Supplement, 27.3.1992 [in Hebrew]).

Second, the American model emphasizes small government and low taxes, on grounds that high taxes distort the economy This argument ignores the fact that not all taxes have the same effect on the economy. For example, high V.A.T. rates in Europe cause much less economic distortion than excessive reliance on direct taxes. Regarding "Small government", there is plenty of evidence indicating that in many cases public provisions under government auspices is more economically efficient and socially effective than private

provisions. For example, public health services in Europe are more effective and efficient than those provided privately in the US (Kaletsky, 1997).

Third, with regard inequality of income and wealth, the US has never claimed to be an egalitarian society. However, over the past two decades there has been a dramatic increase in the income gap, which has aroused concern even in accepted American terms, The great increase in wealth among selected groups in America has been accompanied by a growing number of working poor and a declining standard of living among the middle classes. Moreover, since the end of the 1960s, a substantial body of literature published in the US has defended inequality and argued against redistribution of income and wealth, thereby reinforcing these trends (Fitoussi, 1997).

The attempt to introduce the American model of capitalism in Israel over the last decade has yielded similar results. The Israeli economist Z. Zussman asserts that one of the major factors linked to the growth of poverty and inequality among families is the great wage differentials among the employee population. In recent years, these wage inequalities have reached levels that are rarely found in other developed countries (*Ha'aretz*, 1997). The European capitalist model, which is based on a different intellectual tradition, rejects the social consequences of the American Model and its various justifications. While it can be argues that the American model may be rather effective in increasing overall wealth, clearly this is not the case when dealing with the welfare of the population as a whole and when seeking social cohesiveness and stability.

The negative consequences of the American experience are very obvious. "A child born in New York today is less likely to live to five than a child born in Shanghai. A young American black man is more likely to go to jail than to college. We have seen a collapse of respect and trust for every American institution and community value" (Quoted in Kaletsky, 1997). These and other social problems caused by poverty and the widening social gap have placed a heavy toll on American society. Any visitor to one of the big US cities in recent years can easily see the implications of these costs.

Certainly, the extent to which a society should tolerate inequality and social gaps is not only a matter of economic management but predominantly a political issue to be resolved in a democratic-political process. Israeli society, therefore, has to decide whether it is prepared to adopt the American capitalist model and accept its negative consequences. Moreover, the question is whether Israel as an immigrant society and developing nation, can adopt such a model without risking dangerous upheavals within it.

The Characteristics of Capitalist Welfare Regimes

Two welfare models have evolved in Democratic capitalist societies: The institutional welfare model and the residual welfare model (Wilensky and Lebeaux, 1958; Kahn, 1969; Abel-Smith and Titmuss, 1974). The institutional welfare model stresses the importance of collective intervention in meeting the personal and social needs of every individual and regards such intervention as a desirable form of societal action. Under the residual welfare model, the role of society should be limited and left to intervene only in those instances where the regular function of the market and sharing family resources have failed to meet the needs of the individual and family. Thus the difference between the two models reflects the difference between the universalistic welfare state which cares for the entire population, and the selectivist welfare state which provides for the weak and poor only.

The welfare regime, that evolved in Israel until the 1970s, was primarily institutional and universalistic in its nature. This was the accepted model in most Western European countries. However, in line with Israel's tendency to emulate the US and adopt the characteristics of the American capitalist model, Israel has been replacing the Institutional welfare model with a residual one. The American model is basically built on the concepts of social and economic individualism, the dominance of market forces and limited government intervention in provision of social protection. The dominant orientation of this model is toward a high degree of social insecurity, depending on fluctuation of the market forces. This clearly results in a much greater degree of individual risk and social uncertainty, inequality, and injustice (Larson, 1996).

The changing orientation of the Israeli welfare regime reflects a decline in the commitment of its elite groups toward a solidaristic welfare policy. Such policies are based on collective intervention in the provision of social care and protection, prevention of increasing gaps in the distribution of income and other resources, and promotion of social integration among various populations in the community. Adoption of the residual American model reflects a desire to undermine the more solidaristic social policies which Israel adopted for many years. Social policies based on European capitalistic models and welfare regimes generally refuse to condone major social gaps and growing inequality. They reject marginalization of the welfare state, which provides the least protection for disadvantaged and poor populations.

Policies adopted in recent years in Israel have focused primarily on drastic cuts in social expenditures and reflect an intention to impose the American welfare model. These retrenchment policies have tended to disregard the

socially injurious effects of these measures. The social and political thinking behind these measures is based on the assumption that the economy should be free and unfettered by social concerns. Opponents of this approach claim that the purpose of the economy is to serve society. Thus, elimination of established societal arrangements that safeguard the living standard of large groups in the population have a corrosive effect and may eventually impede economic growth and development. In the current political climate, however, advocates of these views are frequently portrayed by the present economic establishment as irresponsible populists whose views will impede economic growth.

The repercussions of imposing the American welfare model in Israel will be felt in the widening of the social gap between various population groups, and growing personal and economic insecurity. The weaker population groups will be the most affected and thus the process of their societal integration will be hampered. The dangers of these developments to the cohesiveness of Israeli society are obvious. The challenge is thus to prevent these negative developments and find an appropriate way to channel the Israeli welfare regime into more institutional and solidaristic directions.

The New Class

Another social policy challenge faced by Israeli society relates to the trend toward disengagement and separation of an emerging new class. Various social theories indicate that changes in production methods may lead to the rise of new dominant social classes. The emerging new class tends to adopt the social and cultural values that conform with its economic status. In recent years we have witnessed the growth of such a new dominant class, which is skilled in operating the electronic age of the computer world. Although this rising class is still in its nascent period, its members have adjusted rapidly to the economics of the computer age and have used it to advance their interests.

The new class of experts skilled in operating the new electronic modes of production do not act differently from the traditional ruling bourgeois class. They give the impression of being an expert status group with no direct interest in politics. However, behind the apolitical façade lies a clear political view of economics and society which has a direct bearing on social policies. This view supports an unrestrained market economy, the reduction of the tax burden, the cutting of government expenditures, and privatization. In all of these areas the views do not differ substantially from those of the traditional capitalist establishment. These views are, however, essentially different from the attitudes of the main working class groups that are not partners to the new information

age. They are also far from the attitudes of those groups that find themselves on the losing side and at the bottom of the new stratification ladder.

The occupational structure of the electronic age offers a clear advantage to the new class of experts who possess the knowledge and skills required to operate the new modes of production. The demand for workers who lack these skills is inevitably diminishing, and there is increasing unemployment among the groups of workers that constituted the main core of the Fordist production mode, and who comprised the backbone of the industrial workforce These groups of workers have to adjust to low wage jobs and diminishing work related benefits. The result of this development is the emergence of increasing polarization within the working population between the new expert class and the other groups of workers who are pushed to the margins of the labor market.

The emerging new class also tends to develop a lifestyle suited to its dominant position. The new individualist lifestyle emphasizes conspicuous consumption, self indulgence, world travel, and a tendency to join esoteric cults. An Israeli journalist, L,. Etgar, described the peculiarities of this lifestyle in the following manner. "[people who] exercise in the right clubs, are good-looking, live in a fancy house, drive the latest all-terrain vehicle, dress well, belong to the leading social groups, and holiday at the 'right' ski resorts with the 'right' people..." (Quoted in Klein, *Ha'aretz,* 6 March, 1997 [in Hebrew]).

This new class has been gaining power in our society. It has been using its power to influence evolving patterns of life, and the impact of that lifestyle is already felt. However, in the sphere of economic and social affairs, the new class has had a particularly profound impact on social welfare and social security policy. The high income attained by this group enables its members to dissociate themselves from the wider population. In the separate niches its members have created for themselves, this class has not only developed better housing but has also established preferential services in education, health and other service areas. As a result of this separation from the general population, the members of this new class are no longer interested in the universal welfare state which provides services for all. They are no longer dependent on these services, since they have created or are in the process of creating a separate system of private services. Subsequently, this has generated a demand for retrenchment and cutbacks of the universal welfare state. In their view, Israeli society no longer requires such services, and to the extent that such services need to be maintained, they should be targeted upon the disadvantaged and poor population groups.

This disengagement lends political legitimization to the demands of this group and other establishment groups that seek to shed the financial burden of

providing for the needs of weaker populations. The increasing support for privatization and the establishment of a separate system of private services reflects the current Neo-conservative orientation of this emerging new class. Ultimately, the trend toward expansion and bolstering of separate social services for strong populations while reducing and cutting services for the population at large could undermine the political stability and social order.

Globalization

Another issue that social policies have to take into account is closely related to the globalization of the world economy. Although the term "globalization" was first coined in the 1960s, it was not widely used in academic circles until the 1980s (Waters, 1994). In economic terms, "globalization" refers to a transition from a nation-state economy to one that transcends national boundaries and is based on competition between different countries (Pierson, 1991). The term is not limited, however, to the economic sphere. It also reflects the manner in which the powers of the nation-state have become limited in an era characterized by the emergence of an elaborate network of transnational connections. Although the nation-state has retained its sovereignty, it is difficult to ignore the fact that it is losing some of its effectiveness. The "state-centric" world is being replaced by an emerging "multi-centric" world, and the interaction between the two creates turbulence. The expansion of the global market is driven largely by its own dynamic. But it is also profoundly affected by the operation of the nation-state and the other global political networks (Waters, 1994).

The transition to a global economy which transcends national boundaries has made an important imprint on the national-welfare state. Global economies are much more sensitive to the upheavals of world trade and rapidly changing international finances. All of these limit the freedom of action and choice of countries in their domestic affairs and welfare policies. Every measure in these areas may influence, and be influenced by, economic competition. Inability to withstand this competition can harm the economy of the nation-state as market forces beyond the state's control are ignored (Esping-Andersen, 1996).

Increasing competition in the world economy thus forces many countries to abandon earlier policy patterns, that constituted the protective base for their welfare states. The major results of these changes can be seen in cutbacks in public expenditure for social welfare and pressures to increase the flexibility of their wage policy and other work conditions. The welfare states of the advanced countries have been forced to confront these pressures in one way or another and to make their labor costs more flexible. In a global economy there are

always countries where relatively low labor costs allow for successful competition with other countries. For example, the Nike shoe company did not hesitate to move from Indonesia to Vietnam when it discovered that labor costs would be lower in the latter (Herbert, 1996 [in Hebrew]). Israeli textile companies are moving their production to Egypt, Jordan and Turkey which offer lower labor costs (Zohar, *Ha'aretz*, 25.9.97 [in Hebrew]).

Notwithstanding these outcomes, the major effect of globalization is in the changed balance of power between employers and employees. Globalization effectively reduces the power of the working population vis-a-vis the industrial establishment. The relative ease with which industry can move its production abroad has contributed substantially to job insecurity, stagnation of wages, erosion of non-wage related wage benefits, and has weakened trade unions. The essential rights achieved by workers over the past 150 years are being undermined in this process. In Addition, globalization makes it increasingly difficult for governments to continue to provide social protection by means of the established social security systems as it becomes harder to raise taxes to fund them (Rodrick, 1997).

These developments limit the ability of countries to maintain the living standard that proper wages and social welfare and social protection systems assured their populations in the past. The issue is how to cope with this problem. Thus, for example, Jordan and Egypt can easily compete with the low wages that already exist in the Israeli textile and food industries. Pressure to lower wage costs will probably enable these industries to sustain themselves in the short term. However, this will occur at the expense of maintaining the low productivity of these industries, notwithstanding technological developments in the world economy.

Clearly, the struggle to maintain the competitive capacity of national economies by reducing labor costs is limited to those sectors in the economy that are labor intensive and employ low-skilled workers. Various countries have adopted different policies to handle this problem. The US and the UK have chosen the strategy of deregulation of labor markets and erosion of wage levels among these employee groups. Consequently, they have relatively low unemployment rates and can better absorb new entrants, especially young people, into the labor market. Low unemployment, however, has been achieved at the cost of creating a new class of low wage-earners, that suffer from economic hardship, and a steep increase in the existing social gaps.

Most European countries have chosen a different strategy, which has focused on increasing labor productivity as a means of maintaining their capacity to counteract competition from abroad. They are prepared to provide generous

compensation to those affected by changes in the labor market in order to prevent the social gap from widening. However, the cost of these measures is a rise of unemployment levels and reduction of the chances of certain population groups, such as women, to enter the labor market and maintain their employment status in it. When given a choice between increasing jobs and equality, European countries have chosen the latter.

The answer to competitive pressures in a global economy is not necessarily found in the reduction of wages and the lowering of the standard of living among the working class - a policy which has been implemented in the US or the UK. An alternative policy is to increase labor productivity above productive capacity - a strategy adopted in Western European countries in their competitive struggle for a position in the global economy. These policies have been chosen in order to be able to continue assuring the working population job conditions and wage levels that will enable them to attain a standard of living that meets expectations for the year 2000.

Clearly, Israel has chosen the strategies adopted by the US and the UK. The question that remains is whether a small, heterogeneous society with a large population that is still in the process of absorption and social integration can cope with the social gaps and inequality that are inevitably generated by this policy.

The long-term solution to this problem in the global economy is based upon education and improved vocational training. Investment in these fields will eventually reduce the size of the working population with low occupational skills that generate low earnings, and that place them at high risks of unemployment. The availability of education and training opportunities throughout the individual's working life cycle will increase occupational mobility to better paid jobs and thereby provide an escape route from the trap of low wages and low standards of living.

Such programs will not prevent competition with countries in which labor costs remain very low. However, countries with a low level of technological development are not a serious competitive threat to developed countries in Europe, the United States, or even Israel. Indeed even the threat to the highly developed economies of the West from the "tiger" economies of Southeast Asia such as South Korea, Taiwan and Singapore which have witnessed rapid economic development and growth, is not as great as we tend to assume. Closer examination reveals that their competitive advantage, deriving from low labor costs, is diminishing with time. These countries have also witnessed a constant rise in labor costs which will continue in the future. Moreover, internal developments in these countries indicate that they will not be able to postpone

the establishment of more comprehensive social protection systems much longer, such that some convergence will eventually be achieved with their advanced counterparts in the Western world (Esping-Andersen, 1996).

Obviously, Israel cannot avoid the current developments in the global economy. However, the social and political factors that brought about the development of the welfare state in various countries continue to play a decisive role in the age of globalization. Each country seeks solutions to globalization within the context of its cultural and political heritage and institutional patterns and within the institutional systems that gave rise to the welfare state. The changes that have taken place were largely influenced by the prevailing political climate, the institutional features of the social welfare and social security operating in them, and the various interests that these systems have cultivated, pursued, and strengthened. The welfare state will thus have to make some necessary structural adjustments in order to adapt to the changes in the global economy. It seems, however, that the welfare state will remain as long as the political tradition of care and the protection of the welfare of all citizens continues to guide our policies.

Discussion

The social, political and economic problems dealt with here have not essentially changed the issues of social welfare and social security policy on the public agenda. The problems we have to deal with in Israel are similar to those found in other welfare states. Moreover, these have not changed much since the beginning of this century with the inception of the welfare state in industrialized countries. The issues of social inequality, growing income gaps, insecurity among large parts of the working population and the difficulties to mobilize the required resources and political resolve to meet the needs of the weaker population groups and to narrow the social gaps are still with us.

The main problem facing most industrialized countries, including Israel, is how to deal with the transition from an industrial society to a society whose new contours are not yet sufficiently clear. We stand at the gates of a new epoch, not only in the sense of entering the next millennium. In earlier periods the beginning of a new era was accompanied with great optimism and expectations for a continuous improvement of the conditions of life. By contrast, the beginning of the new millennium is permeated with growing pessimism and apprehension of what the future holds. The atmosphere is characterized by declining expectations, lack of confidence in possibilities for progress and improvement in the station of individuals and society (Taylor-Gooby, 1997).

The insecurity we face with the advent of the new era derives not only from the recent collapse of major ideologies, such as that which prevailed in the Soviet Union, but also from the decline of central institutions and structures that evolved and operated in the present century. The diminished power of the working class is of major significance in this context. For example, the assumption that the working class shares a common consciousness that can be mobilized to improve social conditions and provide care and protection for all, has now little base in reality. In contrast, we are witnessing an increase in the strength of financial entrepreneurs and industrialists, who work together effectively to further their interests. Institutional changes that are gaining momentum such as privatization, cast aside the general interest and enable small groups of financiers to impose their interest on the general public.

Changes in patterns of employment and attempts to increase the flexibility of labor markets have had far-reaching implications for the entire system of labor relations, that evolved since the beginning of the century. This is clearly reflected in the erosion of labor legislation, designed to protect workers against unfair work conditions and exploitation of weak worker groups. This trend is also reflected in anti-union legislation as in the UK and in court decisions aimed at weakening workers organizations. As a result, there has been a significant decline in union membership and in the power of the unions.

All of these developments require innovative and creative thinking with regard to social welfare and social security policies. They also reaffirm the importance of the welfare state and the essential role it has to continue to play in combating social insecurity and preventing further growth of inequality and social gaps. Our capability to make the transition to the new era without major upheavals in the existing social and political order depends largely on our success in producing new policies that suit the needs of our changing societies without returning to the policies of unrestrained capitalism that characterized the earlier era. The challenge before us is to secure social policies that are compatible with the needs of the 21st century and not to return to policies of the 19th century.

A clarification of these problems and a fruitful discussion of possible solutions to them, in order to help direct "social policy in the right direction", as intended by the founders of the journal, set a serious challenge to the next fifty issues of *Social Security*.

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PRIVATE FINANCE, "SUPPLEMENTARY INSURANCE" AND REFORM OF ISRAEL'S HEALTH SYSTEM: PERILS AND PROSPECTS

By Dov Chernichovsky*

Introduction

Like the reforms initiated in the developed industrial nations, the OECD[1] member states, the recommendations presented to the Israeli government in 1990 by the Netanyahu Commission, and the ensuing National Health Insurance Law (NHIL) enacted in 1995, were designed to establish in Israel universal entitlement to care and a health system characterized by sound economic and organizational features (State of Israel 1990). The aim of these features has been to promote social equity, to prevent unchecked expansion of national health expenditures, to enhance client satisfaction from care, and to improve production efficiency (Chernichovsky and Chinitz 1995; Shirom 1995).

In light of these goals, it is essential to examine how private funding and particularly the highly debated privately-financed supplementary insurance are to be integrated into the publicly supported or financed health system, as these can seriously impinge upon the character and future of Israel's newly designed system. Such an investigation should be objectively focused and as free as possible of the ideological baggage that frequently intrudes into discussions of the issue.[2]

Accordingly, within the context of this paper, a number of background features relevant to the issue are described. The pertinent concepts and their

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* Ben Gurion University of the Negev, Israel and The National Bureau of Economic Research, USA.

The views expressed in this paper are the author;s alone.

1. OECD is the Organization for Economic Cooperation and Development.
2. The reader's attention is directed to our use of the concept "publicly supported services", or "services under a public contract", rather than "public services". In Israel, as in the majority of OECD countries, services are publicly funded or are based on principles of public finance. But in Israel, as well, excluding government-owned health institutions, the majority of service suppliers and contractors are not public in the sense of being directly owned by the government. There suppliers are profit-oriented or, in most cases, non-profit oriented organizations, which operate under the terms of a public contract (In Israel Chernichovsky, 1995; Hurst, 1991).

ramifications for the achievement of the goals of a modern health system are defined and briefly reviewed. Finally, an international comparison of the relevant issues is presented together with pertinent conclusions regarding the Israeli reform.

Background: The Israeli System

To put the discussion into perspective, some major aspects of Israel's health system should be noted.

First, life expectancy at birth in 1995 was 79.5 for females and 75.5 for males. These are among the world's highest life expectancy levels. Infant mortality rates, which are sensitive to the quality of health services (and the general standard of living) were 8.1 per thousand live births for the period of 1991-1995. These rates are among the worlds lowest.

Second, Israeli expenditures on health, as a percentage of the gross national product (GNP), reached 8.7% in 1995 according to the latest available data (Central Bureau of Statistics (CBS), 1997). For the purposes of international comparison, 1992 data will be cited. In that year, Israel's expenditures were 7.8% of GNP, a figure which is about the average expenditure on health of OECD countries during that same year (CBS, 1995; Greenwald and Scheiber, 1994). That is, Israel's allocation for health is equivalent to that of the most developed industrialized democracies. When taking GDP per capita (1992) into account, the predicted value of health expenditures in Israel, based on the OECD average, should be about 7% of GNP.[3] During the same year Israel spent approximately $950 per capita (according to the official rate of exchange), as opposed to the expected or predicted sum of $810. In other words, Israel expended about 17% more than the sum predicted by its GNP, excluding any adjustment similar to that introduced by G. Ofer (1987) for the relatively young age of its population.

Third, Israel has no lack of real resources: manpower: equipment, or technology. The number of practicing physicians in Israel was estimated at 3.6 per 1,000 (1993), as compared with the OECD average of 2.5 practicing physicians per 1,000 (Ministry of Health, 1994; Scheiber, Poullier and Greenwald, 1994). In other words, there obviously exist supply pressures in Israel, not present elsewhere among developed nations.[4] These pressures very probably induce enlarged demands for care in the system that, in turn,

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3. This estimate is based on the following linear relationship, according to OECD data (1990): *Health expenditures per capita = - 520.034 + 0.1148 (income per capita).*
4. It is reasonable to assume that the number of non-active physicians in Israel does not exceed 21% of the above figure, considering the country's rate of individuals aged 65+

contributes additional pressure to raise the amount of national expenditures on health. Moreover, this occurs despite the minimal, if any, inherent potential, given the existing high level of health, for improving the general level of health of the population.

Fourth, Israel's health system is marked by the extensive use of Western technology, much of which was developed in the US in order to solve problems of, among other things, high-cost manpower. Within the context of the Israeli system, some of this technology is economically unjustified in view of the relative abundance of medical manpower (and the power of the medical unions in resisting any possible reduction in wages). In other words, Israel displays a tendency to adopt new technology that, almost as a rule, increases the cost of care in Israel despite the minimal potential of technology, and contributes in the short term to any reduction in the cost of services, by means of the introduction of automation or savings in manpower.

Fifth, the proportion of private, out-of-pocket, expenditure on health in Israel is relatively large compared to OECD members. In Israel, in 1992, the average expenditure was about 28% of total health expenditure by comparison with a figure of 24% (1992) in the OECD countries. This point is underscored by the fact that in Israel the anticipated value, given GDP per capita, is 20%.[5] This means, that taking into consideration the nation's GDP, private expenditure on health in Israel is higher than in OECD countries. This fact is quite significant. A high rate of private expenditure on health usually induces a high proportion of total expenditures of the GDP on health. This is the result of the relatively limited ability to control private expenditure. In systems based on public finance principles, like the Israeli, the proposition of private finance in national health expenditure can serve as an indicator of inequality in access to health services. It can also serve as a criterion for the estimation of consumer dissatisfaction with publicly funded services. The tolerance of gray and black medicine (under the table pay and private practice in conjunction with public finance) also indicates supply-based pressures — within the public system — which also influence demand outside the system.

The rise in the proportion of private health expenditure in Israel during the

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among its pensioners. Within Israel's population aged 30+, the population relevant for calculating the number of physicians, the rate of active physicians is estimated to be 3.6 per 1,000.

5. This datum is based on the following linear relationship: public funding = 90.6 - 0.00089 (GDP per capita). We should note that the data does control for black (illegal) and gray (semi-legal) medical services, paid for under the table, which may increase the reported values for Israel.

1980s indicated, at least at the time, the crisis in the system. This crisis eventually gave birth to the Netanyahu Commission and the National Health Insurance Law. The difference between the majority and the minority opinions among the Commission members was, to a considerable degree, attributable to disparate interpretations with regard to private *versus* public spending (State of Israel, 1990, vols. 1 and 2). The majority perceived the increase in private funding as a *symptom* of the system's ills and its inability to adapt to the changed circumstances, namely an aging population, and the consequences thereof, namely rising standards of leaving and consumer expectations, as well as a reduction of government funding as part of the war against inflation. The minority opinion, on the other hand, believed this phenomenon to be the source of the crisis. Nonetheless, both opinions supported the strengthening of public funding principles in the system, irrespective of the specific percentage of GDP expended on health. Among its many aims, the purpose of this strengthening was to foster equity within the system and, no less important, to promote macro-efficiency by means of budgetary controls and the reduction of unnecessary costs, as discussed below.

Sixth, the National Health Insurance Law rationalized only one area of the reform as proposed by the Netanyahu Commission, namely finance.[6] The law did not rationalize two other critical areas: firstly, administrative decentralization and secondly, increased competition within the system between, on the one hand, existing and prospective sick funds, and on the other hand, service providers.

Seventh, the allocation of funds in accordance with a capitation mechanism established by the law, is intended to prevent capitation recipients, i.e. the sick funds, from increasing their income as a result of the introduction of a method that would enable the funds to differentiate between patients and treatments respectively. In other words, that law aims to promote competition for individual subscribers by means of competition on quality of care and service to be further discussed below.

Basic Concepts

The ensuing discussion of our topic requires the following definitions:

- Public Finance Principles (PFP) - Finance of health services[7] derived from

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6. Nevertheless, the law does even this only partially. The law's disregard of the Commission's suggestions regarding solution of regional issues, and its non-inclusion of "distance" in its capitation formula, prevent an equitable allocation of health funding.
7. The term *service* also refers to the products which are part of the service.

income-based or even risk-based mandatory contributions, which are not necessarily channeled through the government's budget (Chernichovsky, 1995 ,1997).

- The Basic Package (BP) - Medical services which are financed by means of public finance principles and which every citizen is entitled to receive or obligated to insure for.
- Public Contract (PC) - Medical services (the BP) paid for or funded by funds raised through PFP, irrespective of ownership and civil service status of the provider.[8]
- Excluded Medical Services (EMS) - Medical services which are not included in the BP.
- Amenities (AM) - Goods and services of non-medical nature that can be purchased in conjunction with medical services.
- Quality Basic Package (QBP) - Actual or presumed quality adjustment of the BP.
- Ancillary Services (AS) - Services of any type (AM, EMS, QBP) not included in the BP.
- Private Basic Package (PBP) - Services (regardless of quality judgment) included within the basic package but purchased with private funding.
- Supplementary Package (SP) - Privately-funded services supplied by insurers/ providers operating under a public contract.
- Private Insurance (PI) - Privately-funded insurance covering ancillary services.

The scope of AS and the SP is illustrated in figure 1, having all the possible combinations of AS and SP. In addition, three possible fundamental public-private mix situations are possible as illustrated in Table 1. In the *purely private sub-system*, the AS and SP of any possible combination (per Figure 1) are supplied by providers who have only private contracts, i.e. financed through private funds including private insurance, even if the providing institution is not privately owned (square 1).[9] In the *purely public sub-system,* the BP is provided by suppliers, of any type of ownership, who have only public contracts (square 3).[10] These two systems can co-exist in the same *fully*

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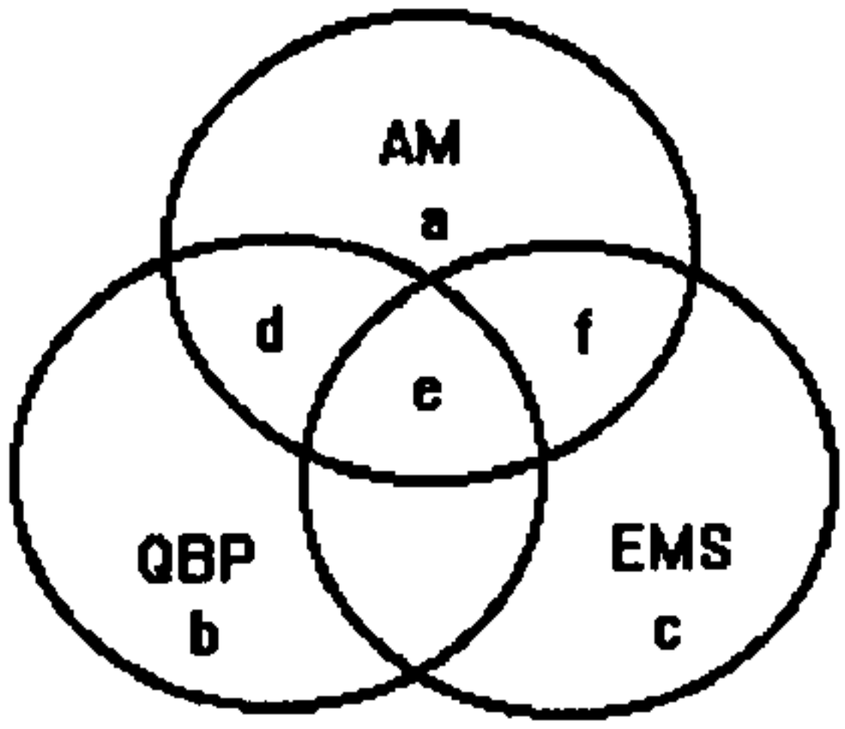
8. The readers attention is directed to the use of the term "public contract" referring in this paper to the source of funding, rather than the means of its management. That is, the term "public reimbursement" used by Hurst (1991), would be a means to pay under a public contract. In addition, providers who are not civil servants can work under public contracts.
9. For an elaboration on this issue, see Chernichovsky and Potapchik (1998).
10. This consideration does not apply to medical goods and services which are part of the BP but which are subject to an uninsurable co-payment which aims to reduce "unnecessary" demands or raise revenues.

Figure 1. Possible Combination of Ancillary Services and Options for Private Insurance



segregated health system. The providers in this system must choose the type of contract under which they operate.[11] In the *combined health system*, the service providers, irrespective of the type of ownership, are uniformly authorized to supply services within the framework of either private (privately funded) or public (publicly funded) contracts (square 3).[12]

In general, when the services under public and private contract are substitutes, let alone when they are complementary, economic theory predicts what is borne out by reality, as we shall see further in the discussion, that in the combined system in which providers can operate under both private and public contracts permits:[13]

- Exploitation of the status and condition of the patient in order to justify privately paid services, especially when the socioeconomic circumstances of the patient are known to the service provider.

- Utilization of public infrastructure and resources for encouraging the demand for privately paid services.

The first evolves from the natural and justifiable interests of service providers in increasing their incomes and other utilities (e.g. research), and a consumer who is ill-informed, and in particular who might be of interest to the provider,

11. Inclusion of insurers/sickness funds in this scheme follows further in the discussion.
12. It is worthy to note that while to pay privately for service is a client's prerogative, he can rarely opt out from contributing to the public system because he pays/insures for services privately. Excluding Germany, which allows the top income decile to opt out, no modern, publicly funded system, has retained this option.
13. The specific incentives depend on the ways providers working under public contracts are compensated. The incentives to exploit the client may be highest where providers are reimbursed through prospective mechanisms (i.e., wages, capitation, DRGs) and least when reimbursed through retrospective mechanisms (i.e., fee for service). See Chernichovsky, 1997.

Table 1. Possible Funding and Service Provision Options

SOURCE OF FUNDING / PROVIDER OPERATING UNDER	Private (including private insurance)	Public
Private contract	(1) Purely private system	
Public contract	(2) Combined system	(3) Purely public system (BP)

e.g. or who has the financial means to pay privately for the service (either directly or indirectly through private insurance). This interest is implemented primarily through referrals from public to private practice of the same provider, either on the premises where he operates under the public contract or other premises.[14] Alternatively, there can be collusion between providers operating under different contracts whereby providers, working under public contracts, refer - for a "commission" – to providers, working under private contracts.

The second tendency, which usually follows from the first, is related to the service provider's incentive to promote private practice through the publicly-funded sub-system by using – when possible, usually when facilities are budgeted – the infrastructure of this sub-system for private practice. In this way, by savings on inputs, the service provider lowers the cost of the services to himself. He also lowers the cost to the client, almost invariably, when compared to the situation where the client needs to pay privately for the full service, including the elements provided through public finance. A common routine in Israel, for example, is for a physician working under a public contract to refer the patient to his private practice, usually to his private clinic, and then to prescribe medications and refer the more expensive treatments to be handled (paid for) under the public contract.

These tendencies eventually undermine all basic objectives of the publicly-

14. This is considered as the exercise of discretionary and discriminatory monopoly power by provider vis a vis his patients.

financed system: quality care and client satisfaction from the public contract; equity; and cost containment. When the services under the contracts are substitutes, providers under public contract have an incentive to prove the public contract inferior to the private contract. They also duplicate services in the health system; the private and public services run by the same providers do not amount to a zero sum game whereby privately-funded services substitute completely the publicly funded services. And, there is differential access and treatment throughout the system.[15]

The Issues

The key issue is whether or not SP is authorized in the *combined* and the *purely public* sub-health systems, and, if yes, its nature given the multitude of possibilities.[16]

With regard to AM, which can constitute part of the AS, the differences of opinion surrounding their status are essentially ideological. Ignoring the ideological element, it is possible to adopt the position that amenities, these patently non-medical goods and services, could be included in a supplementary package (provided by-and-large in hospitals) even in the purely public sub-system. This position is based on the assumption that patients or their family members who are willing and able to pay, are fully capable of judging the necessity for those items, lacking any apparent medical significance. Even in this case, the issue arises whether the medical staff will not discriminate, if only for purely psychological reasons, in favor of those predisposed to allow themselves extra comforts. Consequently, the inclusion of amenities in the SP, largely not subject to insurance, in a purely public sub-system is not

15. In this regard, it is worthwhile noting the comments made by Prof. K. Mann, the late general manager of Hadassah Hospital, who testified before the Netanyahu Commission, that the costs of Iranian patients (during the Shahs reign), hospitalized at Hadassah, one of the main Israeli medical institutions, were subsidized by the institution (the "Israeli people"). In regard to our discussion, his testimony raises a most serious issue, i.e., subsidization of foreign nationals treated in publicly funded institutions. This problem may be already developing in the Israeli system to the increasing number of patients from the former USSR, treated in publicly funded Israeli institutions. For our purposes, this situation is especially serious as it regards the subsidization of foreign citizens, which is comparatively more serious than subsidization of local citizens.
16. In order to adequately comprehend the issues, we stress that the legal ownership of a service provider is irrelevant to the discussion. What is important is whether or not the provider that delivers a service is reimbursed by public funds. For our purposes, a government-owned hospital, for example, whose total income is privately funded, does not hold a *public contract*, and is to be considered as any other private service. Conversely, a privately-owned facility funded through public funds operates under a public contract.

particularly problematic, provided that we are not discussing such items as private rooms, special nursing services, etc. — goods and services which might have medical implications for the purchasers and their surroundings, and there is a risk that they may be subsidized by public funds. That is, we consider provision of a BP plus privately-finance AM still as a purely public sub-system.

With regard to medical services excluded from the BP or non-amenity AS as part of the SP, we must distinguish between services which are substitutes or complements to those available in the BP, and those excluded altogether, usually (in Israel) long term and dental care. As for the first, in developed nations such as Israel - the basic approach is that if medical goods or services are truly requisite from a medical standpoint, then they should be part of the BP. This approach is based on the fact that in these nations, no connection has been found between the level of expenditures on health and the level of health found in the population (OECD, 1990); in other words, the exclusion of nonessential medical goods and services from the BP is presumed not to undermine a nation's general level of health.[17] This issue of "non-essential care" also touches upon the meaning of the term *medical service,* and the fact that medicine is not an exact science. For developed countries, one of the fundamental reasons for establishing a public-funded health system is to guard against expenditures on medical goods and services whose necessity and urgency, in terms of their influence on health, cannot be assessed by the average consumer. This holds particularly true when suppliers — which in Israel are particularly numerous — have the interest and the capacity to encourage demand for these goods and services in order to increase their incomes and other utilities such as research. In other words, everything that is excluded from the BP is a-priori considered as "non-essential" to the *public's* well-being or worthy of public funding. Accordingly, it is not in the public's interest to encourage the growth in health expenditures in favor of the service suppliers' income and undermine equity and overall efficiency, while not contributing to the average level of health found in the population. In special cases, if presumed needed care is not included in the BP, the system can solve problems ad hoc, just as the Israeli systems has successfully done to date.[18]

Consequently, the authorization of a *combined system*, including EMS to be provided by providers holding public contracts, defies at least the cost

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17. This conclusion might be different for developing nations where the resources constraint may prohibit the acquisition of effective medicine (Chernichovsky, 1995).
18. This point touches on the complex issue of updating or modifying the BP which is influenced by public health, economic, technological, and not the least by political considerations (Chernichovsky, 1996 and Chernichovsky and Kunitz, 1998).

containment and equity objectives of the modern health system. And, as the client cannot judge medical treatments, the service content, quality, and efficiency under public contract might deteriorate as well, as suggested earlier in the discussion. In this particular regard it is important to stress already at this point in the discussion the positive potential role of sickness funds (which do not *provide* privately-funded services) as guardians against this particular type of moral hazard on the part of providers. This argument can be extended, to a degree, to services which are not substitutes or complements to those in the BP, (e.g., long-term cases) if the inputs of services under public contracts (e.g., general beds) can be used for the EMS.

As for "quality basic package" (QBP) or PBP, the issue, at least in Israel, revolves around (a) scheduling appointments and (b) choosing physicians, within the publicly funded system. With regard to the former there is a tendency to confuse two issues: firstly, the very existence of a waiting list and, secondly, the means by which it may be shortened.[19] Economists tend to see waiting lists as long as they are reasonable and under control - criteria which are simple to define - as positive second best factors. Such lists indicate the absence of excess capacity in the health system. The providers are liable to create a vicious cycle of generation of waiting lists to increase capacity, and promote private factors that contribute to the rise in health expenditure without necessarily raising the average level of health in a population.

Moreover, the option of shortening waiting lists by means of PBP, within a publicly funded system, creates incentives for suppliers to create such lists as a method of encouraging PMP. Accordingly, it may be the case that an acceptable waiting list is a necessary evil within a publicly funded system. In addition, by means of appropriate incentives, we can shorten waiting lists in this system without resorting to the PMP option.

The matter of choosing a physician also involves several of the issues raised above, the issue of private contracts to providers who have public contracts as well as the issue of jumping the queue by choosing a particular physician.

The relevant question then concerns not the actual existence of a waiting list in a publicly funded system. Rather, the question is, within a publicly funded system, should those thrown to the end of the line or handed over to inexperienced physicians necessarily be those unable to pay for (or to insure themselves for) those privileges? Moreover, suppose the entire population were to insure for or were capable of buying these privileges. Clearly, both equity

19. In a pure private system, these means are of no concern to the general system as long as they fall within the limits of the law.

and cost containment objectives are undermined when PBP are offered by providers who have public contracts.

It is true that the prevention of choice, of any type, especially that of determining one's place on a waiting list or opting for the physician of one's choice, results in a decline in satisfaction — both for those capable of paying for as well as for those providing the service. Nonetheless, the phenomenon contributes to increased satisfaction among the general population which desires a healthy system, free of the exercise of non-medical discretion, in order to preserve the rights of the citizen in a publicly funded system.

Those who are willing and able to pay over and above the required health taxes may obtain the desired services in the purely private system, as defined above, which (in Israel) is available to all.

The Modern Health System's Basic Package (BP)

The discussion has, so far, assumed a well-defined BP, understood by all. However, the attempt to clearly define a medical BP has been likened to chasing after rainbows. Even with regards to existing technology, a concurrence of opinion is rarely to be found among physicians. The problem is severely intensified when dealing with a constantly changing technology. Moreover, the various consumers in the modern health system have different expectations (of that system), and those expectations are themselves rapidly changing.[20]

Accordingly, the best that can be done is to specify a number of broad ill-defined categories of rights under the public contract: e.g., primary medicine, pediatric and adolescent medicine. The issue lies beyond the technical problems of defining a BP. Rather, fundamentally the issue is to introduce maximum freedom of individual choice under the public funding umbrella. This means eliminating despite the public funding direct intervention by the state and, to a considerable degree, by the service providers (excluding the sick funds in their roles as service managers) in the organization and even definition of services (Chernichovsky, 1996).

Indeed, a central idea in the Israeli reforms proposed by the Nethanyau Commission was to allow the individual freedom of choice between sickness funds that compete on the basis both of different methods and qualities of providing the BP, i.e. on QBP, and perhaps also on the contents of the BP.

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20. The use of the term *supplementary basket* in Israel is misleading. It implies that a well-defined basket does in fact exist, part of which is publicly funded, and the remainder is to be privately funded. However, no basket can be definitively set, and there is no limit, in terms of services and degree of payment, to the "supplemental" elements.

Implementation of this goal is accomplished through the capitation system. In this system, still-healthy individuals transfer funds, by means of payments made directly to the state, represented (in the case of Israel) by the National Social Security Institute, to the sickness funds of their choice. This system entitles the individual access to the BP which is not uniform, at least with regard to the manner in which it is delivered (Chernichovsky, 1996).

Reality has shown (paradoxically) perhaps, that over-specification of the BP and the existence of a SP, even if the latter contains chiefly *ancillary services*, which are often ill-defined, may diminish the freedom of choice within the system to such an extent that it may undermine the very idea of a SP. Consider, for instance, the cases of Germany and France. Both countries offer a very liberal SP including elements which are contained within the basket covered by mandatory insurance (PBP). In both countries, in order to counter the adverse consequences of the SP on national health expenditure, the state imposed system-wide restrictions, rather than restrictions on that part of the system operating within the framework of public contracts. The most widely discussed current example of this is the maintenance of a rigid national *prescriptions registry*, which permits the registration, and the consequent prescription, of generic drugs only. Thus, in Germany and France, even those who wish to purchase certain drugs in the private market, outside the framework of the mandatory insurance system, may no longer be able to do so. In terms of policy, this means that whatever goals the state cannot achieve by means of its selective control mechanisms within the public part of the system it achieves by means of blanket regulations imposed on the national system, private as well as public.

Another example, in this instance from a health system diametrically different in character from the European cases, is that of the state of Oregon in the United States. This state has instituted a particularly rigid BP (under the auspices of Oregon Medicare and Medicaid) with a precisely defined set of treatment priorities which has considerably eliminated medical discretion regarding either patients or treatments. That is, physicians, or patients comparatively speaking, are not permitted much input into deciding about the manner in which public funding or treatment is to be allocated. Any exercise of choice is thus only (permitted) outside the public system.

Neither of the situations described above, in which the state severely curtails the choice of the provider and the client, one nation-wide and the other system-specific, is desirable in Israel. Nor should they be necessary if the state succeeds in dealing (with cost-control and equity) questions wisely through the public financing mechanisms.

Indeed, the central and unique guiding principle of the Israeli reform is competition between the sickness funds and the service providers with respect to subscribers within the framework of the publicly funded basic package (BP). The intention has been that the sickness funds should compete on the basis of that basket. Those funds which succeed, among other things, in *supplementing* the BP with more ingredients that could comprise the AS, especially those which could be (e.g. waiting lists) associated with the PBP, will secure the subscription of a larger portion of the insured population and a greater cut of the public health budget. However, wherever there are instances of AS service provision, let along the QBP, which is privately funded but linked to the public funding system by those same insurers and identical service providers, this undermines the basic principle motivating the reform.

That is to say, the linking of private funding to public funding, especially, at the provider level, not only diminishes equity and the ability to control health expenditure; it also reduces the sickness funds' and providers' incentive to satisfy its consumers by means of the BP.

A Tale of Two Nations

Canada and Australia have two health systems which are of particular importance for the purposes of our discussion. The two nations are similar to one another economically, culturally, politically, and administratively. These two federations maintain, by means of taxation, universal entitlement to a BP based on public funding principles.

Regarding AS or a supplementary package (SP), the approaches implemented by Canada and Australia are almost polar opposites. In Canada, primarily by means of legislation regarding the granting system operated by the federal government, an almost complete separation between the public and private systems was instituted in 1986. Community physicians who treat patients under public contracts, are practically prohibited from having private contracts receiving private compensation, either directly from the patient or indirectly from the insurer, for any SP. The same applies to state-budgeted hospitals. Hence, the private system is completely separate from the public one; that is, Canada has situations (1) and (4) of Table 1, existing side by side, or it has a purely segregated system.

In Australia, the 1984 National Health Insurance Law laid down that the SP would essentially contain rather broadly-defined *ancillary services*. The Australian system entitles the individual to pay service providers for AS either directly or indirectly, even if the latter operate under the terms of a public contract. Within the framework of community medicine, the SP covers AS,

which are not included in the publicly-funded basket, such as dentistry and pathology (laboratory exams). In cases of hospitalization, the Australian SP covers private hospitalization. Broadly-defined amenities are allowed in publicly-funded hospitals.[21] An individual interested in private hospitalization is entirely free to purchase such services, but without any state reimbursement either directly or through an insurer in a private hospital that is ineligible for government funding.

Private insurance only covers the difference between the price of the medical service determined by the government, and the level of state reimbursement for that service: The individual cannot insure against payments beyond the level set by the government. Hence, the Australian government oversees all service prices, and does not permit the use of insurance to cover higher costs. By these means, while containing the level of health expenditure, the government also guards the citizen against possible exploitation by service providers.[22]

Furthermore, the Australian (private) insurance companies, which are not *sickness funds, are required to accept every potential subscriber at a uniform* rate (the community rate) for each subscription plan. It is possible for insurers to charge different rates according to the insurance packages or plans they offer. However, each individual subscriber within each package or plan is insured at a uniform insurance rate, independent of age, risk factors, or income. In this way, privately- funded insurance in Australia helps maintain equity, compared with a regular private insurance scheme, and has a system which is in many ways is supplementary to state insurance.

In spite of those, the following are observed in Australia:

- The relative share of private funding of public hospital costs has been increasing over the years.

- Public hospitals, whose income is derived from public sources, prefer to accept patients who either pay directly or who carry private (supplementary) insurance, despite the fact that these patients in general do not receive any additional service (The Manchester Unity Friendly Society, 1991; Waldby et al., n.d.).[23]

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21. It is important to emphasize, once more, in this case as well, that the majority of Australian hospitals, recognized as *public hospitals*, are not state-owned. In principle, the hospital owners have to decide on the market in which they wish to operate.
22. In this regard, and considering the case of Germany and France, cited above, the Australian Federal Government is currently demanding legislative (!) authorization to enter every *available* drug/medical technology into the system, an act which might increase national health expenditures by about 10 million Australian dollars.
23. We once more note that the incentive to receive a *private patient*, is particularly large when the service provider is budgeted or receives any other futurity payment, such as

- There is an increase in those elements of community service (examinations, etc.) either for which individuals are entitled to pay or they are entitled to privately insure themselves (Deeble and Lewis-Hughes, 1991).

Despite the above, there is no conclusive evidence to indicate that those possessing supplementary insurance receive different or better service than who receive such services within the public system, particularly in hospitals (The Manchester Unity Friendly Society, 1991). Also, high-income individuals tend to insure themselves privately. However, the elderly in every income group tend to do so just at the time when their judgment concerning both their rights and the nature of supplementary insurance has dwindled while their anxiety has increased (Wilcox, 1991).

In addition, it is worth considering the political dynamics of the Australian situation. The Australian system was transformed from an almost completely private system to a public one. The introduction of national health insurance became politically feasible only after, among other things, agreement had been reached concerning the SP, which was essentially a politically motivated gift to the service providers and insurance companies. The situation has been quite different in Israel. The approval of the National Health Insurance Law did not depend on the good will of providers.

The problem presented by the Australian system emphasizes the reasons for adopting a Canadian solution. Indeed the Canadian developments are particularly relevant to Israel in light of the Australian experience. Approximately 11 years after Canada adopted national health insurance, a special investigative commission was appointed to examine two issues. Firstly, were the provinces transferring payments designated for federal health programs to other non-health related, programs? Secondly, what influence was exerted on the rest of the system by the SP (labeled *extra-billing*)? At the head of the commission was Mr. A. Hull, who had formerly served as chairman of the committee (1961-1964) that formulated the principles underlying Canada's national health insurance. This committee had sanctioned the institution of a *supplementary service basket*. In other words, those who had initially authorized this provision then made the following recommendations: "If extra billing is permitted as a right practiced by physicians at their sole discretion, it will, over the years, destroy the system, creating in that downward path a two-tier system incompatible with the societal level which Canadians have attained." (Taylor, 1968, p. 23).

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capitation or salary. In a situation like this, no additional income accrues from the provision of public service, although additional incomes do accrue when providing private services.

This approach was adopted by yet another commission which examined the health system and which, in 1986, introduced the final revisions to the Canadian legislation — amendments which brought about the situation described above, i.e. any physician or institution treating patients within the framework of public funding or a public contract, is prohibited from receiving any private funding.

The Israeli Solution — Options and Directions

The Israeli health system is significantly different from the Canadian and Australian systems. In Israel, the sickness funds mediate between, the state which funds and guarantees the BP, and the providers. This difference confers a degree of flexibility, in theory, at least, when comparing the Israeli to the Canadian or Australian systems as far as the public-private mix is concerned.

For *sickness funds* or *insurers*, which do not provide services, the interest and the capacity for exploitation of a patient is less than that same interest, and capabilities, when considering the service *providers*. Moreover, if adequately organized and regulated, such sickness funds and insurers can safeguard against potential exploitation of the providers.

Theoretically speaking, all the possibilities displayed in Table 2 are attainable in the Israeli context. Excluding the option of purely private or public systems, which are analogous to the Canadian solution, and according to which private and public contracts cannot be mixed, at both sickness fund and provider levels, any of the five combined systems is possible. It should be clear that all or some of these options can coexist within the same national system.

The type 2 option was already operative, to a considerable degree, prior to the introduction of the National Health Insurance Law in 1995: publicly funded "insurers" sickness funds did not, in essence, offer private insurance, although they could contract with suppliers offering services which were either under public and private contract. There were minor exceptions, mainly in the area of dental care. The operations of "Maccabi Magen", part of the Maccabi sickness fund, has represented a system of types 1, 3 and 5. But, the sickness funds, the largest in particular, prohibited their own employees form engaging in private practice. The government required the same from employees in its own hospitals. These provisions in fact rendered the official segregation in the system before the Law. The purely private sub-system in these scheme has been negligible; the operations of the Shiloah Insurance Company represented by a type 4 and 5 system.

Taking in consideration all of the above, the question arises: What is the

Table 2.Options of Ancillary Services and Private and Supplementary Insurance by Sickness Funds/Insurers in a Publicly Funded System

INSURER/SICKNESS FUND / SERVICE PROVIDER	Operating under public contracts only	Operating under public contracts but authorized to provide private supplementary insurance	Operating under private contracts only
Under public contract, providing only the BP	Purely public	Combined – Type 1	—
Under public contract, but also authorized to provide a SP (+ AM as defined above)	Combined – Type 2	Combined – Type 3	Combined – Type 4
No public contract, not authorized to provide the BP	—	Combined – Type 5	Purely private

optimal alternative for the Israeli system given the theoretical possibilities and the factual and political situation? The factual situation is that the largest sickness fund in Israel is also the largest provider. That is, it has a provider's interest. Politically, the pressures by the medical profession to keep private contracts in conjunction of public contracts is great, amounting to a de-facto legitimization of existing gray and black medicine. That is, the most desired solution, akin to the Canadian system, of a fully segregated system, may be impossible in Israel today.

To take advantage of the existing sickness funds system, as services organizers and manages, and to avoid the perils discussed thus far, Israel should strive to promote combinations of types 1 and 5, in addition to full segregation, and at the same time try to eliminate combinations of types 2, 3, and 4. This approach would provide a number of important benefits including some that are potentially supportive of the core goals of the Israeli reform, goals which remain far from realization. Such a disassociation, firstly, might assist the entry into the sector of new insurers which in time might become recognized sickness funds (in as much as the bulk of the funding will remain

publicly provided). This would probably have a beneficial influence on the number of sickness funds which is too small today, as well as on the intensification of the competition among them. Secondly, the full separation between private and public contracts would create pressure on the service providers to "get off the fence"; that is, the providers would cease to be amorphous in terms of status and become either private firms, public trusts, or stay under public and quasi public ownership, and assume whatever responsibilities the legal and institutional standings entail, largely more managerial accountability, almost regardless of type of contract. In this way, the funding system would facilitate the realization of an additional goal of the Israeli reform which has been ignored by current legislation, i.e. the incorporation of hospitals as public trusts and the encouragement of competition between service providers.

To start moving in the direction suggested here that would also exploit the potential of private finance, the following can be instituted with time:

- A community rates system: Setting different rates for different insurance plans would be permitted but made available at a uniform rate for all purchasers of a specific plan regardless of this risk.
- Universality of private ("supplementary insurance"): Every insurer or sickness fund must accept all potential subscribers irrespective of the sickness fund to which they subscribe for the purposes of receiving the BP.
- Separation between private and public contracts plus supplementary insurance (as just stipulated) at the provider level: Prevent the provision of services under public contract or supplementary insurance by providers who work under private contracts.

Were co-payments to be incorporated into public funding of the BP in Israel, as considered from time to time, it should be possible to introduce supplementary insurance, as suggested here. The ceiling of co-payment (a prerogative of sickness funds) and the insurable portion of that payment should be determined by the government, considering the preferred policy and its possible outcomes.[24] Co-payment, within the publicly funded system, is meant to fulfill two principal aims: firstly, to provide additional funding to the system (whether for the purpose of net funding or substitute for public funding); and secondly, lead to a (temporary) reduction of demand

If the main goal of policy is to (temporarily) reduce demand, the government could decide not to insure or allow insurance of the co-payment. In such a case,

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24. This discussion is based on the assumption that the relevant elasticity of demand is below zero, and that the insurance premium is "fair", covering the expected expenditure.

the portion of the co-payment would in effect, be 0% of any co-payment. If, however, the purpose of that policy is to interfere as little as possible in demand, but raise funds, the insured rate would be over 0%, and could reach 100% of participation. This last option could make the added funding more equitable. In addition, insurability of the co-payment according to the provisions stipulated above, would reduce the possibility of sickness funds to use the co-payment mechanism for cream skimming. In general, the level of private funding due to the co-payment would depend on the ceiling price set by the government, the demand elasticity for care, and the insurability of the co-payment. In any case, the government would be obligated to contend with the adopted policy's implications for mainly equity.

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PRIVATE-PUBLIC MIX IN GOVERNMENT ACUTE-CARE HOSPITALS IN ISRAEL: AN ASSESSMENT OF THE PRESENT STATUS AND FUTURE DEVELOPMENTS

By Arie Shirom and Zippi Amit*

Introduction

The objective of this study was to assess proposals to introduce privately-financed inpatient services into government acute care hospitals in Israel. The issue of public-private mix in government hospitals is discussed (a) in the broader social and economic context of the Israeli system of health care, (b) in terms of the gradual development of the private sector within government hospitals in Israel, and (c) as representing an attempt to partially commercialize acute care hospitals. We summarize some of the experience gained in advanced market economies and then present the lessons gained in the few not-for-profit acute care hospitals that have already introduced privately-finance inpatient services. We conclude by surveying the advantages and disadvantages of these proposals.

Does the proposed introduction of privately-financed inpatient services into government hospitals have an added value to the Israeli health care system? If so, to whom? Is this a new medical service, one that supplements the inpatient services provided on an equal basis to those who need inpatient hospitalization? Is it possible that private medical services actually improve inpatient services in government acute-care hospitals, by bringing in more resources, and by allowing certain patients to choose their physician? These are the questions examined in this article.

The term private medical services refers to a medical or related service provided for a fee to patients hospitalized in government acute-care hospitals. In Israel, it has been referred to by the acronym SHARAP, and therefore we shall use this abbreviation to refer to the proposed new service in this article. SHARAP may or may hot be included in the basket of health services provided under the National Health Insurance Law, implemented in Israel since January

* Faculty of Management, University of Tel Aviv, Tel Aviv, Israel.

1, 1995 (see below for more details). The most common example of SHARAP is when a patient in a government hospital is allowed to choose the surgeon who will perform a required operation. This physician then receives special payment from the hospital for this service, while the patient pays for the physician's services through the hospital. The insurer, in Israel one of the four public, not-for-profit sickness funds (SF), may cover the costs of hospitalization and part of the costs of the surgical procedure.

By way of comparison, we shall also refer to additional medical services (known as in Israel by the acronym SHARAN). According to recent (i.e., January 1998) amendments to the National Health Insurance Law of 1995, each of the four SF may and has in fact offered to those enrolled in it a package of additional medical services. This package represents supplementary insurance provided by the SF, allowing for the provision of medical services that are not included in the basket of health services covered by the National Health Insurance Law. Representative items in the additional medical services currently (1998) included in the packages offered by all SF are alternative medicine, second opinions, additional coverage of organ transplantation costs performed out of the country, and partial reimbursement of surgical and other procedures undergone in private inpatient or outpatient services. While some overlap does exist, there are substantial differences between the SHARAP arrangement and the supplementary insurance arrangement, which will be explained below. For reasons discussed later, this article will not deal with under the table or black medicine.

The Israeli Health Care System

The descriptive and analytic literature on the Israeli health care system is not extensive (for useful sources, see: Chernichosky and Chinitz , 1995; Ellencweig, 1983, 1992; Shuval, 1991, 1992). Therefore, a brief summary of its main features follows.

Sickness funds (SF). Primary and secondary care is provided by four SFs, which cover all permanent residents of Israel. Practically, this means that all permanent residents of the country have access to a relatively wide range of health services, defined within the Law and referred to as the obligatory basket of services, through their membership in a SF. These SF resemble, in several respects, the staff-model health maintenance organizations (HMO) in the USA. The Law further stipulates that there is a free choice of a SF, and a SF cannot refuse applicants. The SFs have complete autonomy how to provide the basket of services to their members, and offer most outpatient services either by their own clinics or by subcontracting with independent suppliers. Of the four SF,

the General Sickness Fund (Kupat Holim Clalit; hereafter abbreviated as KHC) is the largest, with about 61% (as of January 1998) of the population as members. It owns and operates a network of public clinics. Most of these clinics are quite large, and include, besides general practitioners and specialists, a variety of diagnostic and laboratory equipment, pharmacies, and other primary care curative services. The KHC has been playing a central role in Israel's health care delivery services as product of its pioneering status, size, and commitment to the ideology of providing health services on the basis of need.

The hospital sector, which is the focus of this paper, includes all non-profit acute-care hospitals under public ownership in Israel. In 1996, there were 34 such hospitals - 11 of them government hospitals and 8 owned by the KHC. KHC is thus the owner and operator of 17% of the country's acute-care hospital beds. The remaining 13 public hospitals are owned by Hadassah, other public organizations, or religious orders. Only 5% of Israel's 13,268 general hospital beds (1996) may be found in privately-owned, for-profit acute-care hospitals (n=13). However, the number of beds in for-profit private hospitals has nearly doubled since 1988. (These data are based on the State of Israel, Ministry of Health, 1997).

The Ministry of Health. The Ministry of Health has the customary ministerial responsibilities for the planning, regulation, and coordination of the health care system, for the general assessment and control of the SFs' operations, and for the initiation of legislation in these areas. Because of certain historical circumstances, the Ministry is also the major provider of individual preventive health services, hospital care (including most long-term care and above 42% of all acute-care beds), and public health services. It regulates the input of manpower, technology and new capital investments in the health sector by licensing physicians, nurses, health institutions, etc. Individual preventive health care services is provided by the Ministry through a network of family and infants clinics, wherein it provides vaccination and routine check-up to infants and their mothers. It also runs some adult individual preventive health services, in addition to the public health services.

Private medical services. Privately operated and consumed medical services are predominant only in dental care, to which about 13% of the national expenditure on health was directed in 1995 (Central Bureau of Statistics, 1997). Private physicians were in the same year responsible for about 6% of the total expenditure on health.

Funding. The public health care system is funded by an earmarked tax levied on employees and by general government revenue.

We present the problem of private-public mix in government hospitals in a

broader social and economic context, as an expression of the policy of privatization of health services, or their subordination to market discipline. Such a policy has been evident in some of the reforms recently carried out in Israeli health services (Shirom, 1991; Chernikhovsky and Chinitz, 1995). Our examination will also refer to the experience gained in several advanced market economies. Data will then be presented on the Israeli experience of implementing SHARAP in a small number of public hospitals. Finally, we present an assessment of the advantages and disadvantages of implementing SHARAP in government hospitals in Israel.

Background to the Proposal to Introduce SHARAP

During the 1990s, a number of key developments occurred, which showed that the introduction of SHARAP in government hospitals is an important factor in the process of setting health policies for the hospital sector in Israel. In mid-January 1992, in an exchange of letters between the Minister of Health at that time, Mr. Ehud Ulmert, and the Israel Medical Association, through the State Physicians Organization, an agreement was signed defining the principles of the reform in the government hospitals. According to documents submitted to the Israel Medical Association, the Minister of Health committed himself in principle to implementing SHARAP in all government hospitals that were going to become public corporations or undergo incorporation outside of the government sector as public bodies. The details of these inpatient private services or SHARAP were supposed to be worked out in negotiations between the parties. In exchange, the Medical Association agreed to cooperate with the process of turning the government hospitals into corporations. This last agreement was never carried out as written, because, among other reasons, in July 1992, when the negotiations between the parties should have been finalized, there was a political turnover, and Ehud Ulmert left his position as Minister of Health. Nonetheless, it is instructive to study the details of this agreement, since it provided the framework for any subsequent discussion among the parties, change of government notwithstanding.

The Minister of Health agreed that mention would be made, either in the National Health Insurance Law, or in the ensuing regulations, that the SF would cover the standard public expenditure set for any SHARAP procedure to the patients, so that they would only pay the incremental cost to SHARAP. A patient who was hospitalized through the emergency room (i.e., on average about 80% of all hospitalized patients in government hospitals), could not receive treatment through SHARAP. A patient who was admitted to a government hospital as a non-SHARAP patient, could not move into the

SHARAP. It should be noted that in practice these limitation do not exist in the few public hospitals (mostly located in Jerusalem) which have been operating SHARAP for many years: patients are allowed to move between public and private status at will.

According to this agreement, a small group of senior physicians in Government hospitals would be permitted to practice private medicine within these hospitals, between the hours of seven and ten p.m. only, in special hospital rooms, which would be designated for private patients. The agreement states that the SHARAP fees would be set by the physicians themselves, who would be allowed to change them at will, as long as the change would not reduce the payment to the hospital, and on condition that the price would be recorded. The hospital would collect the money for the doctor, and would give the doctor his share, after deducting the hospitals costs. The physicians' representatives would be allowed to appeal to the Minister about the size of the hospitals reimbursement, and the Minister would have the final word regarding this matter. The agreement set certain limitations on the senior physicians' ability to practice private medicine: their SHARAP practice would be limited to 35% of their overall activity; they would not be allowed to give private consulting services to non-SHARAP patients; the files of SHARAP patients would be run by the hospital and would be subject to the hospital's quality control; a doctor could not treat a patient under SHARAP if he had treated him during the previous year as a regular patient.

This was the first time in the history of Israel that the State-employed physicians were given a binding document by a government Minister which allowed the implementation of private medical services in government acute-care hospitals. Another precedent related to these negotiations was that the Association of State-Employed Physicians became a partner in planning the corporate policy of public hospitals. In the past, the Medical Association only reacted to steps taken by the Ministry of Health, and usually was not a partner to the formulation of new policy relating to such an important sector of the health services (Yishai, 1990).

Sale of Private Health Services by Government Hospitals

At the beginning of 1992, six Government hospitals were registered as corporations, and a board of directors was appointed for each of these hospitals. However, by the end of 1997, these hospitals had been given only very limited authority with regard to pay, labor relations and property management. At the writing of this work, these semi-incorporated hospitals still do not act as independent economic entities. Formal labor agreements for

corporation employees have not yet been signed with the labor unions representing the non-physicians among government hospital employees.

In certain areas, the six incorporated hospitals, and subsequently all other government acute-care hospitals were given some powers beyond those allowed to regular government units. This refers mainly to the fact that each hospital is supposed to function on the basis of a business plan, which includes a balanced operating budget, where expenditures are dependent on income. The business plan is submitted to the Ministry of Health. The new board of directors, chosen for each incorporated hospital, hardly convened at all, and has performed primarily as advisory boards to the respective hospital directors. Thus, from a regulatory and practical operating standpoint, government hospitals can not implement the agreements signed between the Physicians Association and the Minister of Health and they have not yet introduced SHARAP in these hospitals.

According to Civil Service Regulations, physicians employed in government hospitals, who are either department heads or senior specialists, are allowed to practice private medicine. To do this, they must apply for permission from the Ministry of Health and the Civil Service Commission. If permission is granted, 5% will be deducted from their salary, and they may have a private practice. Over 70% of State-employed heads of departments applied for and received this permission (see Netanyahu Committee Report, I, 320-321 and II, 229-231). The State Service Regulations explicitly prohibit private practice within the hospitals. Thus doctors are explicitly forbidden to take moneys from patients who were, or could be, treated by them in the hospital. The Netanyahu Committee Report (Part I, 320) found that these regulations are violated almost openly, and with the knowledge of the Ministry of Health, which takes no steps to enforce them. At the same time, the sale of additional services by the hospitals, including those found in the frameworks of the sick funds supplementary insurance, is an alternative to SHARAP. The question is: to what extent can government hospitals sell services on the private market?

Government hospitals were allowed, since 1996, to sell medical services not included in the basket of health services provided under the National Health Insurance Law. The money received for these services is supposed to be transferred to a special fund, dedicated to medical research and development of medical service infrastructure. This fund has been active for several years in most government hospitals, and the plan is to have a branch of this fund in each hospital. A government hospital is allowed to sell medical services for up to 20% of its income. The term income relates to the projected hospital income as listed in the budget law. The hospital must meet the projected income, and if

it does, it may sell medical services, with the exception of services provided by the basic basket, on the open market. In addition to selling services not included in the basket, such as cosmetic surgery, the hospitals may sell certain types of lab tests, as defined by the Ministry of Health (for example fetal albumin, ameniosynthesis, MRI and periodic medical check-ups). They may also sell new types of technologies, as approved by the Ministry of Health.

The purchasers of these services are supposed to be mainly the SF, who make arrangements with the hospitals within the framework of supplementary insurance options (including those offered by the SF); the Ministry of Defense; insurance companies; and private patients, like tourists.

The regulations issued by the Ministry of Health also set down rules for the employment of State employees by the fund during afternoon hours. Payment to these employees, who will be employed by an SF during afternoon hours, will be executed according to agreements to be signed in each hospital separately. The hospital management will negotiate with the representative of the workers, and the payments are to be determined in accordance with their profession, skill, and experience. These employees, including physicians, are to be employed by the fund, and under no circumstances as independent contractors.

In 1996, these funds in the government hospitals employed close to 5% of the total number of employees. The additional services are offered in particular with regard to surgical procedures. These procedures take place during the afternoon hours, the sick funds pay for them directly into the above-mentioned fund of the respective government hospital, and all the staff participating in these procedures are compensated through the fund. As a result of these arrangements, a large part of the advantages of SHARAP have already been achieved. The physicians stay in the hospital during the afternoon hours, the staff receive extra pay, and it is possible to shorten waiting lists for surgical procedures. The physicians have a clear interest to refer in-patient procedures to these funds.

The policy of the successor of Mr. Ulmert, Minister of Health Sneh, with regard to the SHARAP differed significantly from that of his predecessor in that it had nothing to do with the incorporation process. Other changes in his policy compared to his predecessors have to do with the transfer of authority for deciding on SHARAP prices to the hospitals, and with determining the principle of dividing the SHARAP income between the physician, his staff and the hospital according to a predetermined formula, as explained above. This policy is intended to compensate physicians, who are employees of public

hospitals, as an alternative to under-the table medicine, by allowing them to practice private medicine within the walls of the public hospital.

Despite this view of SHARAP as an alternative to under-the-table (or black) medicine, this paper will not address the issue of under-the table medicine, for several reasons. Firstly, one of the lessons gleaned from the Israeli experience in implementing SHARAP in public hospitals (an experience which will be discussed below) is that it is possible for SHARAP and under-the-table medicine to co-exist. Secondly, the so-called black medicine in Israel is heterogeneous and multi-faceted, beginning with the gray areas of contributions to various departmental funds, and ending with slipping money to a doctor in order to be pushed up the waiting list for an operation in acute-care hospitals, which is one of the manifestations of under-the-table medicine. A third reason has to do with the explanation of why black medicine exists. There are a number of structural explanations for the existence of this phenomenon in Israeli public hospitals, which include the method of management, the procedures for setting dates for operations, the authority and methods of operations of department heads, and quality control practices. Thus it appears that under-the-table medicine in Israel is a complicated phenomenon, multi-faceted and rich in possible explanations, and there is no evidence that it has any direct link with the existence or non-existence of SHARAP. For all of these reasons, the phenomenon of under-the-table medicine deserves to be discussed separately. The proposed new law, initiated by Minister Sneh, was never submitted to the Israeli Parliament due to the strong opposition of the Medical Association and the KHC, the largest SF, for different reasons.

Open Market and Health Services

Former Health Minister Sneh's policy on SHARAP was a reflection of a philosophy which in principle supports the introduction of open market principles into public hospitals in general and Government hospitals in particular. Therefore, it is advisable to review some of the basic principles and norms related to the implementation and appropriateness of open market principles to the provision of health services. Private health services, as described above, combine open market principles and a public health system. First we will review why the world's developed countries treat health services as a public product, which is taken for granted as an essential part of the social services in the modern state.

Health services began developing as social services due to a consensus in society that allocating resources for health to the population on the basis of market principles created serious injustices in their fair distribution (Doron,

1979), including wide gaps between morbidity and mortality rates of stronger and weaker population groups. The welfare State has a commitment to provide its citizens with a certain minimum level of social services, which include health, education, housing, social security and personal welfare services. These services are perceived as serving any individual in society, throughout his or her life span. A social service may be defined as one which uses collective means to supply needs that society has taken upon itself to supply (Doron, 1989). In most OECD countries, this social policy reflects an underlying belief that health services should not be viewed as a product to be governed by market forces, but rather as a product that allows individuals in society to ensure the supply of these essential services to themselves (Maynard, 1993).

Health economists view the provision of health services through the open market as a significant market failure (see for example Newhouse, 1981). This market failure is created because health services are characterized by a radical asymmetry of information between consumers, on the one hand, and service providers, on the other. There is a large information gap between the patient and the service provider - i.e. the physician. Demand for health services occurs when the patient is not in good health, suffers from anxiety, and therefore his judgment is affected by his physical infirmity. The physician determines what the patient needs, and when and how he will receive treatment. The patient does not know what he needs, and is not equipped to assess the quality of care that he receives. Thus, an almost complete dependence is created of the consumers on the service providers. The literature on this issue emphasizes the moral hazard of physicians who expand their output for the sake of increasing their income, a phenomenon especially common where there is an abundance of physicians (Rice, 1984). A similar phenomenon exists on the side of the consumers, who tend to over-consume unnecessary medical services, whose cost to them is negligible.

One of the results of this market failure is that the larger the part of private medical services (i.e., out-of-pocket payment by the patient to the physician) in the health services of developed countries, the more expensive these services will be in terms of the national expenditure for them (Shirom, 1994). In Israel, one of the explanations for the crisis in the health system in the late 1980s and early 1990s was the creation of a vicious circle which occurred following the government policy which significantly slashed its participation in the funding of the health system at that time (Netanyahu Commission, 1990, II, 118-140; Yishai, 1993; Doron, 1994). Consumers were forced to pay increasingly larger out-of-pocket sums, both in sick fund membership fees and in direct payment to private suppliers of health services. The dwindling governmental funds

available to the health system resulted in the flourishing of various types of health services supplied by the private sector, thus bringing about a rise in the share of public expenditure on health within the gross national product (Kop et al., 1994). In an attempt to lower this rise in the national expenditure on health, the government continued slashing the allocation to health services out of the government budget, creating a vicious circle. Expensive private health services do not necessarily imply improved outputs of the health system. Israel offers some examples of this, such as dental services, which are mostly private in Israel. These services are relatively expensive, but despite their high cost, there is a decline in the level of dental health in Israel (see Netanyahu Commission, 1990, I, 431-439).

The market of SHARAP has many characteristics that lead to the conclusion that there is no real competition in this market, there are no incentives for improving efficiency, and there is no social equality. According to the models described above, including the one proposed by Minister Sneh, this market is largely characterized by physician dominance of the cost and process of care. The above-mentioned ethical pitfalls are even more prominent when the patient pays the physician directly. The purchase of the product is carried out in circumstances of great anxiety, especially when dealing with complicated surgery or other critical health treatments. The individual purchasing the service cannot compare between different suppliers, as there are usually only a small number of experts in a certain field in one hospital who are allowed to practice privately. Many hospitals in Israel, particularly in peripheral areas, have a local monopoly. Because he lacks information, the purchaser of SHARAP usually leaves the decision at critical junctures of the therapeutic process in the doctors hands. In light of the clients' vulnerable position, and the physicians' superior knowledge, it is very likely that situations occur whereby the private physician's decisions are affected by the monetary compensation that is closely linked to the number of medical procedures that he carries out.

In the regular in-patient services, the purchaser, i.e. the patient receiving the services, has the option of going through his sick fund. The physician's reimbursement is not related to the number of medical procedures he carries out, since the physician is an employee, who receives his salary from the hospital. The ethical danger of creating a demand for health services under regular hospitalization conditions is small, as long as transferring patients from the public to the private service is prohibited. Regular patients, in a general publicly-owned hospital, are not directly under the responsibility of a specific doctor. Thus the conclusion is that theoretically speaking, the claim whereby the activation of SHARAP in hospitals means the invasion of in-patient

services by open market forces (according to one of the models described above) is problematic, and implies a misunderstanding of the principles of market failures which characterize health systems. Apparently the intentions of those who favor the introduction of private services into hospitals have nothing to do with the private market, or with free competition in the private sector.

A study conducted in Israel (Schechter and Shavit, 1992) attempted to assess the demand for SHARAP services in Haifa. The authors claim that introducing SHARAP into the public in-patient system, to be directly paid for by consumers, without allocating additional public funds, would allow certain consumers to directly interact with their chosen physician, and that the wider the choice available to the consumer, the better his well-being. The problem is that expanding the choices available to consumers who are able to pay for SHARAP may decrease the well-being of other patients, in that they may have to wait longer for operations and may receive less attention from their physicians. However, it also seems that to claim that by using SHARAP the consumer pays for a higher level of health care is problematic, under the aforesaid circumstances.

One of the more salient features of market failure in health markets is the fact that in critical decision junctures in the process of medical care, the SHARAP patient has only partial and very vague knowledge about the quality of care. Usually, he cannot judge the product he has purchased, since most of the more severe illness (heart disease, cancerous tumors, cardiovascular disease) have no clear etiology. Thus, for example, in the case of heart disease, the risk factors known to medicine (smoking, hypertension, obesity, high levels of LDL etc.) explain only half the variance of this morbidity in the population (Schnall, Landbergis and Baker, 1994). The extent to which SHARAP does in fact improve the quality of services in hospitals needs to undergo careful empirical testing. Indeed, certain empirical evidence, which appears to undermine the presumption that SHARAP improves hospital services, will be discussed below. In any case, according to the theoretical arguments presented above, it is clear that this assumption is problematic and open to contention.

Private Medical Services in OECD Countries: Experience and Lessons

Trying to draw conclusions from the experience of other countries with private medical services is difficult and fraught with problems. Health services in the developed countries are the result of gradual development over many years, a product of environmental conditions and social and cultural influences, which characterize each country individually. The in-patient systems in these countries differ in the ownership structure, in their modes of operation, in

the ways they are funded, and in how they interact with community health services. The system of salaried physicians employed in an Israeli hospital differs from the consultant system in England, and differs, too, from the Dutch method whereby specialists hire the services of the hospital. In Israel, too, private acute-care hospitals usually operate on the basis of a regular but very small staff, which supplies only essential services, while most of the physicians arrive from the outside, under various temporary employment arrangements.

In England, the private medical service arrangement in public hospitals served as a way for the government to recruit the support of physicians when establishing the National Health Services in 1948 (Higgins and Rosenthal 1993). The government agreed at that time to allocate a certain percentage of hospital beds for private practice of physicians in hospitals, most of whom were independent physicians. The private patients hospitalized in these private beds enjoyed a very significant benefit: their operation date was pushed up. At that time most elective surgical procedures had quite long waiting lists. Prior to the rise to power of the Conservatives in 1978, the private sector in England was small - only about one or two percent of the population used it (Higgins and Rosenthal 1993). When the Conservative party came to power, these arrangements became more common, with the government canceling many of the restrictions that existed. According to some estimates (Appleby and Yates, 1995) in 1986, the last year for which there are data, about 20% of the elective surgical procedures were carried out in private beds in public hospitals - i.e. under private medical services. It should be noted, however, that most operations in hospitals (at least over two-thirds) are not elective.

Physicians in public hospitals in England are allowed a private practice of up to 10% of their NHS salary, but the authorities do not supervise these doctors incomes from private practice (Limb, 1994). British medical literature has raised claims that many specialists who are employed in public hospitals in England double and even triple their salary from private practice (Butler, 1994). In general, the literature points out that the privatization and liberalization policy of the Conservative government is expressed mainly in this latter direction of thawing out the contracts of senior physicians in NHS hospitals, so that they can practice privately. Most for-profit hospitals in England (about 65% of hospital beds, following many years of ongoing expansion, similar to the situation in Israel) are almost completely dependent on NHS physicians, who come to practice privately, with specializations in very specific and lucrative types of elective surgery (for example, most abortions are carried out in private hospitals - see Higgins and Rosenthal, 1993).

In France, the private in-patient for-profit sector was traditionally larger -

about 20% of all hospital beds. The approach to private beds in public hospitals has changed in recent years, following changes in government: left-wing governments tried to limit and reduce them, with the intention of achieving more equality in the allocation of state funds to public medicine, while right-wing governments, such as the government of Jacque Shiraq in 1987, opened up the private bed arrangements (Yishai, 1994). In general, the 1991 reform in French hospitals emphasizes reimbursement arrangements, which focus on employees sharing savings achieved as a result of improved efficiency, measurement and improvement of quality of care, and global budgets for hospitals, which encourage the design of strategic programs for hospital development (Bach, 1993).

In the context of this paper's focus, Sweden is an interesting country for several reasons. Health services are organized according to regions, and the local authorities are responsible for running the public health services. Community health services revolve around clinics, which employ salaried physicians, but unlike the situation in Israel, there is no ongoing contact between the patient and the family physician in primary care medicine: patients arriving at the clinic are seen by the doctor on duty. Because of this arrangement, the community physician in Sweden does not act as a gatekeeper for hospitals, and many patients in need of consultation go directly to the hospitals to receive medical treatment. (For a more extensive description, see the references in Glennerster and Manes, 1994; Saltman, 1994). The result is that in Sweden the whole health system is biased toward hospitals, and about two-thirds of the national expenditure on health is spent on this sector, in contrast to about half of the average expenditure in OECD countries (Glennerster and Manes, 1994).

As in many other countries, Sweden has introduced reforms into its health system, but not private medical services in hospitals. The Swedish approach is to improve efficiency and cost effectiveness through supervised and controlled competition among different organizations. Public physicians are allowed a private practice to a limited extent, and in recent years there has been a significant expansion of the for-profit private sector in the Swedish health system (Higgins and Rosenthal, 1993). For example, internal competition is achieved through the local authority, which is responsible for health services, signing contacts with the private sector for open heart surgery when the public sector cannot meet the demand for these operations, or offers them at a relatively high cost, compared to the private sector. (In 1998, for example, over a quarter of all open heart operations were carried out by private for-profit hospitals, under this tender method (Higgins and Rosenthal, 1993). In general,

the transfer of moneys from patients in the public sector of the in-patient services, to salaried physicians in this sector, is still prohibited.

SHARAP in Two Public Hospitals in Jerusalem

Two non-profit acute-care hospitals in Jerusalem - Hadassah and Shaarei Zedeck - have established SHARAP services. This presents us with a micro-laboratory, from which we may learn of the possible results of introducing SHARAP into publicly-owned acute-care hospitals. Both these hospitals are publicly-owned, non-profit organizations, and each is a closed economy. The Hadassah hospital operates a branch of its SHARAP service in Tel Aviv. In both hospitals, data were gathered from several sources. One important source was testimony which appears in the protocols of the Netanyahu Committee. Hadasssah's SHARAP arrangements are described in a document available to the public, titled "Hadassah SHARAP: Private Medical Services" (ed. Prof. Reches, 1993). The Sha'arei Zedeck hospital uses a SHARAP agreement which was signed by that hospitals senior physicians (on 31.3.76, amended by an additional agreement form 31.10.84). In addition, interviews were held with a number of SHARAP physicians in each hospital, as well as with non-SHARAP physicians, with the head nurse in the surgical department, and with other staff members. In some cases, we were asked not to mention the respondents position. In both hospitals, the SHARAP services include all types of tests, clinical treatments, operations, medical consultations, and other advisory and consulting services provided by the hospitals medical staff.

We will now discuss the general characteristics of the SHARAP service in both hospitals:

(a) Patient Treatment. Usually, patients choose the senior specialist whom they wish to consult before, and sometimes immediately after, they apply to the SHARAP offices. In Hadassah, it is possible to transfer to SHARAP even after hospitalization, if the patient decides to be under the care of a particular physician who works in SHARAP. The SHARAP administrative staff are available to advise the patients and their families about the physicians and to organize the contact. In both hospitals a SHARAP booklet is available, which includes the names of the senior physicians in the different hospital departments. Having chosen the physician, the patient is referred by the SHARAP office to a meeting or meetings with this physician in the hospital's out-patient clinics. Payment for the treatment and hospitalization is made to the hospital, on the day the patient is admitted to a ward. Some of the patients have vouchers from their sick funds, which covers the standard hospitalization fee, and they have to make up the difference for the SHARAP services.

(b) Physician Reimbursement. The management of both hospitals committed themselves to keeping a separate revenue account for each SHARAP physician. In Hadassah, SHARAP activity has set prices, and the SHARAP physician is entitled to 35% of the hospital's total revenues from a SHARAP patient. The Sha'arei Zedeck hospital has a different arrangement. For services of the clinical lab, x-ray and pathology, the hospital collects a cap of about 46% of each incoming payment, while for other medical services supplied under SHARAP the hospital collects about 26% of all revenues. Of the remainder, the hospital deducts 15% for a special continuing education fund for SHARAP physicians, which covers professional training programs. The hospital management also pledged to cover the car expenses of each physician participating in SHARAP out of the remainder, up to the maximum sum set for senior civil servants. Whatever moneys remain, are paid to the physician as a bonus.

(c) SHARAP Staff. Both hospitals place limitations on the medical and nursing staff included in the SHARAP arrangement. Only a small number of senior physicians who are full-time permanent employees of the hospital, may be included. Each of these physicians is supposed to sign a personal contract (a personal addition to the physicians collective work agreement), which obligates him not to practice privately outside the hospital. For example, the Sha'arei Zedeck contract, which was signed between the hospital and representatives of the senior physicians, states that each permanently-employed senior physician, who is working full time in the hospital, and who wishes to join SHARAP, must accept patients, with or without pay, only in the framework of his or her employment in the hospital, including under SHARAP. That same agreement also includes a clause whereby any physician who joins SHARAP pledges that his participation in SHARAP will not in any way undermine the work that he must carry out within the framework of his hospital position. A similar pledge appears in the agreement with the Hadassah physicians.

Neither hospital offers a special reimbursement arrangement for medical or nursing staff who are not included in the SHARAP list, but who are actively involved in delivering care to SHARAP patients. Thus, for example, it is perfectly possible that a surgeon will be reimbursed for a SHARAP operation, while the anesthetist and operating room nurses will not be reimbursed. Further, only a relatively small group of doctors are included in the arrangement - those who have attained the position of senior physicians in full-time jobs. A partial response to the feelings of discrimination that this situation created was given by Hadassah, with the creation of a new framework in 1992. This new arrangement (called by the Hebrew acronym for Personal Medical Care - TARA) allows physicians who are permanently employed in

Hadassah, but are not yet senior physicians, to practice under SHARAP for fees that are about 75% of the SHARAP fees. They are also subject to additional limitations: they must treat their private patients only in the afternoon hours, in a private clinic rented from the hospital for this purpose. On the other hand, the regular SHARAP physicians are allowed to receive private patients during the hospital's regular working hours.

In Sha'arei Zedeck, about 10% of all the physicians entitled to practice under SHARAP do not utilize their right, for a variety of reasons. Some have a private clinic outside the hospital. In this hospital, as well as in Hadassah, there are many physicians who have additional part-time jobs in the sick funds, as independent physicians. They frequently choose to receive their sick-fund patients in the hospital offices, for which they pay a certain sum to the hospital. This arrangement has nothing to do with SHARAP.

(d) Treatment of Surgery Patients. If the physician treating the patient under SHARAP decides that an operation is required, the SHARAP patient joins the general waiting list for that particular surgery. However, in both hospitals, the SHARAP physicians have some discretion as to the patient's place on this list. The State Comptroller, in his report on Hadassah, noted that in some departments, the waiting period for operations among SHARAP patients was shorter than among regular patients in those departments (State Comptroller, 1988, 185-186). The arrangement in Hadassah is, that a SHARAP patient who has paid his bill, is scheduled for surgery at the first available slot (Netanyahu Committee, II, 232). In both hospitals, the surgery and other treatments of SHARAP patients take place during the regular working hours, and the patients are hospitalized in the wards together with the other patients. As far as the ward staff are concerned, including physicians not included in the SHARAP arrangement, there is no difference between SHARAP patients and other patients. They all receive the same care. The medical and nursing staff on the ward are not even supposed to know who the SHARAP patients are. The list of surgical patients does not indicate who are the SHARAP patients. However, it is well known in these hospitals that some doctors have many SHARAP surgical patients, and that these patients usually enjoy special attention from their doctor. Thus the SHARAP patients can be easily identified, albeit informally. In Sha'arei Zedeck, the head nurse on the ward is supposed to be informed of the SHARAP patients on the ward. We were unable to receive updated data on the extent of income from SHARAP in the two hospitals under discussion. However, at the time, Sha'arei Zedeck hospital was asked to submit figures on its income from SHARAP to the Netanyahu Committee. These data indicate that the SHARAP turnover tripled in the five

years between 1984 and 1989, in real terms. Between, 1986-1988, this hospital's income from SHARAP amounted to about 10% of the hospital turnover, i.e. about 1.8 million dollars, half of which was net income. In each of these hospitals, there is a separate accounting system for all of the SHARAP's financial activities, as well as a separate account for each of the physicians, which is credited according to his activities.

Sha'arei Zedeck has a price list for visits to the SHARAP clinic, and these prices are updated by the physicians. As for surgery, the price is set by each SHARAP physician according to his discretion. It appears that in this hospital there is competition among physicians in similar specialties - among the more senior and well-known physicians and those that are less senior. In Hadassah there is a set price list for visits to the clinic and for surgery, which is decided on by the hospital's Fees Committee, including representatives of the SHARAP physicians. The payment by the SHARAP patient includes the operation itself (as explained above, the price for this is set by the physician in Sha'arei Zedeck and by the Fees Committee in Hadassah), operating room services, payment for the anesthetist and various tests. These payments are decided on by the hospital, and are not connected to the operation fee. From all these payments, a sum is deducted for the hospital.

Since in both these hospitals operations are performed primarily during the morning hours, there is a limit to the number of SHARAP operations that may be performed, in order to minimize the preference given to the private patient over the public patient. Thus, in Hadassah, there is a cap of up to 20% SHARAP operations per unit of operating room time. During interviews, we were told that this limit is not adhered to. In Hadassah, the SHARAP clinic is open throughout the day. In Sha'arei Zedeck, on the other hand, the SHARAP clinic opens only after 3 p.m. Therefore, the SHARAP clinic's afternoon activity may be viewed as an additional output of the Sha'arei Zedeck hospital.

At the request of the Netanyahu Committee, Sha'arei Zedeck submitted data on the extent of SHARAP clinics' activities, out of all the hospitals' out-patient clinic activities. These data show that on average, visits to the SHARAP clinics constitute only 17% of the total activity of out-patient clinics. On the other hand, in 1986-1988, more than a third of the activities of the gynecology clinic were carried out under SHARAP. The department of plastic surgery has a noticeably high percentage of SHARAP operations - over half. Apparently these are operations not included in the Sick Funds basket. Relatively high SHARAP surgical activity may be seen in ophthalmology: over 10% of the operations are carried out under SHARAP.

The general conclusion that may be drawn from these data is that the

demand for SHARAP is highly selective, and focuses on well-defined areas. A SHARAP physician whose specialty falls among the areas in demand, will carry out many procedures under SHARAP, and this will be reflected in his salary. On the other hand, a physician in internal medicine or pediatric wards, where the demand for SHARAP is low, will hardly perform any SHARAP procedures. Unfortunately, we were unable to obtain more up-to-date data from these hospitals

Summary: Evaluation of the Contribution of SHARAP in Public Hospitals to the Health System

In this final chapter, we will attempt to examine the supposed contributions of SHARAP to the Israeli health system. This will be done by examining each of the principle reasons for introducing SHARAP into acute-care hospitals, in light of the experience gained in Israel and in other developed countries. Our general conclusion is that SHARAP in public hospitals is a policy aimed primarily at benefiting a select group of senior physicians in those hospitals. The true meaning of SHARAP in hospitals, that were built and are run by taxpayers' money, is to transfer the control of assets and equipment into the hands of this group of physicians, thus promoting their immediate economic interest. The market principles are, in this context, nothing but a code word for allowing public resources to be transferred to a group of physicians, who hold a monopoly over treatment of patients in public hospitals.

Does SHARAP Enhance Patient Well-Being? The assertion of enhancing the patients freedom of choice and thus his well-being (see Schechter and Shavit, 1992) is largely hypocritical. As we have seen, this freedom of choice is *a priori* extremely limited by the hospitals local monopoly and by a small number of physicians (largely heads of departments) who are included in SHARAP. Further, this freedom is available to the patient under conditions whereby all the knowledge about his illness is in the hands of that same person who is offering him the SHARAP service; the control over the healing process is also in the hands of the seller of the service, and the patient is usually in a condition of anxiety. Under these conditions, aggressive marketing of SHARAP may become an offer that cannot be refused.

With regard to the issue of freedom of choice and patient well-being, it is important to mention the large variety of supplementary insurance policies offered by all the sick funds through associations and insurance companies associated with the sick funds. These supplementary insurance schemes are offered in accordance with the National Health Insurance Law, and related regulations. They offer to anyone, for an additional sum paid to the sick funds,

and under competitive conditions, a broad spectrum of private medicine options, including the SHARAP services in Jerusalem's private hospitals. For example, let us look at the supplementary insurance plan offered by the Meuchedet Sick Fund, which is called Meuchedet Adif (as publicized in April 1995 in a brochure published by that sick fund). It covers options to be hospitalized in private acute-care hospitals (Assuta Tel Aviv, Horev and Elisha in Haifa, and Herzliya Medical Center, the Wolfson Surgical Center in Jerusalem and AMC in Rishon Lezion), and well as use of SHARAP services of both Hadassah and Sha'arei Zedeck in Jerusalem. This latter is limited: the sick fund will only participate in 30% of the difference between the cost according to Ministry of Health fees and the surgery fees charged by the Assuta hospital in Tel Aviv. Supplementary insurance policies offered by other sick funds are basically similar to this example.

In these supplementary insurance schemes, the sick fund represents the lone client against the power of the hospital, which is supposed to represent all of its employees. In SHARAP, the patient stands alone against the administrative authority and monopoly of knowledge and expertise held by the doctor. Therefore, supplementary insurance does create a certain balance between the power gap that exists between these two sides. Further, these supplementary insurance plans are offered by law and supervised by a national authority (the Treasury's Insurance Supervisor). Thus, from the point of view of social justice, and of maintaining the patient's interests as a client of the hospitalization services, supplementary insurance plans are clearly preferable to any SHARAP arrangement. These supplementary insurance schemes also provide a practical answer to the claim that SHARAP arrangements funnel moneys paid by those who can afford it from private for-profit hospitals to public hospitals (see, for example, the Netanyahu Committee Report, I 317). From the point of view of the insured client, if he has supplementary insurance as described above, he has the ability to choose between the private sector and the public sector, since the sick fund has in effect contracted with both to buy potential services.

Does SHARAP Transfer Public Resources to the Affluent and the Physicians? Economists Shechter and Shavit (1992) claim that a case can be made for the creation of different levels of quality in health services, with different prices, as is common, for example, in education. In their defense of this value judgment, which supports the creation of inequality in the health services, they state that there is no truth to the claim that SHARAP siphons public resources to the affluent, thus creating medicine for the haves and medicine for the have nots (ibid., 318). The basis for this factual claim statement cannot be found in that same article, since its subject is a theoretical

projection of the demand for SHARAP, based on a very problematic methodology. In any case, the facts described above, regarding the experience gathered in Israel and other developed countries about private medical services lead to the reverse conclusion. SHARAP, in fact, has to do with siphoning public resources to a thin layer of senior physicians and rich patients. The ceiling set by Minister Sneh for implementing SHARAP in Government hospitals - 35% - is, of course, a global estimate, with a downward bias. It is well known that in the Government public hospital sector there are considerable differences among hospitals in efficiency, structure of activity, level of investment in infrastructure, etc. For example, if, according to the Sha'arei Zedeck hospital's estimate the correct ceiling for SHARAP activity - as related to diagnostic services such as imaging and pathology and to clinical lab tests - is almost 47%, then all the SHARAP activity in these categories of medical activity in Government hospitals would be linked to the transfer of public resources to the physicians. Since most public hospitals in Israel have no information system that allows for the pricing of medical services, and no one knows what is the real price of SHARAP, we may assume that there will also be a transfer of public resources to SHARAP users, through hospital-subsidized fees.

Does SHARAP Have a Favorable Impact on Physicians' Satisfaction with their Work and on Work Relations? Will the implementation of SHARAP in public hospitals increase physician satisfaction with their salaries? Will the additional remuneration for the groups of physicians included in SHARAP bring about better work relations between the public employer and the Physicians' Association and the Organization of State-Employed Physicians? An analysis of the data concerning physicians' salaries during, and immediately following the 1984 physicians' strike led Zusman and Zakai (1993) to the conclusion that the deep sense of discrimination which accompanied this strike derived first and foremost from the growing inequality within the group of hospital-employed physicians. A relatively small number of senior physicians enjoyed significant salary raises (partly because some of them were in administrative positions, which allowed control over the division of duty rosters and on-call rosters). The chances of reaching the top and being promoted were diminishing, from the point of view of the junior physicians, whether because there was no real expansion in the acute-care hospitals, or because the number of junior physicians in the hospitals kept growing, following the influx of thousands of doctors, immigrants from the former Soviet Union, who were taken on for specialization and observation (Nave and Nirel, 1995).

That same group of senior physicians, who are the main beneficiaries of the introduction of SHARAP into acute-care hospitals, because they include heads of departments, control also the intake, promotion, and work conditions of their junior colleagues. The implementation of SHARAP under these conditions could only increase the gaps between the salaries of the senior physicians and those of other physicians in the public hospitals, including beginning specialists, specialists and residents, who are not included in SHARAP (according to the existing regulations). The leaders of the 1984 physicians' strike were mostly members of this group (Zusman and Zakai 1993). Thus it is possible, that implementing SHARAP would only exacerbate the feelings of discrimination among groups of physicians in the in-patient sector. In any case, our feeling is that there is no basis to the conclusion that implementing SHARAP in public hospitals would bring about good industrial relations among hospital-employed physicians.

In some countries, such as Germany (Krikman-Liff, 1990), community doctors have a clear salary advantage. Physicians working in the community are considered the most important link in the chain of health services, because they are the link between the patient and other components of the health system since they are responsible for coordinating the services provided to the patient, and because of the significance of their work for prevention of disease and for improving the health status of most of the population (see more citings in Shirom, 1994). The idea is that the in-patient system is in contact with a very small part of the population, and is mostly preoccupied with the maintenance of very ill patients suffering from chronic and incurable diseases, such as heart disease or cancer. The introduction of SHARAP into public hospitals would adversely affect the remuneration of community-based physicians, as opposed to hospital physicians.

To conclude, official, recognized private medicine in public hospitals provides a small group of senior physicians with a package of benefits and remunerations, which is unparalleled in Israeli work relationships. There is no other group of salaried employees who enjoys even a remotely similar package to that of these senior physicians who will continue to enjoy permanent employment, pension arrangements and sabbatical benefits, as salaried employees. As employees of public hospitals, they will have access to the best and latest technological innovations in medicine, that will be purchased by the State from the Ministry of Healths development budgets. At the same time, their employer will allow them to hold private practice within the public institution that employs them, allowing them also (for example, according to the policy proposed by ex-Minister Sneh) to set their SHARAP fees themselves.

Will SHARAP Improve the Quality of Care in Public Hospitals? Another issue is the effect of SHARAP on the quality of patient care in public hospitals. It is claimed (see, for example, Netanyahu Committee, I, 317), that the main consideration which guided Hadassah when it decided on introducing SHARAP in 1954, is a valid one: attracting good physicians to work in the public system during afternoon and evening hours as well, and ensuring their presence in the hospital for longer hours, both for the benefit of their private patients, and for the good of the public patients. Quality of care in hospitals has many important aspects. For the sake of brevity, we will relate primarily to the question of the effect of SHARAP on the rate of unnecessary hospitalizations and unnecessary hospital days - these being extremely important issues for the individual patient as well as for the health system and its expenditures - and relate less to the question of how SHARAP affects the number of hours physicians spend in the hospital.

Even prior to the wave of immigration from the former Soviet Union, the relation of doctors per population in Israel was one of the highest in the world. The 13,000 working age physicians who were in Israel in 1989, were joined by about the same number of immigrant physicians from the former Soviet Union, who worked as physicians prior to immigration (Nave and Nirel, 1995). Of this last group of immigrants, about 9,000 applied to the Ministry of Health for a license to practice medicine in Israel (Nave and Nirel, 1995). Theoretically, this unprecedented increase in the supply of physicians in Israel should have directly caused a decline in physicians' pay overall, and some reduction in the income of each individual physician, under the assumption that the demand for their services would change more slowly. In fact, there is a well-known phenomenon, well documented in literature, whereby under these conditions both the price of medical services, and the extent of supply, will rise, rather than decline, following the creation of demand by the physicians themselves (for literature review see Pauly, Eisenberg, Radany et al., 1992). The fact is, in the labor agreements signed for 1993-1994, the physicians' organization attained the highest achievement of any organized group of employees in the Israel economy (see, for example, Institute for Social and Economic Research, 1995, p. 2).

There is evidence in the literature that physicians cause an increase in the demand for medical services through their control of specialty knowledge, their monopoly of curative processes, and their influence on the conditions of medical services. Most studies that compared the relative frequency of operations and surgical treatments of patients between those who paid in advance and those who paid by fee for service found a higher frequency among

patients of the second group (Achdut and Geva, 1994, p. 22). This means, that when a physician has a direct monetary interest in carrying out a specific procedure, he will act to increase the demand for medical services. Indirect evidence for this phenomenon may be obtained from studies conducted about unnecessary hospitalization and unnecessary hospital days in Israel (see Moses, 1993). These phenomena are increased and enhanced when the reimbursement system is by medical procedure (fee for service), which is the accepted method in SHARAP (see, for example Hornbrook and Berki, 1985).

To these effects, of the number of physicians and the reimbursement system, is added, in the Israeli context, the tendency toward defensive medicine. This term refers to physicians' tendency to conduct tests, to hospitalize, and sometimes even to perform surgery in order to protect themselves from future malpractice lawsuits. According to evidence given to a government commission headed by Judge Kling (see *Globes*, 19.5.95), this phenomenon has become very prevalent in Israeli hospitals, and its result is that insurance expenditures for physician malpractice in Government hospitals increased by over 300% during the years 1992-1995. Because of the cost of this insurance alone, hospital physicians may prefer SHARAP, which is practiced inside the hospital.

Social Considerations of Implementing SHARAP

An additional, and in our estimation crucial, aspect of implementing SHARAP in public hospitals has to do with the broader social effects of SHARAP. There is no doubt that the introduction of SHARAP into public hospitals would bring about the creation of two levels of care in the hospital and differences in access to all types of care offered by SHARAP according to the patients' financial status. Under present conditions, where there are waiting lists for surgery and allocation of physician time, which are presently dictated by the judgment of department heads who are senior physicians, it makes sense that the preference of SHARAP patients in access to treatments that have waiting lines will become the norm. This preference has become a regular phenomenon in hospitals that implement SHARAP, with regard to surgical operations.

Implementing SHARAP in public hospitals will expand the gaps in Israeli society and create injustice in the distribution of in-patient services. If indeed SHARAP is implemented in all Government hospitals, as envisioned by ex-Minister of Health Ephraim Sneh, then this would contribute significantly and directly to societal polarization in Israel and would undermine the sense of solidarity that still exists in Israeli society (Zusman, 1995). The public health services are supposed to be an important and valuable tool in enhancing the sense of societal solidarity in Israel.

We have not been able to come up with any evidence that SHARAP will enhance the quality of care in hospitals or create new resources (in addition to those that may be obtained through supplemental insurance). SHARAP encourages and advances a relatively small group of physicians in hospitals. This is the only group for whom there is solid evidence that it would profit directly from the implementation of SHARAP. Will the concern raised in the literature (Yishai, 1993) come true, whereby health management by physicians will become health management for physicians?

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HALAKHA AND PATRIACHAL MOTHERHOOD - AN ANATOMY OF THE NEW ISRAELI SURROGACY LAW

by Carmel Shalev*

Introduction

The second half of the 20th century has been a period of innovation in medical technology with much significance for social relations of reproduction. The invention of the contraceptive pill changed our attitudes towards the control of pregnancy and its prevention, and allowed for the differentiation of female sexual and reproductive activity. The development of blood-typing and genetic tests altered radically the legal procedures for proving paternity, and influenced deeply our understanding of the uncertainty of biological fatherhood. Various methods of medical imaging gave concrete and human shape to the image of the fetus in its mother's womb. And the very moment of conception was transformed, by means of in-vitro fertilization, from being a mysterious event taking place in the hidden spaces of the woman's body to an overt and exposed occurrence in the laboratory petri-dish.

All these matters touch upon primordial elements in the most basic relations between men and women and between parents and children, and affect fundamental structures of human society. It is not surprising that many of the social changes made possible by the scientific progress do not in fact take place. Reproductive relations in this era of medical technology give rise to sharp controversies and harsh disputes. Despite the medical capability, hundreds of thousands of women throughout the world die each year from factors related to pregnancy and childbirth, because of inadequate education and lack of access to safe, effective and affordable methods of family planning of their choice, and to primary health-care services that could enable them to go safely through

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* Director, the Ethics Unit, The Gertner Institute for Health Policy Research in Israel, Tel Hashomer,Israel.

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pregnancy and childbirth.[1] For many of the world's women the control of fertility and reproductive autonomy remain a matter of life and death, while the heads of the great religions continue to oppose vehemently legalization of abortion.[2]

In most parts of the world, the central questions of population and fertility are ones of poverty and development. On the other hand, in developed countries the most pungent discussions concern infertility and methods of its treatment. The technology of medical fertilization, which employs the use of donor gametes (sperm and ova), raises serious normative and ethical questions about the structure of the family and spousal relations, and the significance of the genetic connection between parent and child. Other questions are of a more pragmatic kind and concern the cost-effectiveness and efficacy of the medical techniques, either in relation to the experimental character of some of the methods or as regards their funding by public health systems.[3]

Israel is among the world's leading countries in research and development of methods of medical fertilization. The incidence of infertility treatment in Israel - measured by the number of clinics per capita - is the highest in the world, four times larger than in the United States, which excels in the provision of commercialized quality medical services.[4] Despite the high cost and relatively low success rates (less than 15% probability of a live birth in one cycle of treatment),[5] the national health insurance scheme covers up to seven cycles of in-vitro fertilization treatment "for the first and second child, for a couple who do not have children from their present marriage, and also for a childless woman who wishes to establish a single-parent family".[6] Criticism of the

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1. Rebecca J. Cook, "International Protection of Women's Reproductive Rights", 24 *Journal of International Law and Politics* 645 (1992); *Report of the International Conference on Population and Development* (Cairo, 1994) (hereinafter - *The ICPD Report*), paras. 7.2, 8.19; *Report of the Fourth World Conference on Women* (Beijing, 1995) (hereinafter - *The FWCW Report*), para. 97.
2. The Holy See expressed a general reservation to both Chapter VII of the ICPD Report (entitled "Reproductive Rights and Reproductive Health") and Chapter C of the FWCW Report (entitled "Women and Health").
3. See text to footnote 6.
4. *The Report of the Public-Professional Commission in the Matter of In-Vitro Fertilization* (Israel Ministry of Justice, Jerusalem, July 1994) (hereinafter - *The Aloni Commission Report*), p. 8.
5. Ibid. Physicians practising in the area claim that these data are outdated, and that success rates are now higher. If this is the case, it may be due to screening of older patients while admitting candidates who present no visible indication of the cause of apparent subfertility.
6. Para. 6(d) of the Second Addendum to the National Health Insurance Law, 1994 (*S.H.* no. 1469, p. 156). Note that the Law does not, however, cover the costs of contraceptive

technology inside Israel is almost non-existent. In the legal literature, the hardships of the medical treatments have been mentioned with compassion, but by way of acceptance of the biblical destiny of woman upon being banished from the Garden of Eden: "I will make intense your pangs in childbearing; in pain shall you bear children",[7] and in such a way as to silence arguments that in any way question the value of motherhood.[8] The cultural atmosphere is such that the centrality of the values of family and childbearing goes unchallenged. At times it seems as if the consumption of medical technology under social pressure borders upon an irrational obsession. The option of childlessness and its acceptance does not exist. Even alternative solutions such as inter-country adoption recede in the face of an unspoken imperative, to realize genetic parenthood at whatever cost. It seems that the value of biological parenthood would justify all means for its attainment, and close the debate to any person who is not herself childless.

In this context it is not surprising that there came about a unique initiative in Israel,[9] to regulate by statute surrogate mother arrangements. The term of surrogacy is used in relation to situations in which a couple are unable to have children because the woman cannot carry a pregnancy. They therefore contract with another woman - the surrogate mother - who agrees to conceive, carry the pregnancy, bear the child, and then surrender it to the commissioning parents,

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devices. Likewise, not all cases of legal abortion in Israel are included in the Law's coverage.

7. Genesis 3:16.
8. In the Nahmani case (CA 5587/93 *Nahmani* v. *Nahmani* 49 *P.D.* (1) 485) there was a dispute between an estranged couple as to the use of frozen embryos, that were fertilized initially with the intention of entering an agreement with a surrogate mother. After the couple separated, the husband objected to continuing the procedure. Tal J., in the minority, referred to the hardship of the treatments as grounds for estoppel against the husband's otherwise sound legal argument: "The woman underwent a difficult and painful invasive procedure in her body so as to produce the eggs, in reliance upon the consent of the man to their fertilization. Upon their fertilization,the woman was denied any other alternative, such as fertilization with 'donor' sperm. She altered her situation irreversibly in reliance upon his conduct. Hence, even if he has correct arguments as to the unenforceability of the agreement and as to the need for ongoing consent at each and every stage of the path to parenthood, and any other argument ... one does not heed them and one does not allow him to make them heard."
9. In most countries there is no special legislation on this matter. In some of the developed countries there is a prohibition against surrogacy either by statute or by case law. In England, for example, the Surrogacy Arrangements Act, 1985 prohibits any related commercial activity. To the extent that surrogacy arrangements do take place, it is in the absence of an express prohibition. In no other jurisdiction is there an official mechanism for approving surrogacy agreements similar to that established by the Israeli statute.

so that they may raise him or her as their own. Beyond the various legal issues that arise, it is clear that the social relations that form in such situations are substantially different from the model of marriage, in which sexual and reproductive relations are exclusive to the couple.[10] It is likewise clear that these situations deviate from accepted norms as to the role of the mother and her responsibility to rear the children she bears. In some jurisdictions surrogacy arrangements are considered to be contrary to the public policy against selling children, and thus invalid.[11] In addition, there is the fear that women who agree to serve as surrogate mothers might fall victim to abuse and exploitation, and that allowing a trade in the reproductive services of women will give rise to a new form of prostitution and international trafficking in women.[12]

In the next section of this article I shall present the new Israeli legislation and its background. In the following section I explicate the *halakhic* rationale of the Law as regards the complicity of infertile women therein and the similarity between the markets of sexual and reproductive services, so as to indicate points where it would be wise to proceed with sensitivity and caution. In the final section I identify further trends in Israeli case law that celebrate motherhood as a trump value, as long as it conforms with *halakha* (the orthodox doctrine of Jewish law).

The Legal Situation

1. The Aloni Commission Recommendations

At the beginning of 1991 a petition was brought before the Israeli High Court of Justice by a married couple against the Minister of Health, asking him to explain why it were not possible for them to fertilize the wife's ova with the husband's sperm for the purpose of subsequent implantation in the womb of a surrogate mother.[13] At the time there was no express provision in Israeli law as

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10. In Israeli law, see P. Shifman, *Family Law in Israel*, vol. 2 (Jerusalem, 1989), 157-168; E. Vilchik, "The Surrogate Mother", 17 *Mishpatim* 534 (1988)(in Hebrew); C. Shalev, "Reproductive Law and the Right to Be a Parent", in *Women's Status in Israeli Law and Society* ((eds. F. Raday, C. Shalev and M. Liban-Kooby) (Tel Aviv, 1995), 503, 526-532 (in Hebrew); and C. Shalev, "Surrogate Mother Arrangements - a Legal and Normative View" in *An Unusual Pregnancy - A Multi-Disciplinary Study on Artificial Insemination* (eds. A. Ben-Zeev and S. Almog) (HaKibbutz HaMeuhad, Tel Aviv, 1996) 191 (in Hebrew).
11. These were the grounds for the decision of the New Jersey Supreme Court in In re *Baby M*, 190 N.J. 396. 537 A. 2d 1227 (N.J. 1988).
12. See, for example, C. Pateman, *The Sexual Contract* (Stanford University Press, 1988) 204-218; M.A. Field, *Surrogate Motherhood* (Harvard University Press, 1988).
13. HC 1237/91 *Nahmani* v. *Minister of Health* (unpublished).

to the legality or validity of surrogacy agreements - neither in the affirmative nor in the negative - but such arrangements were not actually practised. The petitioning couple wished to enter an agreement with a surrogate mother through an agency in California that was to provide the necessary intermediary and professional services. Because of significant differences between the cost of medical treatment in Israel and the United States, the couple wanted to perform the procedure of in-vitro fertilization in Israel, but the physicians refused to do so on the basis of regulations enacted by the Minister of Health under the Public Health Ordinance. The petitioners challenged the regulations, arguing that they exceeded the authority vested in the Minister in that they restricted their right to receive infertility therapy, infringing upon fundamental rights of reproduction without express statutory authorization.[14] The petition ended in an out-of-court settlement with the Ministry of Health by which the couple were allowed to perform the fertilization in Israel.

A short while later the Minister of Justice and the Minister of Health appointed a professional public commission, headed by former Judge Shaul Aloni, to examine the matter of in-vitro fertilization in all its aspects (hereinafter - the Aloni Commission). According to the letter of appointment, the task of the Commission was to examine the social, ethical, *halakhic* and legal aspects of the methods of treatment related to in-vitro fertilization, including surrogacy agreements. The report of the Commission covered many issues pertinent to medically-assisted reproduction, including the fundamental right to privacy, the principle of informed consent to treatment and to participation in experiments or innovative therapy, gametee donations and records thereof, the use and disposal of fertilized eggs (pre-embryos),and the definition of parenthood.[15] Likewise, the report addressed the religious implications of the technology, in respect of the status of the children born from different medical methods of fertilization. However, of all the varied

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14. The basis for the physician's refusal was found in regulations 11 and 13 of the Public Health (Extra-Corporeal Fertilization) Regulations, 1987 (see footnote 21 below), which prohibited the *implantation* of a fertilized egg in certain circumstances, despite the fact that the couple were asking merely to perform the *fertilization*. The risk entailed in acting contrary to the regulations is, on the one hand, losing the official recognition of the Ministry of Health in the hospital department, which is a condition for the provision of services therein, and, on the other hand, personal exposure to professional disciplinary proceedings under the Physicians Ordinance [New Version], 1976 (3 *L.S.I.* [N.V.] 80).
15. For a review of the main recommendations of the Aloni Commission and the central points of controversy between the majority and minority opinions, see C. Shalev, "Insights on the Report of the Commission in the Matter of In-Vitro Fertilization", 3 *HaMishpat* (1995) 53.

issues dealt with by the Commission, the matter of surrogate mother agreements received by far the most public attention.

The recommendation of the Aloni Commission on this issue was to avoid taking an extreme position, one way or the other. The Commission was aware of the fact that in many countries, surrogacy arrangements had been prohibited by either the courts or the legislature. Furthermore, there was not before it any example of foreign legislation that expressly permitted surrogacy and allowed for the legal enforcement of such agreements. It was also cognizant of the complexity of the human relations that form in connection with a surrogacy agreement. At the same time, the Commission was guided by the principle of respecting the constitutional right to privacy in family life and autonomy in reproductive decision making, and of refraining from undue state interference in such matters, except for weighty reasons.[16] The Commission was of the opinion that societal interference in agreements between individuals should be exercised with the utmost caution, and that the fundamental right to privacy in reproductive matters should be respected as a matter of principle, notwithstanding all the inherent risks of surrogacy. It recommended, therefore, that surrogacy agreements should not be prohibited entirely under criminal law, but nor should they be encouraged or allowed without restriction, because of the human and legal complexities.[17]

The scheme that was proposed by the majority on the Commission[18] was to allow surrogate mother agreements on condition that they receive prior approval, before conception, from a statutory committee that would exercise discretion in reviewing each single agreement on its merits and confirm that the parties to the agreement had understood the meaning of their obligations thereunder. In light of the prohibition of such agreements in other countries and the possibility of forum-shopping for a convenient jurisdiction at the inter-state level, the Commission recommended that the proposed statutory scheme should apply only if all the parties were residents of Israel and if the agreement was to be carried out in its entirety inside Israel. The intention was to eliminate the potential for reproductive tourism[19] and ensure that the statutory

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16. CA 413/80 *A* v *B* 35 P.D. (3) 57, at 81. The right to privacy is guaranteed under sec. 7 of Basic Law: Human Dignity and Liberty
17. *The Aloni Commission Report* (supra n. 4), para. 7.4.
18. The two members in the minority did not disagree with the very principle of regulating surrogacy within known limits, but with the details of the regulatory scheme and the scope of the desirable limitations.
19. Note that the combination of the Law of Return, 1950 (4 *L.S.I.* 114) and the National

committee could fulfil its function as a supervisory mechanism to prevent mishaps in the performance of surrogacy agreements.

The Aloni Commission recommended further that the parties to the surrogacy agreement undergo psychological screening, and that the commissioning parents receive professional counseling to consider all possible alternatives, including the option of childlessness. The Commission did not lay down any criteria regarding the eligibility of a woman to be a surrogate mother, except for the obvious limitation that she not be a minor (considering that minors lack legal capacity in general). According to the majority, there would also be no restrictions upon the right of the infertile couple to choose the method of medical fertilization (artificial insemination of the surrogate mother with the sperm of the commissioning father, or in-vitro fertilization and implantation of an egg taken from the commissioning mother, or a donor, and fertilized with the sperm of the commissioning father).[20] In addition, the Commission recommended unanimously that the surrogate mother should be entitled to payment for her services, to cover the actual expenses of conception, pregnancy and birth, and in compensation for her time, suffering, loss of income or temporary loss of earning capacity. Likewise it recommended that a woman should not be allowed to serve as a surrogate mother more than once, unless she were to carry a second pregnancy for the same commissioning couple. Finally, the Aloni Commission recommended that there be a criminal prohibition against any payment to intermediaries in relation to a surrogacy

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Health Insurance Law, 1994, might frustrate the policy of preventing reproductive tourism. A Jewish person who immigrates to Israel, is considered a resident, and thus entitled to national health insurance coverage, immediately on arrival in the country. She would, therefore, be entitled to fertility treatment free of charge (aside from payment of the health tax). This could provide a financial incentive for Jewish people to come to Israel for reproductive purposes, receive the medical services in Israel, and then return to their own countries after concluding the treatment.

20. The question put to the Commission was whether to permit surrogacy where the carrying mother is also the genetic mother. This is often referred to by medical professionals as "partial surrogacy", as opposed to "full surrogacy" which results from in-vitro fertilization where the surrogate mother is not the genetic mother of the fetus. Some of the Commission members thought that surrogacy should be allowed only where there was symmetry among the commissioning parents in terms of their genetic connection to the child. The majority, as mentioned in the text, considered that the method of conception was not normatively significant. *The Aloni Commission Report*, paras. 7.16-18.

agreement, unless permitted by the statutory committee, for fear of commercial exploitation.

Several months after publication of the Commission's report another petition came before the High Court of Justice, this one brought by a number of childless couples asking it to declare as invalid regulations 11 and 13 of the Public Health (Extra-Corporeal Fertilization) Regulations, 1987 - by virtue of which doctors were continuing to refuse to take part in surrogacy arrangements.[21] In its response, the State conceded that the challenged provisions of the Regulations were *ultra vires*, in the sense that their subject matter merited primary legislation, and not regulations enacted under the Public Health Ordinance. The State agreed, therefore, that the regulations should be voided of legal effect, except that it requested that the Court stay its decision for several months, within which time the Government would initiate legislation "in this sensitive, complex and difficult issue". The Court responded positively to this request,[22] after noting the need to define by statute clear rules and standards in relation to surrogate mother arrangements, and being of the opinion that it would be undesirable to create a situation, albeit temporary, in which there would be no legal rules to regulate the matter.[23]

Within a short while the Government indeed published the Surrogate Mother Agreements (Approval of the Agreement and Status of the Child) Bill, 1995.[24] The introduction to the Bill's commentary stated among other things

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21. HC 5087/94 *Zabro* v. *Minister of Health* (unpublished decision of 17 July 1995). Regulation 11 of the fertilization Regulations provided: "A fertilized egg shall not be implanted except in the woman who shall be the mother of the child." Regulation 13 provided: "An egg taken from a donor shall not be implanted in a woman unless it has been fertilized with the sperm of the woman's husband." In a narrow technical reading, regulation 13 does not apply, because there is no "donation" of an egg - in the sense of giving to another - insurrogacy arrangements. The donor of a sperm or an egg does not intend to be the parent of the child-to-be, and when they give their genetic material to another they relinquish and revoke any connection to it. This is not the case with respect to the commissioning parents in a surrogacy agreement, who fully intend to raise the child themselves.
22. The Court decided that the Regulations should be considered void as of January 1, 1996. In a subsequent decision of 31 January 1996 the Court admitted a second request by the State to postpone the date until 6 March 1996, to allow for completion of the legislative process.
23. For the view that legal tools for addressing surrogacy could be found in the existing law and that the Regulations could have been voided without special legislation, see M. Korinaldi, "On the Question of Surrogacy in Israel: Some Comments on the Aloni Commission Report" 3 *HaMishpat* (1995) 63 (in Hebrew).
24. *Hatza'ot Chok 5796*, p. 259.

that the Aloni Commission had been appointed in the wake of doubts as to the legality and reasonableness of the Extra-Corporeal Fertilization Regulations "and for the purpose of examining the issue of surrogacy in all its aspects", and that it had recommended to regulate the matter by statute which would permit the making of such agreements "in a controlled manner". The proposed law, it was stated, "is designed to allow surrogate mother agreements with various reservations and in a controlled form". The statute was indeed enacted within the time schedule set by the Court for voiding the regulations, except that it differed in some essential ways from the scheme recommended by the Aloni Commission. Whereas the Commission's recommendations were founded on the principle of the privacy and autonomy of the parties to the arrangement - and especially of the surrogate mother - the guiding principle of the statute, which was dictated by political considerations, is preservation of the rules of kinship according to Jewish *halakha*.[25] The Aloni Commission had not ignored the religious considerations, but nevertheless acted from a liberal world-view of individual liberty. Its approach was that the relevant information in this respect should be provided to the parties to the agreement, who should be left to decide for themselves how to proceed on the basis of such information. In the statute, however, the *halakhic* considerations took the form of restrictions on the discretion of the parties (whether or not Jewish).

The result, as shall be explained forthwith, is legislation that perpetuates patriarchal structures of reproductive relations, in that it subjects the birthing capacity of the woman to the genetic continuity of the man, exploits the body of the woman as a tool for satisfying the needs of the other, denies the woman economic independence, and celebrates the value of motherhood within marriage as an end that justifies all means.

2. The Surrogacy Law

The Surrogate Mother Agreements (Approval of the Agreement and Status of the Child) Law, 1996[26] [hereinafter - the Surrogacy Law] regulates the relations

25. The political consideration was that the matter could not be left unregulated (despite legal opinion to the contrary) and that without the consent of the rabbis and religious parties it would not be possible to pass legislation in the Knesset. Under pressure of the *Zabro* petition to the High Court of Justice some rabbis were consulted as to the conditions under which surrogacy might be permitted according to Jewish law, and their response served as the basis for the conditions that were laid down in section 2 of the Bill. It should be noted that the *halakha* is by its very nature a system of pluralist opinions, and that in the matter of medically-assisted reproduction there are also varied and often contrary views.
26. *Sefer HaChukkim 5796*, p. 176. The term "surrogate motherhood" or "surrogacy" is not used in the Hebrew. A strict translation of the statute's title would read "Embryo Carrying Agreements".

between a man and a woman who are a couple (the "intended parents") and another woman (the "carrying mother") who agrees to carry a pregnancy for them. The Law has two main parts: the first deals with approval of the agreement between the parties by a statutory "approvals committee", and the conditions thereof; whereas the second deals with the status of the child and the determination of parenthood in his or her respect.

The Law begins by setting forth prior conditions of a surrogacy agreement in terms of the eligibility of the parties. Aside from the requirement that they be Israel residents above the age of legal capacity, the Law adds that, as a rule, the carrying mother should not be a married woman[27] that she should not be a relative of either of the intended parents,[28] and that she be of the same religion as the intended mother.[29] The law prescribes further that the sperm used for in-vitro fertilization be of the intended father, but that the carrying mother should not have a genetic relation to the child-to-be.[30]

The mechanism that the Law provides for the legality of surrogacy arrangements is through the prior approval of a statutory committee composed of relevant professionals (physicians, social worker, psychologist and lawyer) and a clerical of the parties' religion.[31] The fundamental theme of the Law is that the parties reach an agreement, which they then bring to the committee for approval. The agreement may include provision for "monthly payments to the carrying mother to cover the actual expenses entailed in performing the agreement".[32] The application to approve the agreement must be accompanied

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27. In the course of the preparation of the bill in the Knesset Labor and Welfare Committee, an exception was introduced to the restriction as to the personal status of the carrying mother under section 2(3)(a), which reads as follows: "the approvals committee may, however, approve an agreement with a carrying mother who is a married woman, if it has been proven to the committee's satisfaction, that the intended parents were not able, with reasonable effort, to enter a surrogacy agreement with a carrying mother who is not married." This compromise was a result of concerns expressed by childless couples that the statutory restrictions would make it extremely difficult to find suitable candidates for carrying mothers, because of the perception, among other reasons, that an unmarried woman does not have support systems, which increases the risk of her rescinding the agreement, since she might not be able to keep her promise to deliver the child to the intended parents after the birth. See below text following footnote 57.
28. Section 2(3)(b) of the Law.
29. Section 2(5). Section 1 defines "relative" as "mother, daughter, granddaughter, sister, aunt, and paternal or maternal cousin, excluding a relative by way of adoption".
30. Section 2(4): "... the egg is not of the carrying mother".
31. Section 3(a)(6).
32. Section 6: "including expenses for legal counseling and insurance fees, as well as compensation for loss of time, suffering, loss of income or temporary loss of earning capacity, or any other reasonable compensation."

by various documents that testify to the seriousness of the agreement and the maturity and readiness of the parties, including a psychological evaluation as regards the suitability of each of the parties to the procedure.[33] One should note the requirement of "a medical opinion that the intended mother is unable to become pregnant and to carry a pregnancy, or that the pregnancy might significantly endanger her health."[34] The approvals committee is authorized to approve an agreement that has been brought before it, if it is convinced that all the parties entered it "by consent and of their own free will, with an understanding of its significance and consequences."[35] The committee also has discretion to withhold its approval on grounds of considerations concerning the health of the carrying mother and the welfare of the child-to-be, or violations of their rights.[36]

A separate chapter of the Law deals with the status of children born of a surrogacy arrangement. The parties to the agreement must give two notices to a welfare officer - the first, at the end of the fifth month of pregnancy, and the second, immediately after birth. The Law determines the right of the intended parents to custody of the child from the moment of birth, while the physical delivery of the child to them shall be in the presence of a welfare officer. In formal legal terms the guardianship of the child is vested in a welfare officer so long as a court has not made an order regarding the intended parents' guardianship (a "parenthood order").[37] The Law relates to the possibility of the carrying mother rescinding the agreement. The rule set under the statute is that the intended parents shall be the legal parents of the child, but if the carrying mother asks to keep the child the court may allow her to do so, as long as it has not issued a parenthood order, if it is satisfied "that there has been a change in circumstances that justifies the withdrawal of consent of the carrying mother,

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33. Section 4(a).
34. Section 4(a)(2). This provision is an example of the cautious approach taken by the legislature in allowing agreements of this nature only under limited circumstances. The approach of the Law is that one woman's mere "convenience" does not justify an arrangement whereby another woman carries a pregnancy for her. The underlying cultural message is that women ought to carry their own children unless a physician decides they are incapable of doing so, and that they do not have choice in this respect.
35. Section 5(a)(1).
36. Section 5(a)(3) refers to terms of the agreement that violate or infringe upon the rights of "each of the parties". The uniform language includes both the intended parents and the carrying mother, but it seems that this conceals the relative vulnerability of the carrying mother and the lack of parity in the parties' bargaining positions, as shall be elaborated below (see text following n. 59 below).
37. Section 10 of the Law.

and that it will not harm the best interests of the child".[38] Consideration of the best interests of the child might also justify a refusal of the court to issue a parenthood order in favor of the intended parents.[39] In such instance, too, the carrying mother may request guardianship of the child. In the case of the court refusing to make a parenthood order in favor of the intended parents, it must award her full guardianship of the child if she so requests, unless this would be detrimental to the interests of the child.[40]

The principle of the Law is that the intended parents are the legal parents of the child. In this vein it included several amendments to other statutes, to determine the right of the intended mother to childbirth benefits under the social security system, and the right of the intended parents to parental (maternity and paternity) leave under employment law. On the other hand, so long as the child has not been born, the Law respects the carrying mother. Under the title "Saving of Laws", the Law determines that no provision in it or in any agreement approved thereunder may derogate from the requirement to obtain the informed consent of the carrying mother for medical treatment, or from her right to receive medical treatment, including abortion.[41]

As regards the status of the child, the Law provides that upon the issue of the parenthood order the intended parents become the sole parents of the child "and it shall be their child for all purposes".[42] The parenthood order is similar to an adoption order, in that it transfers the legal parent-child connection from the birth parents to the adoptive parents. The Law, indeed, contains further provisions that refer to Israeli law regarding the adoption of children. First, the parenthood order shall not affect any legal prohibition or permission as to marriage or divorce.[43] Second, a special register shall be kept of all the orders

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38. Sec. 13 of the Law. The language of the statute, "the court shall not approve it unless ...", indicates that this is an exception to the rule that a parenthood order shall be issued to the intended parents in accordance with the agreement.
39. Section 11(b) of the Law.
40. Section 14(a) of the Law.
41. Section 18 of the Law. A pregnancy may be lawfully terminated by approval of a medical committee on any one of the grounds set out in section 316 of the Penal Law, 1977. One of the grounds is that the pregnancy is extra-marital (see text to n. 58).
42. Section 12(a) of the Law. Compare with the more guarded language of section 16 of the Adoption of Children Law, 1981 (35 *L.S.I.* 360, at 363): "The adoption creates the same duties and rights between the adopter and the adoptee as exist between parents and their children and confers upon the adopter, in respect of the adoptee, the same powers as parents have in respect of their children."
43. The prototype of this provision is found in section 5 of the Women's Equal Rights Law, 1951 (5 *L.S.I.* 171).

issued under the Law. The right to inspect the register is regulated by reference to the provision of the Adoption of Children Law, 1981 in regard to the adoption register, so that it is given to the Attorney-General, marriage registrars, and a chief welfare officer, as well as to an adoptee aged 18 years or over and by permission of a welfare officer.[44] Other than these, no person has right of access to information contained in the register.[45]

Policy Considerations

1. The Halakhic Rationale

If we compare the Surrogacy Law to the recommendations of the Aloni Commission, we discover several substantive matters on which the two regulatory schemes differ and which give an indication of the different considerations of their underlying policies:

(1) the Law sets limitations on the eligibility of the carrying mother: (a) she may not be a married woman, (b) or a family relative of either one of the commissioning parents, and (c) she must be of the same religion as the intended mother;

(2) the Law requires a genetic relation between the intended father and the embryo; and

(3) the Law requires registration of the children born under surrogacy agreements in a special register.

As already said, the policy of the Aloni Commission was to restrict state interference in matters which the Commission considered to be protected by the fundamental right to privacy. As opposed to this, it seems that the policy underlying the Law is to lay down rules that conform with the requirements of Jewish religious law (which in Israel is the binding law in matters of marriage and divorce), with regard to the competence of the child-to-be to marry under the *halakha*, as shall be explained forthwith.

(1)(a) The prohibition against the carrying mother being a married woman derives from a *halakhic* debate - in which there is a division of opinion among the accepted authorities - on the question of the *mamzerut* (bastardy) of the child. According to Jewish law, a child born to a married woman from a man who is not her marital partner is a *mamzer* (a bastard), and the child may only

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44. Section 30 of the Adoption of Children Law, 1981; section 16(c) of the Surrogacy Law.
45. Values of privacy and confidentiality find expression in other sections of the Law. As a rule, court hearings shall be in camera (section 17). Similarly, disclosure of statements made during the meetings of the statutory approval committee is a criminal offence with a penalty of one year imprisonment (section 19(c)). Compare with sections 21 and 34 of the Adoption of Children Law.

marry other *mamzerim* or converts. That is to say, the *mamzer* is not competent to marry ordinary Jews. This rule applies only to the extramarital child of a married woman, not to that of a married man. The child of an unmarried Jewish woman carries no marriage impediments.[46]

It is clear that the prohibition of adultery applies as regards extramarital sex and any resultant pregnancy, but the question is whether it applies also to a pregnancy that is created from the genetic material of a man other than the woman's husband, without sexual intercourse. Many of the *halakhic* authorities are of the view that there is no problem of the child's marital capacity unless its conception was the result of a forbidden sexual act. But the secular legislature chose to adopt, as the rule, the more cautious and restrictive *halakhic* approach that fears for *mamzerut* even in the case of genetic adulteration, so as to preclude any doubt as to the child's capacity of marriage. The exclusion of married women from eligibility to be carrying mothers thus results in the rule that only unmarried women may be such. The exception to the rule, allowed for in the statute, is a reflection of the more lenient *halakhic* view.

(1)(b) The restriction that the carrying mother may not be a family relative[47] of the intended parents also stems from the laws of *mamzerut*, because in addition to a child born of a married woman's adultery, *mamzerut* also results from other forbidden sexual relations, including incestuous relations, and sexual intercourse between persons who are related in a degree that prohibits their marriage. Here, too, there arises the same question upon which the authorities divide, whether the substance of the prohibition is the forbidden sexual intercourse, or the mixing of genetic materials from a man and a woman who may not marry each other.

The Aloni Commission gave express consideration to a proposal that these two restrictions be incorporated in Israeli law, and rejected it. It said there:

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46. See A. Rosen-Zvi, *Israeli Family Law: The Sacred and the Secular* (Papyrus, 1990) 97, 133 (in Hebrew); B. Shershevsky, *Family Law* (2d ed., Rubin Mass, 1977) 343-358 (in Hebrew). *Mamzerut* is thus a means to punish the adulterous wife through ostracizing her child. The law of bastardy or illegitimacy serves this purpose in all legal systems. See C. Shalev, *Birth Power: The Case for Surrogacy* (Yale University Press, 1989), 29-32. I have expanded upon this matter as regards Jewish law elsewhere, e.g., in "Women Israel: Fighting Tradition", in *Women's Rights - Human Rights: International Feminist Perspectives* (Routledge, New York, 1995), 92-93.
47. The definition of "family relative" in section 1 of the Law (see n. 29 above) excludes a family relation by way of adoption. The reason that an adoptive relation is not regarded as a family relation is that, according to the *halakha*, adoption does not sever the ties of the biological family, and for this reason it does not affect the laws of prohibition and permission in marriage and divorce. See section16(2) of the Adoption of Children Law.

"The Commission also considered a proposal to determine by law that a surrogate mother may not bear a family relation of the first degree to either one of the commissioning couple, and also that she not be a married woman. Both of these requisites have Jewish *halakhic* significance. If the surrogate mother is related to either one of the couple, or if she is a married woman, there is a risk of harming the offspring due to the question of *mamzerut*. On the other hand, it was suggested that each case should be examined individually to establish the reason why the woman wishes to carry a pregnancy for another woman. It may be, for example, that a family relative or a married friend of the childless woman is willing to carry the pregnancy for her, and the choice should be left to the commissioning parents. According to this approach, the *halakhic* aspects and the risk of uncertainty as to the personal status of the child-to-be should be included in the information and counseling offered to the persons who apply to the multi-disciplinary committee, but such considerations should not be the basis for *a priori* restriction."[48]

(1)(c) The statutory requirement that the carrying mother be of the same religion as the intended mother stems from another aspect of the *halakhic* rules of affiliation,which pertain to the Jewishness of the child.[49] In general the Jewish lineage of a person is determined through the mother. But the question is: what would be the status of a child conceived from an egg of a Jewish woman, and carried and birthed by a non-Jewish woman. The answer draws from a talmudic discussion about the conversion to Judaism of a pregnant woman, the question being whether her child requires a separate conversion after its birth. The answer is that the religion of the child is determined by the religion of the mother at the moment of birth. In other words, it is the moment of birth that determines motherhood, whereas it is the moment of conception that determines a paternal relation. Interestingly enough, indeed, the child of a non-Jewish woman is not legally affiliated to its Jewish father even if the mother converted during the pregnancy.[50] It is noteworthy that these rules, too,

48. *The Aloni Commission Report*, para. 7.13.
49. This does not apply to non-Jewish persons resident in Israel. Section 2(5) of the Surrogacy Law allows the statutory approval committee to deviate from the same-religion rule "where all parties to the agreement are non-Jews", on the basis of an opinion of the clerical member of the committee, who is representative of the parties' religious community according to section 3(a)(6). The Law does not provide for the possibility of an inter-religious couple.
50. M. Korinaldi, "The Legal Status of a Child Born from Artificial Fertilization with Donor Sperm or Eggs", *Jewish Law Annual*, vol. 18-19 (1992-1994), 295, 310-315, and in particular, footnote 39.

relate to marital impediments, since a Jew and non-Jew may not marry under Jewish law.

(2) The Law determines that "the sperm used for extra-corporeal fertilization shall be of the intended father".[51] This is one of two alternative versions brought in the legislative bill. The other proposed option was that "the sperm *or the egg* used for extra-corporeal fertilization shall be of *one of the intended parents*"[52] [emphasis added - C.S.]. Indeed, the Aloni Commission had not set any restrictions as regards the genetic relation between the intended parents (or, for that matter, the carrying mother) and the embryo. The majority view was that "the method of conception ought not be significant".[53] The minority view was that surrogacy agreements may be approved only where the genetic material of both the intended parents is used. The intermediate approach of the Law is not explained in the commentary to the Bill. It might result from thinking that the use of medical technology, or the complex arrangement of a surrogacy agreement, are justified only for the purpose of genetic reproduction. But in any event there is a question, why the legislature chose the more restrictive of the two options proposed in the Bill. Why does the Law not allow the alternative that the egg be of the intended mother and the sperm of a donor?

The *halakhic* rationale of this restriction derives from the rules of affiliation to a sperm donor, even though there is no intrinsic problem with the possibility that only the intended mother be genetically related to the embryo. The rule is that paternity is established at conception whereas maternity, as already mentioned, is established at birth. However, in the case of a child born of a "chance" conception without sexual intercourse - "from emission of sperm on a sheet" - most of the *halakhic* authorities hold that it is not affiliated to the source of the sperm, except as regards marital prohibitions of incestuous relations because of the grave consequences of *mamzerut*.[54] And as there is no identifying registration of the use of donor sperm in Israel, there is a *halakhic*

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51. Section 2(4) of the Surrogacy Law.
52. Section 2(4) of the Bill (see footnote 24 above).
53. *The Aloni Commission Report*, para. 7.18. This was the conclusion reached on the question whether to prohibit the use of artificial insemination with the intended father's sperm as a means of conception, as opposed to in-vitro fertilization (see n. 20 above). Contrary to the Commission's position, the Law does not permit this option, because it prohibits any genetic relation between the carrying mother and the embryo. This means that the egg must come from another woman (either the intended mother or a donor), which makes it necessary to employ in-vitro fertilization.
54. M. Korinaldi, *op. cit.*, 300.

advantage to the use of the sperm of the intended father, since knowledge of his identity allows caution in the matter of the forbidden relations of the child.

(3) Finally, Besides concerns about *mamzerut* and Jewish lineage, there is another pertinent consideration within the *halakhic* rules of affiliation and marriage, which relates to the need for clarity in establishing the parent-child relation and certainty of genetic parenthood. This is the fear that "a brother will marry his sister", that is, the fear of sibling marriage. The concern is that if we do not know for sure who are the parents of children born of medically-assisted reproduction, we might inadvertently sanction an incestuous marriage between half-siblings who were conceived from the same sperm or egg donor, the children born of such a forbidden relation being *mamzerim*. This consideration underlies the requirements that the intended father be the genetic father of the child, since there is no identifying registration of the use of donor sperm.

The same consideration explains the Law's provision for keeping a special register to record the children born of surrogacy agreements. The matter of a special register for all children born of medically-assisted reproduction was one of the issues upon which the minority divided from the majority on the Aloni Commission. The majority considered that the benefits of such register as regards the right of the child to know its biological origins were outweighed by the risks of stigmatization from administering a registry intended to prevent marriages prohibited by Jewish law. Given the low statistical probability of marriages forbidden under the *halakha*, it concluded that to accord a right of inspection to marriage registrars might violate the fundamental right to privacy to an extent greater than necessary, and that there were less invasive ways to prevent sibling marriage. The Commitee's recommendation was to establish a medical, non-identifying register of gametee donations, to be used only for statistical or policy-making purposes, or research. The Law, however, provides for a special and separate register of births resulting from surrogacy arrangements, creating the danger of stigmatization of the children.[55]

2. The Patriarchy Between the Lines

(a) The Cry of the Infertile Woman

An innocent reading of the Law on its face, without probing the intricacies of

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55. *The Aloni Commission Report*, paras. 4.1-4.13. The concern about the possibility of half-sibling marriage is pertinent to all forms of medically-assisted reproduction involving donor gametees, and ought not justify a special register for surrogate mother arrangements. On the other hand, it is possible that the right of the child to information about the circumstances of its birth is stronger in the case of surrogacy.

the *halakhic* rationale, reveals a portrait of a social scheme that is similar to the one described by the Canadian writer, Margaret Atwood, in her book *The Handmaid's Tale*. Unmarried women (handmaids) carry pregnancies for married women (wives) of the ruling class who cannot do so themselves, and bear children related genetically to the husbands. The birthing mother has no genetic relation to the child. Her socially defined purpose is to satisfy the need of the infertile wife to provide her husband with offspring, while that need is internalized in the deep yearning of the barren woman for motherhood. The body of the birthing mother serves as an incubator for reproducing a child affiliated, by virtue of the law, to the married couple. The body of the barren wife mediates her husband's genetic continuity.[56]

I have already mentioned that the Surrogacy Bill was the result of a petition to the High Court of Justice by a number of childless women and their spouses. They were also part of a lobby in the legislative process that exerted public pressure on politicians and rabbis, who did not want to be seen as obstructing their goal of motherhood. The cry of the infertile women to be allowed to realize themselves as mothers became an overwhelming emotional impulse to elevate motherhood as an object justifying all means. If the price was to accept the dictates of a religious establishment, then so be it.

The lobby of the childless women explains two additional elements in the Surrogacy Law. One is the exception to the rule that the carrying mother may not be married,and one is the restriction that she may not be genetically related to the child. The marital status exception was a rabbinic compromise that conformed with the more lenient *halakhic* authorities, as explained above. The *halakhic* concerns as to the *mamzerut* of the offspring are remote, and it seems that the basic interest of the Jewish religious establishment is that Jewish women reproduce Jewish children.[57] The interest of the childless women to be able to enter agreements with married women too was not motivated in any way by an egalitarian ideology, but by the fear that a carrying mother might change her mind at the last moment and refuse to surrender the child at birth.

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56. In *The Handmaid's Tale* conception was attempted by means of sexual intercourse at a humiliating private ceremony in which the wife participated by embracing the handmaid. It is interesting to engage in the mental exercise of considering a statutory scheme such as the Surrogacy Law if it involved sexual reproduction.
57. S. Kahn, "Gentile Sperm and the Rabbinic Uses of Non-Jewish Bodies for Jewish Reproduction" (manuscript of paper delivered in Morocco, 1996, available from author). As opposed to this, the basic position of the Catholic Church is to broadly oppose any use of reproductive technology, considering it to be a forbidden interference in Natural Law and the divine scheme of the world.

From their point of view, a married woman was a more credible and reliable candidate, because one could assume that she had support systems that would assist her in keeping her word. Another assumption was that she would be likely to have previous birthing experience.

As for the genetic relation between the carrying mother and the child, here too the lobby of the childless women had an interest that took the form of technology and progress. I explained above that the Aloni Commission did not attach any significance to the mode of conception and did not propose any regulation of this matter, including of the genetic relations among the adult parties to the surrogacy agreement and the child. The Law, in contrast, determines that the sperm must be of the intended father. This requirement stems, it will be recalled, from *halakhic* considerations as to the certainty of paternity. But at the same time it poses the genetic continuity of the man at the center of attention.

On the other hand, the Law provides that the egg used in in-vitro fertilization may not be that of the carrying mother, forbidding a genetic relation between her and the embryo. This also means that the less intrusive medical procedure of artificial insemination may not be employed. The rationale for this rule is the fear expressed by the childless women that there is a greater probability of the carrying mother becoming emotionally attached to the child, and the consequent increase in the risk of her readiness to surrender the child after birth. I am not aware of any scientific study that supports this fear. Among the hundreds of surrogacy agreements that have been performed in the United States and England, most have employed artificial insemination as the means of conception, and there have been only a handful in which the carrying mother has changed her mind and refused to go along with the agreement.

In any event, the outcome of these two rules of genetic relation is a reproduction of the male model of parenthood (genetic) and a depreciation of what is unique to the female model of parenthood (gestation). The core genetic relation is the married man's, the genetic continuity of the married woman is secondary if it does not facilitate the husband's, and the genetic identity of the carrying mother is insignificant, aside from the requirement that she be Jewish. Having no genetic function, and agreeing to the severance of any legal relation to the child, she becomes a symbolic receptacle for nurturing the married couple's child.

It must be noted that the Law contains some provision to protect the carrying mother from abuse. First, it provides a very important rule, already mentioned, that the agreement to carry a pregnancy for the intended parents does not derogate from her autonomy as regards medical treatment, including

termination of the pregnancy, which may be performed legally in cases of extramarital pregnancy.[58] Second, the statutory approval committee must be satisfied that the agreement is not detrimental to the rights of any one of the parties.[59] However, the forced neutrality of this rule conceals the fact that the parties are clearly not in equal bargaining positions. The intended parents are a priori much stronger. They enjoy a higher social status as married partners, cultural support for their interest in having a child, and probably also an economic advantage over the carrying mother. In addition, their legal position under the Law is far more solid and predictable, since they are presumed to be the legal parents.

(b) The Value of the Carrying Mother

Furthermore, the Law reinforces the ideological structures of patriarchy in its regulation of the matter of payment to the carrying mother. One of the foundations of patriarchy is that women's reproductive labor has no economic value and that the work of motherhood is done for free. The Law appears to digress from this convention, because it does make allowance for payment to the carrying mother. But a closer look at the details of the statute show that this is not entirely true. The Law does not use the language of payment for the "work" of the carrying mother, or her "personal services". Instead it chose to use the terminology of "covering actual expenses" and "compensating for loss of time, suffering, loss of income or temporary loss of earning capacity".[60] Moreover, the amount of payment is subject to the approval of the statutory approval committee and is not a matter of freedom of contract as in personal services and labor contracts. And if the carrying mother receives payment beyond the approved sum she is liable to criminal prosecution for an offence carrying a maximum penalty of one year imprisonment and defined as follows:

> "Any party to a surrogacy agreement or any person on their behalf who offers, gives, requests or receives consideration in money or kind in connection with performance of a surrogacy agreement without approval of the Approval Committee, is liable to one year imprisonment."[61]

The criminal provision assumes once again a seemingly neutral position of addressing "any party to the agreement", but the inclusion of the carrying mother is noteworthy. The law in England, for example, prohibits all

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58. Section 18 of the Surrogacy Law (see n. 41 above).
59. Section 5(a)(3)(see n. 36 above).
60. Section 6, see text to footnote 32 above.
61. Section 19(b).

"commercial" activity in connection with surrogacy, but expressly exempts the carrying mother from the criminal norm.[62] Note that the Aloni Commission had recommended aiming the criminal prohibition against payment to intermediaries, for fear of exploitation. But the Surrogacy Bill, in contrast, did not restrict in any way the for-profit activity of third parties, such as commercial go-betweens. The apparent explanation for this was that Basic Law: Freedom of Occupation was taken to prevent (constitutionally) such statutory intervention in the business of brokers, whereas the activity of the carrying mother was not perceived to come within the scope of the protection afforded by the Basic Law.

The final version of the Law rejects this approach, and extends the criminal prohibition also to persons acting "on behalf" of the parties to the agreement. Nontheless, there is an underlying view that the carrying mother's activity is not work, or occupational. One would not want women to become professional bearers of children, since they might be exploited. Yet this protective paternalism becomes twisted into the criminalization of unapproved payment to the carrying mother. Moreover, a proposal to guarantee a fair wage to the carrying mother floundered against the objection that this would increase the costs of all the ancillary services that go into the making of a surrogacy agreement in a geometrically exponent chain reaction.

Criminalization of the act of the carrying mother accepting additional payment leads the discussion to a new context - sex work and prostitution. If one regards the criminal law of prostitution as the legal regulation of women's sex work, then it appears that there is no prohibition against the giving of sexual services as such. Indeed, the patriarchal law of marriage provided that the husband had a proprietary right to the sexual services of his wife, and for free. But the essence of prostitution is the criminalization of payment for extramarital sex.

How do we explain that a normative marital activity becomes criminal when performed as an economic market transaction? The simplistic answer is: patriarchy, that is, the ideological regime of the rule of man over woman, through social, cultural, political, legal and economic structures, that is based among other things on the differentiation of good and bad women (wives and prostitutes) known as the madonna-whore dichotomy. Sexual prostitution

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62. The Surrogacy Arrangement Act, 1985, sections 2(2)(a) and 2(3). Similarly, the English act that regulated abortion before the 1967 statutory reform exempted the pregnant women from the criminal prohibition. Israeli law inherited this humanitarian approach in its own abortion laws, as is still evident in section 320 of the Penal Law, 1977.

exists by virtue of a double standard that allows men polygamy and confines women to codes of modesty, while separating decent women from sluts. It has been a subject of controversy for centuries, even though the normative parameters of the debate vary from time to time. Once the prostitute is a messenger from the devil, once she is an emotional deviant, and once she is a danger to the public health. But what has been constant throughout history is that it was always the woman who did the sex work that suffered. It appears, ultimately, that the prostitute is punished for doing for money what the good woman does out of love.[63]

One may ask, is the sex worker a victim or an entrepreneur? Is she exploited or is she a free agent of her sexuality? But what is quite evident is that the most common reason for prostitution today is economic need and the lack of employment opportunities for women. It is also clear that criminalization excludes prostitutes from protection of the law and exposes them to the unscrupulous exploitation of international crime and trafficking networks. In most cases prostitution is the principal source of livelihood for women living in poverty, and in many places it is the only occupation in which a woman can make more money than a man. Sex work, sometimes presented deceptively as entertainment so as to lure women, has become one of the predictable occupations of women workers migrating from rural areas to cities, and from poor to wealthy countries. Where women have been socialized to believe that their main asset is their body, the choice of sex work is an understandable conclusion. At times it is a matter of survival and providing for a family. At others it is a rational choice of an occupation that has the advantage of independence and flexible work hours.

Yet we relate to sex work differently than we do to other forms of labor and employment, because it is performed in a cultural context in which the man uses the power of money to buy sexual control of a woman's body. The sex worker might appear at first glance to be challenging the role defined for her by patriarchy. She might be an autonomous agent of her sexuality - rational, active and detached. She may be seen as proof that women can make an economic gain from patriarchy. But she might be unable, ultimately, to undermine the patriarchal regime and overcome its deeply seated habits. She might become rather an accomplice in an industry that perpetuates its fundamental double

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63. A. Jolin, "On the Backs of Working Prostitutes: Feminist Theory and Prostitution Policy", 40 *Crime and Delinquency* (1994) 69; B. Cheney, "Prostitution - A Feminist Jurisprudential Perspective", 18 *V.U.W.L.R.* (1988) 239, 244.

standard of male potency and female modesty, embodied in Jewish discourse as *yetzer hara* (the evil urge) and *tzniut* (modesty).[64]

Any attempt to represent prostitution according to a liberal contractual model of personal autonomy and liberty to negotiate and enter transactions in a free market,[65] without addressing the parameters of patriarchy and the gender structure of sexuality, is bound to be lacking. At the very least, even if prostitution were not criminal in one way or another, the general taboo on sex (which is related to the value of female modesty) would surely have some effect on costs of transaction in the market place in its obstruction of the free flow of information. It appears, too, that a socialist or neo-marxist model - aimed at empowering the sex worker to improve her work environment, pay and social security, to participate in decision making and organize in labor unions, and the like[66] - would likewise be inadequate if it did not also address the root value symbols of patriarchy as regards sexual relations. The sale of sexual services is different from the sale of personal services, including bodily labor. A construction worker sells his labor force (manpower) and the employer has the prerogative to instruct him to which use he shall put his bodily functions. But the sex worker, in contrast, sells the use of her very body while the client buys the right to be her master for a limited time. In this sense she is more like a slave. He pays her to surrender to him the control of her body in order to gratify his needs and passions.

The reason it is so difficult to prove the rape of a prostitute is the same as the explanation of the legal impossibility of marital rape, and both have survived in many countries to this very day. The status of marriage implied that the wife had agreed to submit her sexual, reproductive and domestic services to the power of the husband, to whom she owed a duty of obedience. Indeed she was considered to be the property of her husband, having almost no independent legal personality. In exchange she received protection and social status. The contract with the prostitute is more limited in its scope, covering only sexual services and for a short time. The woman gets paid in return, but the hierarchy of master and subject remains the same.

We enter transactions to serve our physical needs and passions in other domestic contexts, such as laundry and food. But there is a difference here too.

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64. Cf. L. Shrage, "Should Feminists Oppose Prostitution?", 99 *Ethics* (1989) 347.
65. See, for example, L.O. Ericsson, "Charges Against Prostitution: An Attempt at a Philosophical Assessment", 90 *Ethics* (1980) 335.
66. See, for example, H. Tinsman, "Behind the Sexual Division of Labor, Connecting Sex to Capitalist Production", 17 *Yale J. Int. L.* (1992) 241.

"The difference between sex without love and prostitution is not the difference between cooking at home and buying food in restaurants; the difference is that between the reciprocal expression of desire and unilateral subjection to sexual acts with the consolation of payment: it is the difference for women between freedom and subjection."[67]

The sexual subjection of women in patriarchy is paralleled by their reproductive subjection, although the forms differ. Whereas sex work is likely to perpetuate the double standard of male and female sexual conduct, the reproductive work of the carrying mother under the conditions of the new Surrogacy Law might reinforce the good mother component of the madonna-whore dichotomy. The intended mother realizes the natural instinct of motherhood (much as the male client realizes the sex urge). And no matter how tolerant we have become of "single-parent" women, nor how supportive the religious establishment may be of Jewish reproduction, there is still a normative preference for children to be born into rather than outside a marriage. In the event of a confrontation between the good woman (the wife and intended mother) and the bad (the carrying mother), the outcome is predictable. The Law determines the power structure clearly.

The Sanctity of Motherhood

I have attempted to uncover the intricate connection of orthodox Jewish doctrine (*halakha*) and the patriarchal subjection of women between the lines of the new Surrogacy Law,[68] and to show the role that the childless married woman plays in this respect. I have suggested that the plight of female barrenness has stirred deep emotions and resulted in the elevation of motherhood as an end that justifies all means. Indeed, the secular culture of women in Israel is that they will pursue all avenues to have a genetic child, which explains the high consumption of reproductive technology. And this drive finds support in legal doctrine.

A similar sentiment in favor of the value of motherhood came to dominate the deliberations of the Supreme Court on a related matter, the *Nahmani* case.[69] There, the Court sat in an enlarged bench of eleven justices for the further

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67. C. Pateman, "Defending Prostitution: Charges Against Ericsson", 93 *Ethics* (1983) 561, 563.
68. For a general overview of this connection and its impact on women's legal status in both the public and private spheres in Israel, see F. Raday, "Religion, Multiculturalism and Equality: The Israel Case", 25 *Israel Yearbook on Human Rights* (1996) 193, 226-235.
69. FH 2401/95 *Nahmani* v. *Nahmani* 50(iv) *P.D.* 661.

hearing of a five-judge appellate bench of the same Court, which had reversed a district court decision to find for the wife in a dispute between an estranged couple as to the use of frozen embryos, that were fertilized initially with the intention of entering an agreement with a surrogate mother. After the couple separated, the wife asked the hospital to give her the frozen fertilized eggs and it refused to do so because the husband objected. The appeal bench had decided, by a majority of four to one, that to continue without the ongoing consent of the partner would be a violation of his fundamental right to reproductive autonomy, and that the woman's interest in motherhood could not justify forcing fatherhood on the man against his will. But at the further hearing, a majority of seven to four, found that the woman's "right" to motherhood was stronger than the man's right to not be a father.

The overwhelming emotional weight given to the value of motherhood in this case is not typical of Israeli jurisprudence. Generally, constitutional theory propounds the view that it is always necessary to balance conflicting interests, and emphasises strongly that no value is absolute. It seems, however, that motherhood comes up trump in all cases, so long as it conforms with Jewish law. This would explain another recent Supreme Court decision invalidating administrative rules and provisions in the Public Health Regulations that subjected unmarried women seeking artificial insemination or in-vitro fertilization to special screening procedures. The Court ordered the Minister of Health to publish a directive that would guarantee that the procedures are performed "in an equal manner".[70] The case of the unmarried women is instructive. Here it appears that women are actually exercising reproductive autonomy, choosing to be single mothers outside marriage, and appropriating the medical technology to serve their own self-defined interests.

This brings us back to the discussion of women as victims or as autonomous agents, as well as to the question of women's complicity in patriarchy. The first matter calls for a comparison with the carrying mother, while the second calls for a comparison with the childless married woman in the surrogacy situation. It should be noted that the novelty of unmarried women having equal rights to those of married women as regards access to publicly funded infertility therapy, is made possible because it feeds into the general culture of compassion for women who are not mothers and does not raise any *halakhic* problems. But whereas the carrying mother is subject to various restrictions, the unmarried

70. HC 998,2078,2444/96 *Weitz et al.* v. *Minister of Health* (unpublished decision of February 2, 1997).

woman gains liberty. And whereas the intended mother is replaying roles dictated to her under patriarchy, the unmarried woman is inventing a new social reality of autonomous motherhood.

Epilogue

Strasberg-Cohen J., writing the majority opinion for the appellate Nahmani bench said: "Not everything that is possible in the technological sense is also desirable from a normative perspective." This, I believe, is pertinent to the Surrogacy Law. Clearly certain limitations are required, and various value systems must be balanced. But it seems that the price paid for this in the case of the Surrogacy Law is a system that structurally violates the human dignity of the carrying mother, in that it creates a scheme of reproductive relations in which unmarried women have children for married women within a system of rules that leaves them little reproductive choice. They may not be related to the intended parents. They must receive an egg donation. The sperm must be the husband's. They cannot choose between artificial insemination or in-vitro fertilization, but must undergo the more invasive of the two. Cynically enough, the only reproductive option they retain is abortion. Moreover, the entire procedure is veiled in a criminal norm of non-disclosure (except by permission of a court) carrying a penalty of one year imprisonment, which applies to all persons, including the carrying mothers.[71] And once the children are born they fade into the background as secrets in a register that might become an impediment to the children's marriage.

I argued at length in the past that the role of the carrying mother in the surrogacy arrangement had the potential to shatter patriarchal patterns that subjected women to the control of men and restricted their possibilities of human realization. I thought that under certain conditions it might transform our consciousness of the social and cultural meanings of reproductive relations. This is what I wrote at the time:[72]

> "I was alerted to the complex issue of surrogate mother arrangements because of the overwhelming opposition that I found in the literature to their legality and morality. In exploring the matter I discovered that the activity poses a radical challenge to fundamental notions in patriarchal ideology, amid a rapidly developing technology that appears to perpetuate those very notions. The surrogate mother conceives intentionally; she bears a child outside the bounds of marriage; she refutes openly the nexus of biological

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71. Section 19(c) of the Surrogacy Law.
72. C. Shalev, *Birth Power*, *op. cit.* (footnote 46), 165-166.

and social motherhood; and she claims a right to participate in the market economy in this regard. She implies that we women, as human beings, are capable of exercising reason with respect to reproduction and of sharing our birth power with those less fortunate than we."

I was aware that the women who actually acted as surrogate mothers were not activists of a radical political movement, and that their consciousness as to the meaning of their action would not necessarily be different from that of the other characters in the role play of the surrogacy arrangement and the public debate on the matter. At the same time I thought that there existed a potential to transform the patriarchal culture of reproduction, and to transcend it to a new human consciousness founded on values of dignity, autonomy and responsibility.

Since then much has been written on the subject, including a keen feminist critique[73] which contributed much to our understanding of the complexities of reproductive relations. In this sense, there has been an evolution in reproductive consciousness. Yet it appears that the continuing impact of patriarchy on the structure of our reproductive relations is stronger.

I believe that the thesis I presented is still theoretically valid. But in the course of the years I have had occasion to test the theory against the reality of human reproductive relations. It seems, unfortunately, that nice thoughts are not enough to overcome the cumulative force of power structures and emotional habits deeply imbedded in the culture, the society and the individual. Even if we call surrogates by respectable names and speak about them in nice words of agreements between a carrying mother and intended parents, the new Law does not herald any revolution or even innovation in our attitude to reproduction, motherhood and women. On the contrary - it merely perpetuates values of a dominant patriarchal culture that does not treat women well. The Law glorifies motherhood and at the same time humiliates it. At the most it is an inventive post-modern interpretation of a fundamentalist tenet - the double standard.

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73. See, for example, P. Chesler, *Sacred Bond - The Legacy of Baby M* (New York, 1988); C. Pateman, *The Sexual Contract* (Stanford, 1988); and the articles in the chapter on "Contract Pregnancy" in *Feminist Perspectives in Medical Ethics* (eds. Holmes and Purdy, Indiana, 1992).

EARLY CHILDHOOD: A PSYCHOLOGICAL PERSPECTIVE ON ISRAELI POLICY

by Charles W. Greenbaum*

Introduction

Policy regarding early childhood covers a wide range of areas, including health, welfare and family issues as well as education. These areas overlap in their impact on the growing child, a phenomenon which creates difficulty for the conceptualization of early childhood education as a specific target of policy. While the need for a national education policy may be easily accepted and understood for schoolchildren, the case for education of preschool children often runs into difficulties. Preschool children are defined here as children in the age range from 0 to 6 who do not attend school frameworks. Some people object to public policy which may affect the socialization of preschool children on ethical grounds, since education for these children is conceived as taking place under the authority of the home, and thus beyond the scope of public policy. Implementation of any educational policy is inherently difficult because children at these ages do not belong to any single framework such as school.

We will argue that national policy regarding early childhood in Israel is of critical importance, and that the lack of such a policy constitutes a serious problem. We will describe the principles derived from developmental psychology relevant to such policy, indicate the problems facing the area of early childhood at this point in Israel's history, and review the basic elements of such a policy. We will also describe the central issues involved in budgeting and implementation.

The Importance of a National Early Childhood Policy

Since most children live in families, early childhood policy is inextricably linked with family policy, although the two are not identical. There is a long-standing argument over whether any country should have a family or child care policy. There have been many many attempts by different countries to formulate such

* Department of Psychology, The Hebrew University of Jerusalem, Jerusalem, Israel.

policies, and Kamerman and Kahn, (1981), have used the study of this experience as a base for formulating new policy. Others have concluded that the attempt to formulate national family policy is a futile exercise.

Steiner (1981), has given several strong arguments against attempts to formulate such a policy. He states that it is difficult to define goals for such a policy, since some of the goals conflict with one another. For example, in a society with limited resources comprehensive policy for all children competes with allocation of large amounts of money for children with special needs. In addition, there are ideological conflicts such as the rights of the unborn fetus against the rights of the mother. Steiner (1981), points out that there is a lack of well conceptualized and valid models of intervention with different populations. As a result, it is often difficult to know which policy (for example grant allocations for families as opposed to day care) is more beneficial for the development of children and the functioning of families. Even if policy is formulated, as it might be in child day care or in child support allocations, there are difficulties in carrying it out because of technical problems, for example, the lack of buildings and infrastructure in which to house day-care centers. Finally, the intended effects of policy may not always work out; for example, the use of child care allowances to encourage mothers to stay at home to take care of their children has had mixed success.

However, Steiner's justified claims and findings against the formulation of child care and family policy may also be used to argue that a national early childhood policy is not only possible but necessary. Many of the problems indicated by Steiner afflict all policy efforts, including health care, education and overall fiscal policy. The difficulties which Steiner correctly points out could be seen as challenges and not necessarily as stumbling blocks. Thus the possible conflict between allocations for special needs of children and overall comprehensive policy may be solved, but this demands discussion among various organizations and interest groups, coordination and the means to carry out decisions. However, the capabilities for rational discussion, planning and coordination are often in short supply in society.

We suggest that a psychological perspective is critical for establishing early childhood policy for a number of reasons: assumptions concerning the psychological development of the child are at the base of all educational policy, and it is necessary to make these assumptions explicit; experiences in early childhood are extremely important for later cognitive and emotional development; and finally, there have been significant strides in psychological research on early childhood in recent years, and this knowledge should be applied to policy formulations.

The definition of policy we use here will be based on that of Gallagher (1990) which states that policy constitutes "the rules and standards by which societal resources are allocates". In order to formulate such rules and standards, we must briefly review relevant knowledge concerning the development of the child as well as the nature of the child's interaction with his social environment.

Basic Psychological Principles Concerning Early Childhood

We suggest the following basic principles concerning early childhood to which most developmental psychologists would agree. Although these principles have been formulated in various ways they appear in most source books and texts written on developmental psychology, and they have provided the basis for previous attempts to formulate child care policy (Stevenson and Siegel, 1984). Much of the thinking behind these principles is consistent with views which emphasize the importance of environment on development as formulated by Bronfenbrenner (1986). We suggest that the central role of the parents and the family in this environment must be taken into account in all policy-making attempts (see Lamb and Sagi, 1985). Finally the principles are consistent with the newly-formulated UN Convention on the Rights of the Child (1990).

These principles are:

- Early childhood experience has a strong importance for the cognitive, social and emotional development of the child throughout the lifespan.
- Neglect of the child in the early years may ultimately lead to developmental difficulties demanding the allocation of resources to repair the damage which are greater than the initial cost of the implementation of preventive early childhood policy.
- Early childhood has importance in its own right: children like adults have the right to age-appropriate experiences.
- The physical and social environment has a powerful influence on all areas of the growth and development of the child.
- The environment of the child consists of sets of overlapping subsystems such as family, learning environment, health care facility, playground and others which demand societal resources.
- The family is the fundamental environmental unit which has critical influence on the development of the child. Lack of a family or dysfunctional family impairs child development and yields extra costs to society for treatment and rehabilitation.
- Supplementary programs for child development (day-care, preschool, or intervention programs such as home visitors) have shown small but consistently

positive effects on the child's cognitive ability, and in certain instances on the child's social-emotional development.

- Early beginnings in programs for child development are likely to be the most effective especially if they are consistently carried out in accordance with the needs of the child and his family.

- Universal declarations of the rights of the child demand equality in the distribution of basic resources for child development to children, regardless of sex, social class, ethnic origin or religion, as well as special allocation of resources to the children with the greatest needs.

Problems Concerning Early Childhood in Israel

Two basic child development problems related to the environment exist in Israel and in many other societies. One may be termed the *preparedness gap:* children whose parents come from lower socioeconomic classes enter the school system with lower-level cognitive abilities than do children from higher socio-economic levels (see Lieblich, Ninio and Kugelmass, 1972; Habib, 1974; and many other studies reviewed in Greenbaum and Kugelmass, 1980).

Less well-known but no less serious is a problem which may be termed the *psychological disability bind.* This refers to the conflict surrounding the education of children with physical or psychological disabilities. We employ this term because the child who has social-emotional or learning disability problems is in a bind (or trap). The child who has a difficulty, he/she must continue to function in a school setting, which may not be equipped to deal with the child's problem, and may even cause him/her suffering. Special education frameworks sometimes work to maintain, not solve, the problem. Gallagher (1990) provides a brief review of some of the issues and problems involved in implementing mainstreaming children in the regular school system on the basis of the American experience with Public Law 94, which mandates mainstreaming children with disabilities in the school system. However, relatively little is known about mainstreaming in preschools. We suggest that mainstreaming the preschool child must be accompanied by supplementary instruction and emotional support outside the classroom,.

A recent pair of surveys carried out by Bendel, Palti, Winter and Ornoy (1987; 1989) demonstrated the extent of the problem of psychological disability in the schools. One survey (Bendel et al., 1987) dealt with prevalence of disabilities among 2-3 year old children, while the second (Bendel et al., 1989) described the prevalence among 7-year olds. The surveys adopted an internationally accepted set of definitions of disabilities formulated by the World Health Organization. These included diseases of the nervous system and

sense organs; other medical conditions interfering with normal developmental functioning; mental retardation, and psychological disorders including behavioral, neurotic, personality and psychotic disorders.

While the prevalence of disabilities among 2-3 year olds was relatively low, the prevalence at age 7 reached very high levels. Out of a total of 7,739 Jewish children surveyed, 17.5% of those in the regular education system had at least one disabling condition. When the children in special education are included in the sample, 27% of the total sample was found with at least one disabling condition.

The largest single category of disability for the seven year-olds was that of the psychological disorders, including behavioral and conduct problems, learning disabilities, and speech and language disorders. Taken together, this category accounted for a prevalence rate of 27.5%, in comparison with a prevalence rate of 2.6% at the age of 2-3. Even though we must be cautious in interpreting this result, since it is not based on followups of the same children, the surveys suggest a tenfold increase in the detected prevalence of psychological disorder between the ages of three to seven. At the latter age more than one quarter of the schoolchildren of Israel have been identified with some disorder, and more than half the diagnoses are psychological in origin. There is also a correlation between the preparedness gap and the psychological disability bind: lower class children show more psychological disorders than middle-class children.

These data, which are not very different from those found in studies conducted abroad (see Stevenson and Siegel, 1984), are subject to a number of interpretations. The large jump in prevalence of disorder from ages 3 to 7 may lead to the conclusion that the disabilities did not exist before the child entered school, and that factors in the school setting caused the disorder. One such factor may be labeling by professionals of deviant or disturbing behavior by children as disorders. These professionals could include teachers, school psychologists, counselors and social workers. The assumption in this line of reasoning would be that teachers and school professional personnel may have a motive in labeling children as disordered or disabled, in order to remove them to special education.

An alternative explanation for the role of the school in the high prevalence of disabilities states that the children's problems are not an artifact of definition but are real problems caused by the school setting, or by an interaction between the school setting and characteristics of the child. School demands and pressures may lead to conflict, anxiety, fear of failure or other psychological reactions associated with cognitive or emotional difficulties.

Some of the phenomena described here could be due to the effects of the two factors we have mentioned, labeling and school demands. However, we suggest that a large part of the prevalence of psychological disabilities is due to inadequate diagnosis and treatment of disorders during the preschool years, and inadequate preparation for later educational demands before entering the school setting. The reason for this conclusion is that there is an increase in prevalence for many of the disorders described in the survey which are not related directly to school, and whose origins exist in early childhood or even in pregnancy. The increase in prevalence of nervous system disorders and mental retardation are indicative of such disorders which are not detected until age 7. For example, mental retardation almost doubled from ages 3 to 7 (from 1.4% to 2.6%); it is difficult to argue that schools increase mental retardation. If problems of diagnosis at early stages exist for retardation and nervous system disorders, it is probably true that there are problems in the early diagnosis of behavior disorders, which are more difficult to detect. We suggest that the increase of these types of disorder point to problems in society's system of diagnosis, prevention and treatment at the preschool stage for developmental disorders generally, and for school related problems in particular.

The high degree of prevalence of psychological problems in young children in schools demands an examination of the preschool preparation the child receives. We suggest that there may be three problems in this preparation, in prevention, screening and intervention. Prevention may be inadequate through faulty provision of medical, social and educational services; there may be inadequate screening at the early ages for developmental problems, and the inadequate intervention for the problems which are detected may be too little and too late. These hypotheses demand an examination of the system of preschool care and education in Israel.

Pre-school Care and Education in Israel

The care of children under the age of six in Israel may be divided into two basic stages according to age: 0-3 and 3-6. The services provided for children at these ages has been described in detail by Jaffe (1982). Daycare policy and quality of care, particularly in the area of family day care, have been described by Rosenthal (1990). During the first stage children receive preventive health care from Family Health Care Stations ("Tippot Halav"), mainly during the first year of life. Israel enjoys an advantage in early screening and diagnosis because of the existence of effective Mother-Child Well-Baby Clinics in each town and neighborhood in the State. Yet, as we have seen, problems in early diagnosis and screening still exist.

Due to pressures from working mothers, a growing number of children are in day-care facilities which care for the children from the morning to late afternoon. Daycare facilities are financially supported and run by women's organizations or by community centers ("Matnassim") with supplementation from welfare bureaus for children in lower-class areas. Most children in day-care attend the facilities run by the women's organizations, but many families have turned to family day care ("Mishpachton"), which individual mothers run in their own homes or in an apartment used specifically for that purpose. Family day care is frequently less expensive and often closer to the child's home. However, it is more difficult to control selection and supervision of the caretakers.

From the ages of three to five most children (over 90%; see Rosenthal, 1990) are in kindergarten facilities which run half a day. Some of these children also attend day-care facilities in the afternoon. At the age of five all children are required by law to attend compulsory kindergartens. Kindergarten facilities are staffed by the Local Authorities and Municipalities and supervised by the Ministry of Education.

The quality of preschool facilities is difficult to evaluate and from what little is known, there are questions regarding standards of care (Rosenthal, 1990). The preparedness gap and the psychological disability bind may thus be traced to two factors which are particularly acute among the lower classes. One factor is the lack of home preparation for the demands of schooling. Lower-class families, in comparison to those of the middle-class, may provide less encouragement and stimulation for learning and less opportunity for the development of skills through guided play (Smilansky, Shephatia and Frenkel, 1976). A second factor is the inadequate nature of the day-care facilities, which because of poor staff/child ratios, inadequate training of the caretakers and lack of equipment, do not offer rich learning opportunities to the developing child.

While these adverse factors in family day-care may exist in Israel, Rosenthal's (1990) research shows that there is a correlation between quality of day-care and constructive social interaction of the child. Rosenthal (1991) identifies some of the organizational factors in supervision which are related to positive behaviors of caretakers. These studies suggest that the family day-care setting may positively influence the interaction of the children in care, and that it is possible to create positive family day-care settings. It should be noted that the cost of day-care (particularly center-based day-care) is prohibitive even when supplemented by government grants, creating a situation in which is is

extremely difficult for people of the lower classes to take advantage of it without aid from the state or other sources.

As a result of this situation there is a large number of children who come unprepared for school and/or have psychological or learning problems which are not detected until they are in school. Even then these problems are inadequately treated. The cost to society in treatment, even when it does take place, is enormous (Kamerman and Kahn, 1981).

The cost is even greater in terms of large numbers of children who are stigmatized because of inability to function in school; children who will not gain the skills necessary to compete on the labor market; and worst, children who in their adolescent years may turn to crime. We suggest that a great many of such problems could be eliminated if present technology and knowledge of child development were to be applied. Current policy shows little sign of dealing with these issues. In Kop, Blankett and Sharon's (1989) recent report, allocations for early childhood education have dropped more in recent years than any other component of the educational system (see Table 7 in that paper). It remains to be seen whether this trend continues during future years of immigration (*aliya*). If it does, the consequences can only be more serious than heretofore.

Special Problems for Educational Policy: A Family Perspective

Much current thinking on the prevention and treatment of developmental disability deals with families at risk of the adverse effects of stress or environmental conditions. The emphasis is on family issues since so much of the education and socialization of the preschool child occurs in the family, and the Israeli experience strongly suggests that family intervention can be effective in reducing individual psychopathology (Elizur, 1989).

In this section we briefly review issues related to five classes of families in which children provide disproportionate degrees of problems for any educational system The considerations are based on Bendel et al.'s surveys which showed that low-income families and families who showed problems in functioning were overly represented among children showing psychological disabilities, and previous studies which identified populations whose children are over-represented in the lower ranges of scores on standardized tests. We also suggest an additional category of family whose children may provide problems for the school system - the families of children with developmental disabilities. The following are population groups of children in Israel who may be considered to be at high risk for problems in the school system.

1. Children from Low Income Families

Israel has a well-established system for providing children's allowances and income supplements through the National Insurance Institute (see Neipris, 1981; Jaffe, 1983). Both Jaffe and Neipris report problems with distribution of these funds, however. Not all Israeli citizens share in all the benefits, as indicated earlier, and there have been recent cuts in the children's allowances, which are no longer awarded for first or second children. The result is an additional downturn in the amount of national investment in children.

2. Children from Immigrant Families

The current immigration (*aliya*) from Ethiopia and the Soviet Union shows again what Israel has learned in the past but failed to apply: that the difference (or lack of fit) between the culture of the immigrant (*oleh*) and the host cultures in Israel impede absorption of the immigrant and thus create the conditions for failure in the educational system. Much of the educational gap in the populations of Israel may be attributed to this lack of fit between the cultures of arranging and providing support for adoption. Institutional care at best is problematic in quality (Kohen-Raz, 1968; Greenbaum and Landau, 1979) and foster care in Israel as elsewhere is problematic (Jaffe, 1983).

Children from dysfunctional families thus provide a disproportionate number of the children who have developmental disabilities who place a burden on the educational system at all levels. The chances for their academic success is low. Educational policy for early childhood should therefore be directed to the strengthening of families in order to better care for their children. The benefits to the children as well as to the educational system are obvious.

3. Children with Developmental Disabilities

Children with developmental disabilities are usually best off growing up in their families particularly when the family can provide a stimulating environment and emotional support (Werner and Smith, 1982). Strengthening families with children who have disabilities both benefits the child and is cost-effective. The greatest need of such families if for social support and information concerning the proper care of the child according to the most appropriate and effective methods. Here early detection and treatment of the child as well as support of the family are crucial for the development of the child.

Guidelines for Child Development Policy

Given the number of factors involved in child development and the various frameworks in which children are found, child development policy would best be served by a package containing a number of measures. The following guidelines, basic to the more specific proposals to be described later, are derived from the knowledge and ethical principles of child development we described earlier.

Family income is a basic element in the education of children. It is widely recognized that family income is correlated with cognitive development and school achievement. Therefore, children's families must continue to be supported through income supplements, and in particular through the use of children's allowances.

Social, medical and educational services must be delivered to all children in the jurisdiction of the country without regard to social class, national origin, or whether or not members of the family participated in military service. All of the foregoing criteria are professionally irrelevant when used as the basis for support of families and children.

Policy must be designed to strengthen family and extrahome environments which promote children's cognitive and emotional development.

Socially disadvantaged groups which are at risk of not being able to provide their children with adequate environments should be given special support, to be outlined below, in the form of day-care facilities and intervention programs.

Policy in early childhood must be coherent and coordinated even though administered by different government offices.

While seemingly obvious, this principle is especially important in child care since children are affected by various measures taken in different governmental components.

Prevention and intervention programs which prepare the child's parents for effective child socialization and programs which begin early in the child's life are to be preferred to programs which begin later. Early intervention programs should be coordinated with later school-oriented intervention programs.

Programs which do not require large set-up costs for building and infrastructure are to be preferred to those that do require such costs.

Specific Proposals for Child Development Policy

1. Courses in parenting and child development should be introduced in all high schools.

These courses could be supplemented by practical training in child care in local day care facilities and community centers.

2. Decentralization and broadening preventive health services: Services provided in health care facilities including Well-Baby Clinics and Child Development Centers should expand their facilities to provide diagnostic, outreach and intervention programs to families of children at risk for developmental delay and psychological disability.

Such health facilities should a) decentralize their activities to provide services in the neighborhoods of the large cities and in small settlements for clients who find it difficult to reach the larger centers; and b) provide services at flexible hours including the afternoon hours for working mothers several afternoons a week.

3. Mainstreaming: Children with developmental disabilities should be mainstreamed at the preschool level in facilities with normal children whenever possible, while supplementary aid should be provided to the children and the families as needed.

Experience with mainstreaming at early ages in the United States has demonstrated the effectiveness of mainstreaming at this age in providing a challenging environment for the child with developmental disabilities as well as orienting the normal child to the differences in children's development (Bronfenbrenner, 1986). Special training and support should be provided to teachers and parents by Child Development Centers.

4. Widening availability of family day-care for children aged 0-4: the option of family day-care should be expanded on an experimental basis in a large area of the country.

The relative costs and comparative quality of family as opposed to center-based day care have been a subject of controversy for some time (Kamerman and Kahn, 1981; Rosenthal, 1990). An advantage of family day-care is that it needs very little investment in the setting up of building and infrastructure. The experimental program of family day-care should include the screening, preparation and supervision of caretakers. If family day-care proves to be of equal quality in comparison to center-based day-care, family day-care should be adopted and expanded on a nation-wide basis, as a supplement to center-based day-care.

5. Making kindergartens (for 4 and 5 year olds) places to learn and play in coordination with schools, on school grounds or in geographical proximity tc schools.

a) Kindergartens in new locales should be built in or near schools; b) The curricula of kindergartens should be made more consonant with those of the early primary grades. In addition to the possible saving on building costs the first measure (building kindergartens in or near schools) has a number of.

advantages: reducing the isolation of the kindergarten teacher; better communication between kindergarten and primary school teachers; use of learning facilities of the school; influence on the school by exposing it to the more flexible learning approach of the preschool; allowing for a more flexible transition from kindergarten to first grade, so that first grade could be an extension of the kindergarten; and easing the transition to first grade for the children,. There is no evidence to our knowledge concerning the harmful effects of kindergartens in or near school facilities.

6. The use of computers in kindergartens should be encouraged for learning while not losing the experiential aspects of play.

This measure has great potential for allowing children to learn through play which gives effective feedback to the child. Such measures could be particularly effective for children with learning disabilities.

7. Early intensive material and psychological support should be provided to families which show signs of being at risk.

Carrying out this recommendation should result in fewer children being removed from their homes. In the event that the child is removed, greater use should be made of foster care and group home care over residential care. For children removed from the home adoption, proceedings should be speeded up so that these children will have a proper environment.

8. The criteria for obtaining income allowances from the National Insurance Institute, which till now have included military service requirements by adults in the family, should be eliminated.

All benefits for children given to Israeli citizens must be extended to children in the Territories, regardless of national origin, and to children of Israeli citizens and residents who have not participated in military service, such as the Haredi population.

9. The system of child allowances (see Jaffe, 1983) and income supplementation allowances for low income families administered by the National Insurance Institute should be continues and expanded.

These are important forms of support for proper environments for children. We suggest that the support provided by such allowances is critical for the adequate development of children in low-income families.

10. Research and monitoring: The above proposals should be tried on an experimental basis under relatively controlled conditions.

The effects of each proposal could be evaluated and the results used to monitor the total system of early childhood policy. Such research would provide information critical for decisions concerning further revisions or expansions of such policy.

Budget and Financing

Financing for the above proposals would come from a number of sources. Some of the programs should actually save money, for example, the family day-care and the inclusion of kindergartens within school facilities. Absorbing kindergartens in or near schools will save building costs considerably in new towns and neighborhoods.

One source of financing is a combination of the private and public sectors which would finance the intervention programs and their evaluation. A second source is the reallocation and shifting of funds in the facilities themselves. Some programs could be absorbed in present budgets of health, welfare and educational institutions by more efficient use of facilities. A third important source is the more effective use of volunteer manpower, including soldier girls, girls in National Service, high school students and pensioners. All of these sources are far from being fully tapped. The fourth and last source would be relatively slight increases in the budgets of the care facilities themselves. Given the recent downward trend in spending on early childhood education, this would be a rebalancing of the budget in terms of overall outlay.

Monitoring of the system would provide evidence that the money spent in the way recommended will be cost-effective in terms of less strain on treatment and correctional facilities during childhood and adolescence. This result has been demonstrated abroad (see Bronfenbrenner, 1986) and there is every reason to believe that even better and more innovative results should be obtained in Israel.

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UNIVERSALITY VS. SELECTIVITY IN CHILD ALLOWANCES AND LIMITS OF IMPLEMENTATION

by Dalia Gordon and Tami Eliav*

Introduction

The article examines the advantages of universality in child allowances (family benefits) over the introduction of selectivity based on means testing. The advantage of the universal system currently used, which achieves good progressivity even without means testing, is presented.

The article also studies the implications of administrative constraints which dictated the method of means testing for child allowance from 1985 to 1992 in Israel, when the criterion for allowance was the income of the breadwinner only.

The theoretical alternative is one in which family income is the criterion for paying child allowances, the principal argument here being that the means test in use was inequitable, creating distortions in the receipt of allowances among families of similar incomes but different in the distribution of these incomes between the earners.

Universality vs. Selectivity in Child Allowances

All Western societies aim, at least in theory, to institute a progressive system of transfer and tax payments, meaning that the wealthy pay more and receive less, while the poor pay less and receive more.

One of the means of achieving vertical progressivity in families of different income levels is progressive taxation. Horizontal progressivity in families of different sizes is achieved by the taxation system, taking family size (number of children) into account, which is the case in most, if not all, modern societies.

Since 1975, Israel's tax system has reflected family size mainly through child allowance payments. This measure was applied as part of the reform in direct taxation proposed by the Ben-Shachar Committee, which formulated its

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* The National Insurance Institute of Israel, Jerusalem.
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recommendations on the basis of conclusions reached by the Prime Minister's Committee on Disadvantaged Children and Youth.

Under this reform, child allowance payments replaced the tax credit for children. Their advantage lies in the fact that, whereas tax credits benefit only those who earn in excess of the taxable income threshold, child allowance payments benefit even the unemployed or lower earners.

However, following accelerated development in social welfare and the subsequent, large increase in public expenditure in this domain, pressure to curb social expenditure is mounting worldwide. The central issue is choosing the most effective way to allocate resources which, by definition, are not limitless. There are repeated proposals to make child allowances conditional on a means test, that is, to turn them into selective as opposed to universal benefits paid to all families according to size, irrespective of earnings.

On the face of it, this suggestion sounds logical. Why pay out to those not in need, when these payments could be diverted to the needy and used to give them increased support?

The answer is that making the granting of child allowances conditional on means testing has a direct influence on recipients' behavior in different areas, and these behavioral changes have important and decisive implications both for progressivity and equity in the redistribution of income, and for saving public money. The main impact is on motivation to work, but there are also effects on other areas.

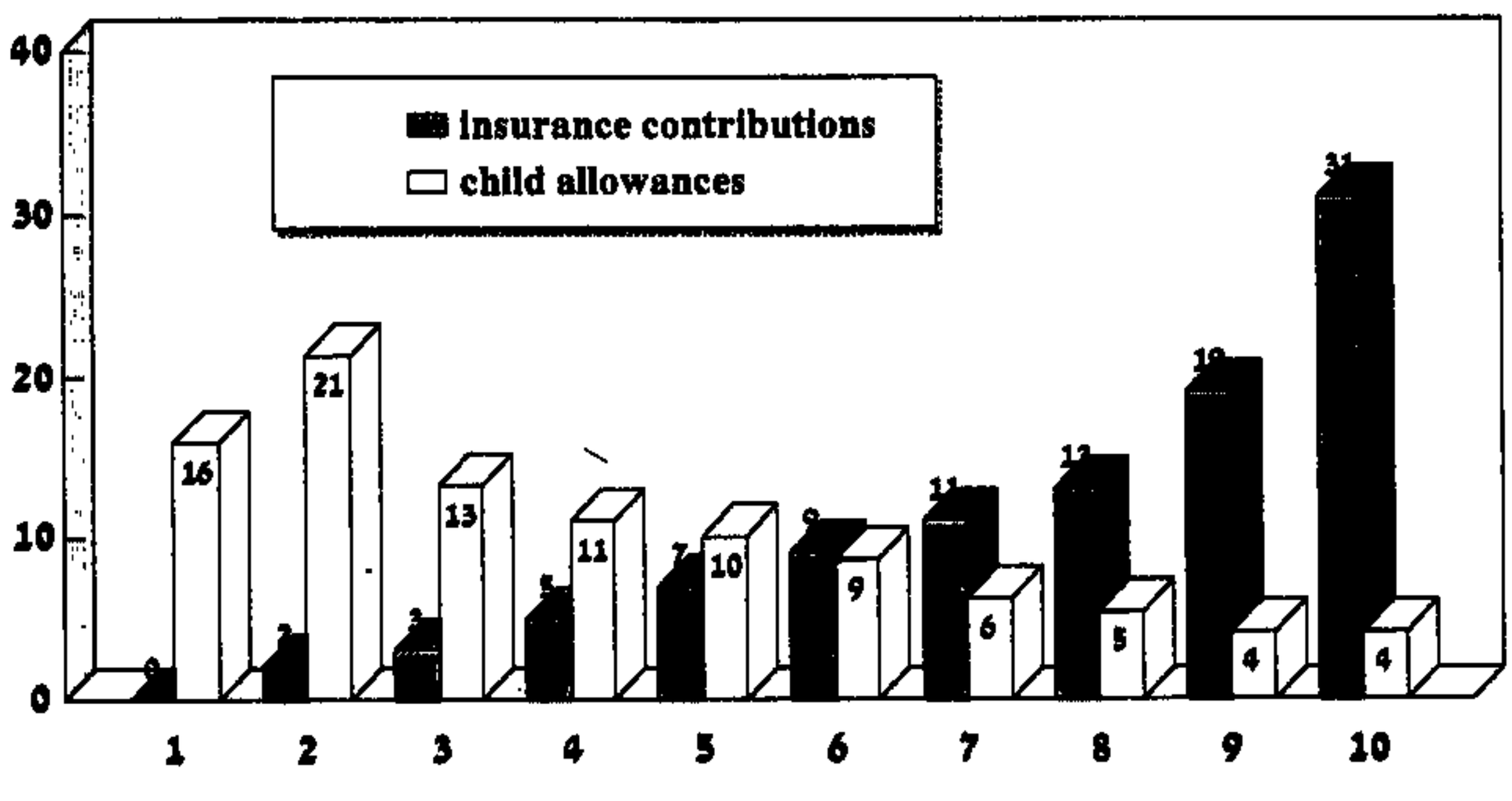
1. A system of child allowances conditional on means testing has a heavy price as it creates a disincentive to work (Gueron, 1990). Even where child allowance is not conditional on means testing, the gap between the level of the income support benefit and the minimum wage is small or even negative (i.e., the level of the benefit is higher than the minimum wage). Thus, for example, a two-child family eligible for an income support benefit received 2,118 shekels in January 1997 (at the regular rate) and about 2,497 shekels (at the increased rate), whereas the minimum wage at that time was about 2,100 shekels per worker. These gaps do not encourage people to go out to work and may even act as a disincentive. Making child allowance also conditional on income level would make work even less worthwhile. In addition, in instituting such a policy the authorities would be sending a negative psychological signal about work (Gabai and Lavon, 1996). A British parliamentary committee also gave its opinion in 1995 that "means testing punishes effort and honesty". The Institute for Poverty Research in Wisconsin, USA supports this view in concluding that selective allowances create disincentives to work (Doron, 1995).

A disincentive to work creates a "poverty trap": Families who find

themselves living on social benefits prefer to continue receiving such benefits rather than going out to work, and as a result maintain their low standard of living (Ehrenberg and Smith, 1994). However, the inherent risk to society is not limited to this aspect, but also relates to the fact that children are raised with no work model to imitate. The outcome, particularly in the medium to long term, is an expansion of the number of those supported by the public purse, the end result being that the illusion of the savings achieved by selectivity turns out to be both a financial and social loss.

2. Throughout the world, selective allowance systems have worked against the poor (Doron, 1995), because the battle to maintain the real value of the allowances can be waged only by those who belong to the affluent strata of society which carry the main burden of financing the social security system (see Diagram 1 below). These strata are ineligible for allowances under a selective system. In addition, in the absence of a satisfactory public social security system, these strata are liable to set up their own complementary private insurance system for example, at their workplaces, or through commercial insurance. These will intensify inequality and increase the total public expenditure on social security (Doron, 1995).

Diagram 1. Insurance contributions and child allowances, by decile[1] (Percentages) 1993



1. Source: processed data on income - Family Expenditure Survey of 1993, Central Bureau of Statistics. Insurance contributions and child allowance data were attributed according to income data.
Insurance contributions and child allowance data were attributed according to income data.

3. The introduction of means testing under the administrative conditions presently existing in Israel would involve bureaucratic complications leading to non-take-up of rights to the allowance, which would affect mainly the weaker strata who need them most (Doron and Roter, 1975; Doron, 1995). Moreover, a complex bureaucratic system increases the tendency to fraud and exploitation of the system.

4. Selectivity attaches a social stigma to the strata eligible for the allowances, which increases social polarization. In Israel, a country of immigrants living under a constant threat to its security, this has special significance. A universal system of allowances greatly contributes to social cohesion, creates a sense of social partnership and helps moderate class conflict and prevent social unrest.

The advantage of a selective system lies mainly in its (short-run) cost. By paying allowances only to part of the population, a significant financial saving is achieved. In addition, the payment of allowances only to families in need theoretically achieves progressivity in the redistribution of income.

The universal child allowance system existing in Israel between 1975 and 1985 and since 1993 has avoided the pitfalls of the selective system described above. Firstly, although it does not involve means testing, it is still highly progressive. Secondly, it achieves horizontal equality between families with the same number of children even if they have different levels of income, compensation thus given for family size in the tax system. Thirdly, since it is universal, it is very simple to operate and does not put the citizen to any trouble, not even entailing submission of a claim. The allowance is paid automatically following direct notification by the hospital of live births, and regarding immigrants with children - by direct report. Being uniform and simple, it lead to full take-up of rights.

Progressivity is achieved by paying child allowances graduated according to the number of children in the family, which, as known by empirical data, is correlated to financial situation. In this way, progressivity is reached without the need for complicated and humiliating means testing. Thus the two top deciles of the income scale (see diagram) pay 50% of total insurance contributions and receive only 8% of total child allowance payments while the two lowest deciles pay 2% of contributions and receive 37% of these payments.

At this point, it should be noted that Israel is not one of the outstanding countries in terms of the level of expenditure on social security. In 1989 national spending on social security in Israel was about 15% of the GDP, while in most developed countries in Europe the expenditure in this area was about

25% of the GDP. The increase in this percentage in the 1980s was also lower in Israel (3.4%) than in these countries (ILO, 1996).

Means Testing for Child Allowances in Israel

Despite the above, proposals to make child allowances conditional on means testing are repeatedly being raised. Only recently the government decided that receipt of allowances for the first and second child should be dependent on a means test. This proposal was withdrawn from the agenda only as a result of widespread opposition by public and professional bodies.

The universal system was breached for the first time in Israel in 1984 when a tax was levied on allowances for the first two children of families with 1-3 children in which the main breadwinner (the man) was in the 45% tax bracket.

In 1985, the child allowance was ceased to be paid on a universal basis for the first child in small families (with 1-3 children). It was paid for this child only to such families where the income of the main breadwinner did not exceed 80% of the national average wage. The objective of this measure was to achieve a financial saving as part of a comprehensive program to stabilize the economy suffering from runaway inflation. It was intended to increase, or at least maintain, progressivity and reduce inequality in the redistribution of income. In 1987 the eligibility threshold for child allowance for the first child was raised to 90% of the average wage and in 1989 - to 95%. In 1990 the allowance for second children in small families was also curtailed. It was paid only to such families in which the main breadwinner earned up to 150% of the average wage. In 1991 the eligibility thresholds for child allowances for the first and second child were equalized and were set at 95% of the average wage. Since 1993 allowances have been again paid on a universal basis to all families with children.

From the experience accumulated in the National Insurance Institute of Israel (NII) during the period of means testing for child allowances, it can be concluded that over and above the conceptual and theoretical limitations described above, the method was not efficient because of operational limitations. These resulted mainly from a lack of monthly data in the NII on total family income, or at least on work-related incomes of the two partners, as data on incomes of employees are not available (on which more later).

In the absence of these data, the following arrangements were made for paying allowances for the first child (and later for the second as well):

The National Insurance Institute, which had been efficiently paying allowances to all families according to the number of children on the basis of information received directly from the hospitals in the form of notifications of

live births, stopped paying allowances for the first child to all families with up to three children.

Recipients of income maintenance benefits and those registered as unemployed continued to receive allowances for their first children directly and automatically from the Institute. Thus, too, payments continued as before to self-employed workers who were eligible for them in accordance with the means test which could be applied because the Institute had data on their income.

Eligible employees received the allowance, when entitled according to the means test, through their employers, who paid the allowance only to men (with children) and to single women with children. The employer received a refund from the Institute, either in the form of a payment or as a credit against his own insurance contribution liabilities.

Groups of families which, on the basis of their categorization, might be expected to receive double child allowance payments as a result of the split administrative arrangements described above, were required to submit a personal claim to the Institute in order to exercise their right to child allowances.

This complex administrative arrangement had the following negative results:

1. Very high marginal tax was created at intermediate income levels. This problem was compounded when the allowance for second children was also made conditional on a means test. Since the payment of child allowances to employees was imposed in certain cases on the employer, it was not possible to graduate the rate of deduction from the allowance to a number of groups according to their income level. Thus only two such groups were established. The allowance was paid in full to those whose income was up to the determined threshold, and was not paid at all to those whose income was in excess of the threshold.

2. As expected from Israeli and worldwide experience, and as previously mentioned, there was a significant lack of take-up of rights on the part of eligible families during the period of means testing for child allowances in Israel (1985-92). It is estimated that only 80% of low-income families entitled to receive the allowance from the employer actually received it. In the early years of means testing, take-up was even lower as a result of ignorance on the part of employees or employers, particularly small employers, and perhaps also due to unwillingness to act as an executive arm of the NII. This harmed mainly the employees of small firms and/or low-wage earners who were unable to claim the allowance from their employer.

3. The splitting of the payment of child allowance between the National

Insurance Institute on the one hand and employers on the other hand naturally hindered proper and efficient functioning. Thus, there were indeed many duplicate payments - at a rate of at least 10%. For example, anyone registered with the Institute as unemployed or self-employed who took up salaried employment without cancelling his self-employed status at the Institute continued to receive a child allowance from the Institute but also began receiving it from his employer. When a fourth child was born, employees received the allowance immediately from the Institute on the basis of direct notification by the hospital where the birth took place. Until the employer was made aware of this, if at all, he continued to pay too, and so forth.

4. The system described created administrative complications in the Institute, in the collection system, in the benefits system (the claims clerks in the local branches were forced to accept many personal claims) and in the computer systems. The administrative costs were not taken into account. Nor is it possible to estimate to what degree the complications impaired the regular functioning of these systems in the Institute.

5. Child allowances, which are legally paid to the mother in order to ensure, as far as possible, that they are used for the children, were paid to the father through the arrangements described.

6. The lack of data on total family earnings led to inequity in compensating families according to size *because only the man's earnings were taken into account.*

The Man's Income vs. Family Income as a Criterion for Means Testing for Child Allowance

In the absence of any general obligation to report family income in Israel, means testing for payment of child allowance to families with up to three children was established, as stated, on the basis of an examination of the man's work-related earnings only, in families with two partners.

The method of means testing was chosen because it was relatively easy to determine, and the allowance could be either subject to tax or could be paid through the employers, who had data on earnings.

A more equitable criterion for the selective payment of allowances would, of course, have been to apply a means test to both partners in the family, at least regarding their work-related income. One of the problems of this type of means testing is the difficulty of obtaining data. It could also be asked how far it is possible to go in testing family income: should it apply only to income from salary or self-employment, or should income from property, capital, etc., be

taken into account? The theoretical possibilities of achieving more equitable taxation as well as a fairer distribution of benefits are many and varied.

Gabai and Kop, in their 1988 study, showed that a family-based tax collection system would give great relief up to the eighth income decile, and increase the burden to some extent on the ninth and tenth decile, i.e., more progressivity would be achieved leading to an improved distribution of the tax burden.

The system described above, based on the income of individuals, is progressive, but problematic in relation to certain groups. Thus, for example,. a family in which only one of the partners worked was liable to carry a heavy tax burden although the total family income was lower than that of a family in which both partners worked, each individually earning less.

The same difficulties which exist in general taxation on an individual basis are even greater when establishing means testing for benefits, e.g., child allowances, on an individual basis.

We shall see below the inequality created by applying means testing for child allowances earnings, as well as the reflection of this inequality in the distribution by income decile according to the man's income and the family income.

The population tested was households with 1-3 children with two married partners under the age of 65. The data were based on the 1992-93 Family Expenditure Survey conducted by the Central Bureau of Statistics and processed by the National Insurance Institute.

Findings

There were about 555,000 households with 1-3 children where at least one of the partners worked. Both partners worked in 55% of these households; in 40% the man worked and the woman did not, and in 5% the woman worked and the man did not.

Table 1. Households with 1-3 children, by number of breadwinners and number of children (absolute numbers) 1992/93

Breadwinners	Total	Number of Children		
		1	2	3
Total	555,200	170,400	230,800	154,000
Both partners working	305,300	93,900	131,000	80,400
Man only working	224,600	66,100	90,200	68,300
Woman only working	25,200	10,300	9,700	5,200

Source: Processed data from Survey of Family Expenditure, 1993, Central Bureau of Statistics.

The determination of entitlement to the allowance on the basis of means testing of the man's income only (as a result of administrative constraints) led to inequality of entitlement to the allowance among families with similar total incomes. Thus families in which both partners worked or the woman alone worked were those where excess payment could occur, and these comprise 60% of the households with 1-3 children. In contrast, in households where only the man worked, there might be no entitlement to the allowance when the man earned only a little more than the threshold and was thus ineligible for child allowance, although the total family income was no greater than that of a family where both partners worked.

In 30% of families where both partners worked, the man's income did not exceed 95% of the average wage. However, in the great majority (about 70%) the family income was higher than 95% of the average wage, i.e., the majority of families which received a full child allowance because of the man's low income would not have been entitled to it if the income of both partners had been taken into account.

The average income of men who were entitled to the allowance (their income being less than 95% of the national average wage) was about 65% of the average wage. The earnings of their wives were even lower (about 55% of the average wage). However, the average combined income of the two partners in these cases stood at 120% of the average wage. Among families where the woman did not work, and the family therefore had recourse only to the man's earnings (about 40% of the total households with 1-3 children), about 40% were found to have incomes not exceeding 95% of the national average wage, about 45% had incomes above 120% of the average wage and about 14% had incomes between 95% and 120% of the average wage. In this last group we see

Table 2. Households in which both partners work, by man's income and family income as percent of average wage (absolute numbers) 1992/1993

Family Income	Total	Man's Income				
		up to 70%	70-95%	95-110%	110-150%	150% +
Total	305,300	49,600	40,800	26,200	56,900	131,900
Up to 70%	8,300	8,300	-	-	-	-
70-95%	17,400	15,200	2,300	-	-	-
95-110%	14,000	10,000	3,800	300	-	-
110-150%	48,500	13,000	19,500	8,900	7,100	-
150% +	217,100	3,100	15,200	17,000	49,800	131,900

Source: See Table 1.

the principal inequality created as a result of taking only the man's income into account: this group did not receive child allowances although their income did not exceed that of families where both partners worked and which did receive the allowance. In other words, families with equal incomes differently distributed between the breadwinners *were not equal before the law which gives compensation in the form of child allowances.*

A further point worthy of examination is the breakdown of families by income decile. An examination was made of families where the man's income was less than 95% of the national average wage, while the family income was higher than that, according to income decile.

The income deciles were determined according to the work-related earnings of an average adult in families with 1-3 children (two married partners, and the head of household younger than 65). The population was divided by income decile, once according to the criterion of men's earnings from work (i.e., families entitled to payment of the allowance), and once according to family work-related earnings. Here different criteria were used: family income (entitling to child allowances) up to 110% of the average wage, up to 120% and up to 130%. The data are shown in Table 3.

Table 3. Households with 1-3 children by income decile* and entitlement to child allowance, by different means tests

	Percent Eligible for Child Allowance (of Decile Population)			
		By Family Income		
Decile	By Man's Income (95%)	Up to 110% of Average Wage	Up to 120% of Average Wage	Up to 130% of Average Wage
Total	37.5	31.6	36.1	39.9
1	100.0	100.0	100.0	100.0
2	97.2	100.0	100.0	100.0
3	66.1	81.8	91.6	100.0
4	41.4	34.4	52.0	69.7
5	30.4	0.0	16.9	29.1
6	24.6	0.0	0.0	0.0
7	10.6	0.0	0.0	0.0
8	2.8	0.0	0.0	0.0
9	0.9	0.0	0.0	0.0
10	0.2	0.0	0.0	0.0

* The income deciles were divided according to average family gross income from work per standard adult.

Source: See Table 1.

The optimal criterion for determining entitlement to child allowances needs to be one which can distinguish between families in need and those who are not in need according to the financial situation of the family as reflected in the deciles: families up to a certain decile (for example, the fifth) would all receive child allowances, and families in the higher deciles would not receive the allowance at all. This situation has, of course, not been achieved.

An examination has been carried out to determine which of the criteria (man's income or family income at different levels) most closely approached this ideal: From Table 3 it can be seen that when only the man's income is taken into account, even in the second decile there are families (though few) ineligible for the allowance, and there are eligible families still up to the eighth decile. Thus, if means testing were applied to total family income, the first two deciles would be entitled to full allowances, and only from the fourth decile onwards (depending on the test threshold), not all families would be eligible. In addition, the percentage of families entitled to child allowances would drop increasingly until, from the sixth decile, there would be no eligible families.

Summary

The principle of the universality of child allowance is an important one which should not be relinquished. It is practiced in most welfare states. The principles of selectivity are generally prevalent in countries in which family allowances were historically instituted in the framework of employment programs which were not universal from the outset.

A selective allowance diminishes the motivation to work and thus widens the circle of those dependent on the public purse.

The universal allowance currently provided in Israel achieves quite a high level of progressivity without necessitating means testing.

Furthermore, it is simple to administer, and thus achieves a high take-up of rights, maintains the value of the allowance, avoids exploitation and stigma and contributes to social cohesion.

Applying means testing to child allowances is detrimental to horizontal equity between families of different sizes. In Israel, the taxation of the child allowance almost completely eliminates any consideration of family size in the tax system.

In addition, the attempt to apply means testing in child allowances under the administrative constraints which dictated that a means test should be applied solely to one breadwinner, and that the payment of the allowance should be split between employers and the National Insurance Institute, shows that the efficiency of its administration was low, take-up of rights was partial and there were many duplicated payments. Moreover, progressivity and equality in the

redistribution of income suffered, and inequity was created regarding entitlement to child allowances in relation to the number of breadwinners in the family: families with one breadwinner who earned a little more than the eligibility threshold did not receive the allowance, whereas families with two breadwinners where the man earned slightly less than the threshold did receive it.

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"NEW CAREERS FOR THE POOR": A REVIEW OF THE CAREER OF AN INNOVATIVE IDEA

by Joseph Katan* and Tali Etgar**

Introduction

More than thirty years have passed since the publication of Pearl and Riessman's book, *New Careers for the Poor - The Non-professional in the Human Services* (Pearl and Riessman, 1965). This book was one of the first publications, and perhaps the most important to raise the idea of employing indigenous workers in human service organizations (HSOs). This idea was designed to achieve two interrelated objectives: first, to fight poverty by providing employment to poor people in HSOs; and second, to promote basic changes in the structure and activities of these organizations and in their interrelationships with clients.

Beginning in the middle of the 1960s, and up to the middle of the 1970s, the idea of employing indigenous workers in HSOs gained considerable legitimacy and support which facilitated and encouraged its implementation in a wide range of HSOs in the US and other Western countries. But since the middle of the 1970s the idea began to decline. It seems that now, 30 years after the publication of Pearl and Riessman's book, the time is ripe for a review and examination of the history of the idea and the factors that affected its course of development.

This review is necessary not only for exploring the fate of this specific idea, but also for identifying and understanding the factors that could affect other ideas and programs designed to cope with poverty and social distress, to form a new structure for social services and to change the fate of poor and other vulnerable populations.

The Non-Professional Employment Idea - Background and Significance

Actually, there was nothing new in the demand to employ non-professional

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* Bob Shapell School of Social Work, Tel Aviv University, Ramat Aviv, Israel, and The Center for Social Policy Studies in Israel, Jerusalem.
** Elem - Youth in Distress in Israel, Jerusalem.

workers in HSOs. These workers, often called paraprofessionals or sub professionals, were always part and parcel of human services personnel. They worked in hospitals, medical clinics, institutional and community services for the elderly, community centers, welfare departments and a wide range of other services. The innovative dimension in the idea put forward by Pearl and Riessman as well as other scholars (Brager, 1965; Grosser, 1966, Sobey, 1970; Gartner, 1971) was associated with their suggestion of an original and new look at the status and functions of the non-professional worker, and a different perception of his/her potential contribution to the functioning of HSOs, and to their ability to provide qualitative and meaningful services to their clients.

According to this innovative view, the non-professional is not just a worker who lacks formal professional education and therefore fulfills only routine and simple organizational roles under the control and supervision of professional workers. Pearl and Riessman and other scholars who raised the idea, view the non-professional workers, and especially those who share common social and cultural background with HSO clients, as indigenous workers who possess several unique and vital qualities. Thus, the indigenous non-professional lacks certain characteristics, such as formal education, but at the same time he/she possesses other characteristics that the professional lacks, but which are not less important.

These workers know the organization's clients well and often share with them experiences of poverty and distress. Furthermore, many of them were in the past, or continue to be, clients of HSOs. Due to their close ties with the clients and the community in which they live, the indigenous workers are equipped with cultural codes, knowledge, values, commitments and life experiences that may contribute to improving the scope and quality of service they can provide to clients.

According to this approach, the employment of indigenous workers is beneficial to the HSOs (strengthening their image and legitimacy in the community and improving their relationships with clients), to the clients (improving the services provided to them), to the workers themselves (obtaining employment, improving their self-image and empowerment) and to the general society at large (reducing unemployment and poverty).

The call for the employment of indigenous workers in HSOs introduced into the conventional narrative that was common in the human services at the beginning of the 1960s several new concepts such as "indigenous theory", "indigenous practice", "praxis", "experiential knowledge" and "closeness between workers and clients". These concepts challenged and even cast doubts

on concepts and perceptions that were dominant among the human services and their professional workers.

Thus, the "indigenous non-professionals employment" idea was innovative, not only because it suggested a new and different look at the functions and status of the non-professionals, but also because it required changes in the structure and operation modes of the organizations and the status and functions of their professional workers. The emphasis on indigenous theory and practice and experiential knowledge, based on subjective experiences, anchored in the worker's own personal background and realities of life and the demand to utilize these resources in the work with clients, did not fit, and even contradicted, the emphasis put by professionals on expertise, knowledge and intervention techniques obtained through formal education and continual professional training. Furthermore, the idea's emphasis on the virtues and qualities of "indigenous practice" and "experiential knowledge" was accompanied by sharp criticism against the weaknesses and inadequacies of professional theories and practices, and their inability to properly cope with the problems of disadvantaged populations.

Similarly, additional ingredients of the non-professional employment idea were in contrast to other principles emphasized by HSOs and their professional workers. The call for employment of ex-clients and their involvement in meaningful organizational roles and the demand to enrich the functions and to raise the status of non-professionals who already worked in organizations, did not fit into the organizational hierarchical structure, its internal mobility patterns and its rules concerning the proper relationships with clients.

These conceptual and practical incongruities between the "indigenous non-professionals employment idea" and organizational and professional principles, could have hindered HSOs readiness to digest this new breed of workers. Formal organizations, as any other social entities, are reluctant to absorb new components that may threaten their stability and survival.

Furthermore, they generally tend to disengage themselves from such elements, or to neutralize their radical and dangerous ingredients. However, the difficulties and blockages faced by many innovative ideas on their way towards concrete implementation originate not only in organizational resistance to change, but also in the disinclination of the initiators of innovative ideas to take concrete steps in order to substantiate them. This tendency may stem from various reasons, such as lack of resources, limited public support, low feasibility, and lack of initiative.

Thus the chances of the "indigenous non-professionals employment idea" to establish a real and long range "career" in HSOs were very slim. However, due

to various factors in play in the US in the beginning of the 1960s, this idea enjoyed a different fate and did indeed succeed in climbing up a path that would lead it towards concrete implementation. These factors will be described in the following section.

Factors Promoting the Indigenous Non-Professionals Employment Idea

A combination of various factors that influenced the US social and political scene in the 1960s have contributed to the emergence of the idea, to its spread and to its implementation in a wide range of HSOs. This was a period of growing awareness of the existence of an "other America" characterized by severe distress and poverty, chronic unemployment, social neglect and hopelessness. This awareness instilled in many people a sense of guilt and reinforced the conviction that American society could not remain indifferent but rather had to take action in order to cope with these problems. This conviction permeated the political establishment as well, especially after the election of Kennedy as President. It led to the development of the "War on Poverty" which signaled a massive involvement of the Federal Government in the development and support of services and projects designed to eradicate poverty from US society.

The government's desire to cope with the problems of poverty and neglect was also influenced by the active struggle of the blacks for equal rights and for their integration into the mainstream of American society. One of the main characteristics of the "War on Poverty" policy was the encouragement and support given by the Federal Government for the identification and implementation of new ideas and programs that deviated from routine and conventional social programs.

The trend to look for alternative services and programs was coupled with a critical attitude towards existent HSOs and their programs. These organizations were blamed for the following (and other) faults: disengagement from the poor; serving the needs of middle class people; estrangement and alienation from clients; lack of commitment to populations in distress; and insensitivity to the needs of disadvantaged populations.

This severe criticism was raised not only by clients' representatives, but also by influential academic, intellectual and professional circles, including reputable social workers who asked the profession to reemphasize its basic commitment to disadvantaged populations (Rosenfeld, 1964; Cloward and Epstein, 1967; Grosser, 1996).

Thus in the 1960s there existed in the US a political, ideological and social climate that provided a convenient and even fertile ground for the emergence,

development, and spread of such an innovative concept as the "indigenous non-professionals employment idea".

The development of the idea in the US and the wide international publicity it gained exposed other countries, including Israel, to the potential advantages that could be derived from the employment of non-professionals. It stimulated them to adopt the idea and to experiment with its implementation. The idea's adoption and implementation in the US and other countries in the 1960s and 1970s' were reflected in various forms that will be described in the next section.

The Implementation of the Non-Professionals' Employment Idea

The idea and its basic principles crossed the US borders and gained considerable support in quite a few countries in America, Europe, Africa, and Asia (Arendse and Normann, 1993; Gidron and Katan, 1985; Schindler and Brawley, 1987). In the US, hundreds of thousands of non-professional workers, many of them clients or ex-clients of HSOs, became employees of a wide range of HSOs including schools, hospitals, medical clinics, community centers, welfare departments, urban renewal projects, services for alcoholics and drug addicts, the "Head Start" project, extension services, offices for economic opportunity and community mental health centers (Goldberg, 1967; Pearl, 1967; Grosser, Henry and Kelly, 1969; Gottesfeld, 1970; Gartner, 1971; Katan, 1974).

The non-professionals performed a variety of roles and tasks in these organizations. Some of them performed routine administrative roles, but many acted as mediators between the organizations and their clients and helped to bridge the gap between them. Another group of workers fulfilled clinical functions in several organizations and a few workers even succeeded in penetrating into higher levels of the organizational hierarchy and fulfilled management and planning tasks (Pearl, 1967; Sobey, 1970; Gartner, 1971; Umbarger, 1972; Katan 1974; Teare, 1978; Scott, 1981).

Thus the aim of employing indigenous workers in meaningful organizational roles was at least partly achieved.

The patterns of non-professional employment shaped in the US were similar to a large extent to those developed in other countries. In Israel, for instance, hundreds of non-professional workers, mostly women, were employed as neighborhood workers, especially in distressed areas, as organizers of building maintenance committees, as counselors in services for alcoholics and drug-addicts, as instructors to young mothers, and as workers in services for the aged (Etgar, 1977; Yaron, 1979; Habassy, 1981; Schindler, 1982; Gidron and Katan, 1985).

Several additional indicators reflected the growing recognition awarded to the "indigenous non-professionals employment idea", and the central place it gained in the HSOs arena. These are:

1. The new concepts raised by the idea, such as "indigenous practice" and "experiential knowledge", successfully entered into the HSOs' arena, and became an integral part of its vocabulary.

2. Universities and colleges developed special programs designed to train non-professional workers and to prepare professionals to work with them (Brawley, 1975, 1981).

3. Programs to employ non-professionals in HSOs gained support from government and non-government organizations in the US and other countries. This support included ideological and political legitimacy as well as allocations of financial resources. Furthermore, in the US the employment of indigenous non-professionals in many social projects was a precondition for obtaining governmental support. This condition was perceived as a mechanism designed to achieve the principle of "maximum feasible participation" of the poor in services affecting them.

4. Hundreds of professional publications on issues relating to the "non-professionals employment idea" appeared in various forms such as books, articles in professional journals and reports. Many of these publications were based on empirical studies. Thus this topic attracted the attention of academic and professional circles and became an integral part of their agenda.

5. Most of the publications portrayed a very positive picture of the achievements of the indigenous non-professionals and their contribution to HSOs. They pinpointed four major aspects:

(a) The outcomes of the intervention of these workers in services such as community mental health centers were similar and sometimes even better than those of professionals (Gartner and Riessman, 1971; Durlak, 1973; Brown, 1974).

(b) Professionals working in HSOs which employed non-professionals were more effective in their work with clients than professionals working in HSOs lacking this type of worker (Grosser, 1966).

(c) The work in HSOs had a very positive effect on the non-professionals themselves. It raised their self-image and sense of empowerment and stimulated their self-development and aspirations of upward mobility (Kastenbaum and Bar-On, 1982).

(d) The employment of non-professionals and the roles they fulfilled enabled HSOs to broaden their activities, to reach out to more clients and to offer them more and better services (Sobey, 1970; Katan, 1974; Etgar, 1977; Yaron, 1979).

Thus most of the publications that reviewed the activities of the indigenous non-professionals praised their performance and supported their involvement and employment in HSOs' meaningful functions.

However, some of these studies (Katan, 1974; Gidron and Katan, 1985) indicated several aspects which throw light on certain inadequacies in the idea's implementation: most of the workers were employed on a temporary basis, their salaries were relatively low, and their employment was funded by special budgets whose long-range allocation for this specific purpose was not guaranteed.

The various phenomena mentioned above probably show that not all the aspirations and hopes attached to the non-professionals employment idea were achieved, but that during the 1960s and the beginning of the 1970s, the idea's implementation could be considered a success story.

However, a review of the status of the idea in the middle of the 1990s exposes a different picture, especially in the US and several other Western countries. The success of the idea in the first stage did not guarantee a steady and continued progress in the development of the idea's future. By the middle of the 1970s the idea's implementation began to erode, although the pace of this change was not uniform in various countries and organizations. Various expressions of the idea's decline and the factors affecting it will be described in the following sections.

The Status of the Non-Professionals Employment Idea in the Mid-1990s

An examination of the current state of the idea's implementation in the US and several other Western countries indicates several major trends:

(a) Non-professional workers continue to constitute an integral part of the HSO's systems, but now generally they are concentrated in the performance of traditional tasks (administrative and routine functions and assistance to professionals). In several organizations they continue to fulfill mediating roles. Evidence indicating their involvement in clinical functions or in higher level organizational positions is rare.

(b) The number of indigenous non-professional workers employed in HSOs is decreasing. This situation reflects both a demise of organizations that especially employed this type of worker, such as organizations established in the US in the framework of the "War on Poverty", and the abolition of functions performed by indigenous non-professionals in organizations that continue to exist. In Israel, for instance, in recent years there has been a reduction in the number of neighborhood workers,. organizers of tenants' associations and instructors of young mothers who had been employed by existing organizations.

It should be mentioned, however, that in recent years there has been a considerable increase in many Western countries in the number of non-professionals working in community and institutional services for the aged. This reflects the increase in the number of elderly people and the growing awareness of the necessity to provide different kinds of services for them. Nevertheless, these non-professionals generally perform routine tasks under the supervision of professional workers. Furthermore, many of them are not indigenous, that is, they are not similar to the clients in their cultural and social background. Thus their employment patterns do not reflect the underlying principles of the "indigenous non-professionals employment idea" and it is therefore difficult to include them in the category of these workers.

(c) The "non-professionals employment idea" has ceased to attract the attention of professional and academic circles. This situation is reflected in the scarcity of publications and studies dealing with the state of the idea in the US and other Western countries. There are, however, publications describing the utilization of indigenous workers and indigenous practice in developing countries (De-Zoysa and Cole-King, 1983; Fernando, 1985; Moser, 1989).

The lack of professional and academic discussion in Western countries on different aspects of the idea and its implications is a clear and striking symptom of its current marginal position in those countries.

(d) In the US and several other Western countries such as Israel, the allocation of government funds designed to enable the employment of non-professional workers in HSOs was considerably reduced or totally stopped. These cutbacks have actually forced many HSOs that employed non-professionals to decrease their numbers, often through dismissals.

(e) The employment of indigenous workers in HSOs such as community mental health centers did not lead to considerable changes in these organizations (Fong and Taylor Gibbs, 1995).

These expressions of the state of the idea indicate that the hope that indigenous workers would initiate and create basic changes in the policies, structure and activities of HSOs was not realized.

Nevertheless, certain clear signs of the "indigenous non-professionals employment idea" still exist in various HSOs. For instance, in Israel these workers are still actively involved, especially in mediating tasks, in a number of organizations. Several social welfare departments employ family aides who assist families in deep distress. The aides accompany these families, mediate between them and relevant service agencies, advocate for their rights and guide them in home management and child rearing (Feller, Bar-On and Eran, 1994; Weissman and Savaya, 1995). In services for drug addicts and alcoholics, ex-

addicts serve as instructors, helping addicts in their withdrawal process (Avrahami, Aviad and Miller, 1995). Ex-prisoners are employed as instructors for prisoners who stay in hostels during the last period of their senrence. Many non-professionals are employed in community and institutional services for the aged, their main task being to help the elderly in washing, dressing, feeding, mobility etc. (Ben-Zvi, 1990).

Veteran immigrants from Ethiopia are employed by several organizations such as local welfare departments, health clinics and the Joint Distribution Committee, and provide services to Ethiopian Jews who immigrated to Israel in recent years. Their main function is to mediate between the new immigrants and the service agencies and to help them to adjust to the new social and cultural environment.

However, the organizational involvement of these workers is characterized by several features which indicate a weakened position in terms of empowerment. First, they are perceived as assistants to social workers or other professionals and not as independent workers. Second, they are supervized by professional workers and work according to their instructions. Third, most of them are employed on a temporary basis, many working part time. Thus, unlike most of the professional workers, they do not constitute an integral and stable component of the organizations' staff. Fourth, the non-professional workers' employment is funded by special budgets, geared to this specific purpose. The continuous allocation of these funds is not guaranteed. Finally, the salary of these workers is considerably lower than the professional workers' salary.

Thus, despite the fact that the indigenous workers fulfill vital organizational roles, most of them have not obtained a permanent and stable position in the HSOs which employed them.

It is worthwhile to indicate that the above-mentioned trends are relevant in Israel and other developed countries. The situation is different in developing countries where the development of formal HSOs is in its embryonic stage and the number of professionals is very limited. In these countries informal indigenous helpers, self-help groups and some non-professional workers fulfill a central role in the provision of assistance to people (De Kadt, 1982; Aredo, 1993; Nagarajan, Meyer and Graham, 1995).

What happened to the "non-professionals employment idea" in the US and other Western countries? How is it possible to explain the deterioration of an idea that had such a very promising start? Did it disappear completely or perhaps just find other channels of development outside the realm of existing and established HSOs? These issues will be discussed in the following section.

Factors Affecting the Weakening of the Non-Professionals Employment Idea

As was previously indicated, the idea's success at the beginning of its "career" can be attributed to various factors, including the growing public awareness of the poverty problem in the US; the conviction that to successfully cope with this problem would require a radical change in the social policies and functioning of HSOs; and the federal government's readiness to promote innovative ideas and new programs that could help in the "War on Poverty". These factors created a fertile ground for the growth of new ideas and programs such as the "indigenous non-professionals employment idea".

Social, political and ideological changes that began in the US and other Western countries in the middle of the 1970s and throughout the 1980s created a different climate that fostered a new approach toward social ideas and programs. These changes included an erosion in the public awareness of the problem of poverty and in its readiness to cope with it, and a growing support for both the value of privatization and limited state involvement in the welfare arena. These new trends were strongly supported by neo-liberal and conservative political parties that won the elections in various Western countries such as the Republicans in the US and the Tories in the United Kingdom.

These changes led to a growing tendency among governments to cancel or cut support for ideas and programs such as the "indigenous non-professionals employment idea". They also led to a weakening in the readiness of HSOs to employ indigenous non-professionals in meaningful tasks, and to view them as a unique group of workers. Furthermore, the willingness of HSOs and their professionals to involve in their ranks this breed of worker, despite the difficulties and risks associated with it, stemmed to a large extent from the existence of supportive ideological, social and political environments which encouraged them to adopt this positive approach. Thus the removal of these incentives denied the idea its main sources of legitimacy and support and contributed to its decline.

However, the fact that the idea was only partially instituted and had limited impact on formal HSOs cannot be attributed only to the policies of these organizations and to their professional workers' attitudes. The indigenous workers themselves did not develop a social movement or organizational frameworks that could promote the idea's implementation and safeguard the workers' interests. Furthermore, the academic and professional circles that raised the idea and supported it in its first stage have redirected their attention and interests to other topics.

This change is well reflected in the absence of attention to the idea and its

implementation in Western countries in the professional literature. Thus the environmental changes have left their impact not only on the HSOs and workers, but also on the indigenous workers and their supporters.

The review of 30 years of "career" of the "non-professionals employment idea" indicates that, despite its promising start in the 1960s, by the middle of the 1990s it plays only a marginal role in the HSOs. HSOs still utilize non-professional workers, but they generally perform routine tasks and do not constitute a mechanism for change in the structure and functioning of these organizations. The hope that these workers would fulfill meaningful roles and exercise their "indigenous practice", "experiential knowledge" and "socio-cultural closeness to clients" was only partly realized in the long run.

This review indicated the difficulty of introducing new and radical ideas and contents into existing and established organizational frameworks. A successful organizational change requires a combination of supporting factors: a friendly environment that promotes the new idea and supports concrete programs derived from it, the organizational elites' conviction that the change will be beneficial to the organization, and the commitment of the change agents to translate the new ideas and programs into practice.

The existence of these supporting factors in the 1960s enabled the implementation of the idea, but the prospects of a continuous successful "career" were minimized with the emergence of new circumstances during the middle of the 1970s. However, the eventual failure of the radical ingredients of the idea to take hold in established organizations did not put a total end to its existence.

Some of the major themes and principles of the non-professionals employment idea found expression in frameworks outside the established system of HSOs.

This development will be discussed in the following section.

Implementation of the Idea in Non-Establishment Frameworks

Since the middle of the 1970s, a growing process of diversification in the welfare arena has occurred in many Western countries. This process is characterized not only by the entry of non-profit and for-profit organizations into the HSOs system, but also in the development of additional frameworks existing outside this system's borders. Conspicuous among them are the self-help groups and the "alternative" organizations.

The data on the exact number of these frameworks are inconclusive, but the impression gained from various sources is that they are developing and spreading very rapidly. For instance, in a small country like Israel with a

population of 5.6 million, there are more than 600 self-help groups, most of them founded in recent years.

One of the major characteristics of self-help groups is the emphasis they put on the concepts of "indigenous practice", "experiential knowledge" and the necessity of cultural and social closeness between helpers and people in need.

Alternative organizations which concentrate on helping people such as abused women, homosexuals and lesbians, HIV carriers, and ethnic minorities also put a strong emphasis on experiential knowledge and practice and non-hierarchical and participative organizational structure (Perlmutter, 1994).

Professional workers are involved in some self-help groups and alternative organizations, but in most cases, professional principles and expertise play a very marginal role in these organizations.

Another helping framework that utilizes "indigenous practice" and "experiential knowledge", namely the informal network, has regained prominence in recent years. Informal networks consisting of family relatives, friends and neighbors, constitute a cornerstone of the "community care" approach that was developed in England and spread to other countries.

Thus ideas, principles and content inherent in the "non-professionals employment idea" occupy a prominent place in non-establishment frameworks that have played, in recent years, an important role in the welfare arena.

In less developed countries, saturated with social problems and distress, solid infrastructures of HSOs and professional personnel do not exist and therefore most of the assistance to needy populations is provided by informal helpers and self-help groups. Both utilize indigenous practice and knowledge based on common experiences with the people. Furthermore, indigenous non-professionals play a central role in social services and projects developed in these countries by their governments or by international organizations.

One of the main challenges faced by these countries is how to mobilize resources and develop a proper infrastructure of social services capable of coping with the myriad of complex social needs, and at the same time to keep and foster the vital resources possessed by informal helpers and self-help groups.

Summary

The non-professionals employment idea that was born more than 30 years ago in the US and spread to other countries brought a new message to established HSOs and their professional workers. The message was that the clients of organizations - poor people, residents of distressed communities, ex-mental

health patients, and mothers with a large number of children - should be employed in these organizations in significant roles.

The idea did not overlook the "non-professionalism" of these workers; rather it focused upon certain unique and positive qualities that these workers possessed, such as indigenous practice, experiential knowledge and cultural and social closeness to clients. It emphasized their importance to the functioning of HSOs and to their ability to provide qualitative services to their clients. Thus the idea challenged the conventional principles underlying the structure and activities of HSOs and their professional workers.

This paper makes a distinction between two main periods in the history of the "career" of this idea. In the 1960s and the beginning of the 1970s, the idea gained considerable support in the US and several other Western countries and was implemented in a wide range of HSOs. However, beginning in the middle of the 1970s, the idea began to lose ground and by today, the middle of the 1990s, the remaining signs of its existence in Western countries are rare.

Many non-professional workers are employed in HSOs, but the gap between the tasks they actually fulfill and the expectations and aspirations of the idea's entrepreneurs is very wide. This paper examined the factors that could have led to these changes, and attributes them essentially to the new ideological and political climate that emerged in the middle of the 1970s.

These changes have undermined the implementation of the idea and halted its development in established organizations. However, the themes and principles inherent in it found other channels of expression - self-help groups, alternative organizations and informal networks - that play an important role in the welfare arena. Furthermore, informal helpers, self-help groups and indigenous workers constitute the main source of social assistance in developing countries.

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THE DEVELOPMENT OF WELFARE SERVICES FOR THE MENTALLY HANDICAPPED IN ISRAEL

by Meir Hovav* and Avi Ramot**

Introduction

Welfare services for the mentally handicapped in Israel first came into being twenty years before the State of Israel was establishd in 1948. The first school for retarded children, "Netzah Yisrael", was opened in Tel-Aviv in 1929. Seven years later, in 1936, Professor Shneirson established the first center for diagnosis in the same city. A year later, in 1937, a school for children with moderate retardation was opened there (Ganigar, 1968a).

Residential-home care was initiated in 1931 by Irena Gester, who opened in Jerusalem a boarding school for a small number of children. This home was to become later the larger "Ruhama" home, established in 1952 in the town of Kfar Saba.

In 1945, an additional residential home was opened in the town of Herzeliya by Mrs. Levtzeler (Marbah, 1968).

The organizational character of welfare services for the retarded in Israel has undergone four major changes since the founding of the state. Thus it is possible to discern four major periods between 1948 and today:

(1) 1948-1961: Early organizational efforts. In this period, welfare services for the retarded were provided as a sub-service in the larger Child and Adolescent Welfare and Youth Protection Services.

(2) 1962-1976: A distinct Service for the retarded was formed in the Israeli

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* Ministry of Labor and Social Affairs, Jerusalem, Israel.
** JDC-Brookdale Institute of Gerontology and Human Development, Jerusalem, Israel.
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In preparing this survey we used in addition to written references also material from interviews conducted with the following people: Mr. Aharon Langerman, formerly general director of the Ministry of Welfare; Mr. Simha Glazer, formerly of the Ministry of Welfare (children and youth); Mr. Yitzhak Shemer, formerly chairman of A.K.I.M.; Dr. Yitzhak Kendel, formerly director of the Division for the Welfare of Mentally Retarded Persons; Mrs. Ahuva Levi, director of the Division for the Welfare of Mentally Retarded Persons.

Ministry of Welfare. During this period, services expanded and moved from a stage of initial experimentation to one of more concrete application.
(3) 1977-1985: Services for the retarded were upgraded from the level of service to the level of autonomous division, granting the service autonomy of authority in budgeting, personnel management and treatment activities. These years were also characterized by the emergence of an ideology and an ethical code regarding birth prevention, residential-home care and community care for the retarded. Planning, research and measurement were carefully invested in. In 1977 the Ministry of Welfare was merged with the Ministry of Labor to form the Ministry of Labor and Social Affairs.
(4) 1986-1994: During this period services continued to expand. Emphasis was placed on legislation, diagnosis, comprehensive family care and parent involvement in treatment.

Initial Organizational Efforts, 1948-1961

In May of 1948, there were in Israel four residential homes for the retarded, housing 150 children, and to 25 special education classrooms serving 350 students. Official records listed 365 children as benefiting from services for the retarded. Even at this early stage, two major trends were apparent in care for the retarded: residential care and community services (Marbah, 1968).

In 1950, the Ministry of Education formed a special unit for Special Education in its Department of Elementary Education. The same year, a Jerusalem-based parent committee was organized to represent the needs of their retarded children and promote development of professional services. A year later, the newly founded organization, called A.K.I.M. (Hebrew initials standing for the Israeli Association of Parents of Mentally Handicaped Children), branched off in Tel-Aviv (A.K.I.M., 1968).

1. Development of Special Education

When, in 1950, the Special Education Division was formed by the Ministry of Education, approximately 400 children were registered in special education settings. Most of these children were not mentally retarded but had dysfunctional adaptability skills or disruptive behavior.

Official records indicate, that in 1957, 22 classrooms were serving 252 moderately retarded children, and 276 classrooms were serving 5,284 mildly retarded children (Marbah, 1968).

These statistics rose steadily so that by 1962, 49 classrooms were accommodating 569 moderately retarded children and 638 classrooms were accommodating 12,028 mildly retarded children.

In 1954, a first curriculum for mildly retarded children was published. The early version of the curriculum was based largely on an article by Naomi Glickson published four years earlier and called "Caring for Retarded Children". In the article, the author claimed that mental retardation affects 6-8 percent of the population (Ganigar, 1968a).

In 1956-1957, the Ministry of Education and the Ministry of Welfare had joint responsibility for a number of day care centers in the towns of Acre, Jerusalem, Tel-Aviv, Be'er Sheva, Lod, Ramat Gan and Petah Tikvah. Each one of these centers served 10-15 children. In 1960 a special home economy class initiated by A.K.I.M. opened in a school in Haifa.

2. Development of Residential Care

The "Ruhama" residential home in Kfar Saba was the first of its kind to be opened following the founding of the State. "Ruhama" was a governmental project headed by a woman named Mrs. Gaster, a pioneer in care for the retarded in Israel. In 1954, a second home, "Givat Shemesh", was opened, to be followed two years later by the "Mekim" home in Ramle. The same year, Meshulam Langerman founded the "Shikma" home in the town of Ra'anana, which was considered for many years the most advanced residential facility in Israel.

Residential homes in Israel were either governmental or private. Private homes were ordinarily smaller and of a more homogeneous nature; for instance, the private "Mekim" home in Ramle catered to mildly retarded children, while the "Amshinov" home, founded in 1957 in the town of Kiryat Ata, was very specifically geared towards caring for severely retarded infants.

Two governmental homes of special significance were the "Kfar Hashvedi" (Swedish Village) home in Jerusalem, opened in 1957, and situated in a former center for lung patients, and the "Bnei Zion" home in the town of Rosh Ha'ayin, opened in 1961. Both catered to heterogeneous populations. Records show that in 1962, 695 retarded people were registered in governmental homes. Four hundred and sixty-nine retarded individuals were registered in privately-run and public homes.

3. Development of Community Care

The two major services offered by the community were special education settings and employment services for the retarded. The Jerusalem-centered "Ma'as" (Sheltered workshops), founded in 1961 for the purpose of providing the retarded with sheltered employment, is generally considered to be the pioneering organization in its field. In fact, efforts to provide retarded

individuals with the opportunity to work were made prior to the establishment of "Ma'as".

In 1955, A.K.I.M. opened a weaving-house in Jerusalem, which constituted the very first sheltered workshop in Israel. In a pamphlet published in 1957 (*Sa'ad*, no. 2, March 1957), Mr. Avraham Hohvald described the Netanya Rehabilitation Center, which operated five factories: a carpentry shop (staffed by 25 workers), a knitting factory (15 workers), a brush factory (7 workers), a textile factory (8 workers), and a mattress factory (12 workers).

The Rehabilitation Center was a privately-owned business enterprise. Presumably owing to its unique nature, the Center was not included in the report published by the Ministry of Welfare in 1962. According to the report, 250 children were registered in day care centers, 50 retarded individuals were employed in "Ma'as" workshops, and 60 children were receiving home care. That year, there were 2,225 requests for help (Aharoni and Ganigar, 1968).

In 1953, A.K.I.M. began publishing a journal titled *Our Retarded Children*, edited by Y. Ganigar, Dr. Spiegel and Dr. Strauss. Six years later the name was changed to *Our Children* (A.K.I.M., 1968).

Organization of the Service for the Retarded, 1962-1977

1. Separation of Care Services for the Retarded

In 1961, Professor Jacobs arrived in Israel for a visit. Professor Jacobs, a well-known European expert, was sent to Israel by the United Nations to help the newly developing state to establish its social services system. The visit was to result in the opening of the first "Ma'as" workshop in Jerusalem and in the decision to separate services for the retarded from the Child and Adolescent Welfare Service.[1] This was achieved in 1962, when the Ministry of Welfare created an autonomous Service for the Welfare of the Retarded. Responsibilities formerly belonging to other divisions in the office were now transferred to the new Service. These included responsibility for residential homes for the retarded, previously under supervision of the Division for Youth Protection Homes; responsibility for retarded children, transferred from the Child and Adolescent Welfare Service; and responsibility for retarded adults, transferred from the General Welfare Unit (today the Division for Family Welfare).

Reorganization, prescribed by the ever-growing complexity of caring for the retarded and by the call for professional services, was designed to encourage

1. The information on this period was taked mainly from M. Kurtz's article (1975), which summarizes the period.

initiative and allow greater flexibility and administrative freedom in cooperating with the authorities within the Ministry of Welfare and outside it (primarily the Ministry of Education and the Ministry of Health).

The organizational shift was not accomplished without opposition, mainly on the part of old-time officials in the Child and Adolescent Welfare Service, who pointed out that the Service had reached an important achievement while being responsible for the retarded. These officials proposed that the Service be the recipient of the additional resources now being channeled towards extending services for the retarded.

The following two events were important factors in affecting the decision to form the separate unit:

1. John F. Kennedy's call at the start of his presidency to invest in resources, professional personnel and research in the field of mental retardation.

2. Professor Jacobs' recommendation to establish a unit devoted entirely to the retarded, as a means of improving services (1961).

2. Development of Residential Care

During this period, special attention was devoted to the issue of residential-home services. Substantial resources were dedicated by the government and private and public factors to the developing of residential home services, and the number of people employed in residential settings rose steadily.

Policy during this period determined that homes be spread throughout the country in order to enable children to remain close to home. At the time, close to home meant a distance of 40-50 kilometers. Plans were prepared for four homes in different parts of Israel: Dimona, Netivot, the Lod area, and Carmi'el. The home in the town of Dimona was the only one actually constructed.

At the time, the trend was to prefer heterogeneous over homogeneous homes. A number of factors contributed to this tendency: the scarcity of professionally trained personnel; the desire to effect interaction between retarded people functioning on different levels; and the need to reduce construction expenses. During this period a five-point definition of retarded individuals requiring care emerged, as follows: nursing cases, treatable, trainable, educable and hyperactive (Avisar, 1979a).[2]

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2. Following is a detailed description of each category:
a) Nursing cases: Members of this group are intellectually defined as severely retarded. These people need constant supervision and care because of their physical disabilities. Functions of adaptive behavior are extremely defective and the patients are dependent

Standards of residential care were set during this period. The ideal capacity of a home was set at 432 people. In effect, this was a compromise between the treatmental-professional approach, which called for small homes, and financial considerations, which focused on construction, maintenance and manpower expenses (the original proposal was a thousand residents per home), The physical and organizational arrangement of 432 residents was based on departments of 12 residents on the average, organized in wings each housing six groups. Each wing was divided into two departments. Rehabilitative residents were organized in departments of 40; uneasy residents were organized in departments of 8, and chronic nursing residents were organized in departments of 10 residents each.

These standards were especially significant in terms of funding: whenever it was decided to open a government home, the Ministry of Finance and the Commission for State Services granted automatic maintenance and manpower permits to meet the demands set by these standards.

Residential planning during this period also attempted to predict population growth and the need to close unsuccessful homes. It was assumed that population growth among the retarded would divide up equally between residential and community services.

Criteria for placement in residential homes were examined. One important finding showed that the most dominant factor in placing children in homes is parents' inability to cope with the child at home (Eaglestein, Sal'i and Raphael, 1978).

3. Diagnostic Services

The first diagnostic center was opened in the Hadassa Hospital in Jerusalem in 1962. During the next few years, two more centers were established: one in 1963

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on the environment. Recipients of this mode of care respond to basic stimuli only (mainly sensual stimuli).

b) Treatable: Severe intellectual retardation. Poor adaptability skills necessitate constant support and instruction. Members of this group do not reach independence and require assistance. They can accomplish jobs which demand skills comprised of one or two actions.

c) Trainable: Moderate intellectual retardation. Members of this group usually reach independence in self care functions. Middling social skills. They are able to accomplish simple tasks and acquire skills comprised of a limited number of activities.

d) Educable: Education (younger people) or rehabilitation (older people) is provided for mildly retarded individuals. These people are able to function on the level of self care, demonstrate normal social skills and have the ability to work in suitable positions.

e) Hyperactive: Various levels of intellectual ability. Adaptive behavior is defective: these people have severe behavioral dysfunctions which bar them from functional independence.

in the Tel Hashomer Hospital near Tel-Aviv, and the other in 1964 in Haifa. The centers' role was to evaluate the health and functioning level of retarded people intended for placement in residential services.

4. Kindergartens and Day Care Centers in Cooperation with the Ministry of Education

These were first established in 1956-57 and later expanded. The kindergartens and day care centers were categorized as training services.

5. Sheltered Workshops ("Ma'as")

In 1961, two A.K.I.M. workshops were operating, employing approximately 50 retarded people. In 1972, Israel was home to 31 "Ma'as" workshops employing 929 retarded individuals. Most of the new "Ma'as" workshops were constructed according to a program built to suit the space and buildings available. With the help of the Israeli Lottery, "Ma'as" projects were constructed all over the country.

6. Home Care for the Retarded

In 1972, the Ministry of Welfare was providing home care for 396 families with retarded members, as opposed to a mere 60 families in 1962. Home care included assistance at home and financial support for special needs.

7. Legislation

A number of significant laws and amendments were passed:

(a) The Residential Home Supervision Law, 1965, which defined residential homes for the retarded and determined the Ministry's authority to amend the law. Residential homes were required to give official notice on housing a retarded child, and the issue of residential licenses was regulated. In effect, this law constitutes the supervisional framework for all boarding homes under the auspices of the Ministry. Amendments were later extended to regulate care inside the homes.

(b) The Welfare Law (Care for the Retarded), 1969, requiring homes to provide services for the retarded. The law presented a definition of the term "retarded", which included as a parameter not only intellectual ability, but also physical disability and dysfunctional social behavior. The law required that a physician or special welfare official be notified concerning the existence of a retarded individual. Cross-professional diagnosis and the need for diagnosis were defined as crucial factors in the treatment process (Schwartz, 1982; Ministry of Labor and Welfare, 1979), Although the law did not explicitly obligate the

government and municipalities to provide services for the retarded, this was regulated by an accompanying ministerial ordinance.

(c) A 1975 amendment to the Welfare Law defined the authorities' reaction to criminal acts committed by retarded individuals (second amendment).

(d) Amendments to the law presented a detailed description of the legal agreement between the family of a retarded individual, the Ministry of Welfare and the municipality in case of placement in residential care (Agreement upon Residential Placement as a Result of Mental Retardation, 24.8.1965).

8. Professional Training

In 1968, a first yearly certificate-granting course for care givers was opened. The course offered partially in-service situations, providing both veteran and inexperienced workers with professional training. In-service courses were opened for home counselors, nurses and social workers, as well as for "Ma'as" and day care center workers.

The Ministry invested heavily during this period in the development of professional and para-professional personnel.

In summary, the number of retarded individuals in Israel benefiting from services grew from 1,524 in 1962 to a total of 5,232 in 1972. This does not include an additional 3,700 individuals diagnosed at diagnostic centers throughout Israel (see Table 1).

Cross-professional treatment was accentuated and social awareness of the need to educate and care for the retarded grew.[3]

Dr. Moshe Kurtz, director of the Ministry of Welfare at the time, wrote the following in summation of the decade under discussion:

> It is as of yet impossible to speak of summarizing, or concluding; our efforts have just begun and they are constantly developing: the road lies before us, I can say even that we stand at its very beginning; what has been done until now is not sufficient, nor is it satisfactory. Yet considering the intense complexities confronting us as the result of dramatic social developments in Israel, and due to the unique roles and goals of our young community - complexities which have become more focused in the last generation - considering this, even the most stringent of judges will admit that every possible effort has been made to remain on guard regarding the retarded community; that we have strived so far to observe, learn and apply in an attempt to draw nearer to the achievements of modern societies worldwide;

3. Bibliography on welfare services during the first two periods appears in Ganiger (1968b).

Table 1. The Development of Residential Services

Year	1962	1972	1977	1985	1994
Governmental	695 (5)	1,338 (5)	2,797 (11)	2,807 (11)	2,181 (9)
Public		493 (9)	292 (10)	547 (27)	871
Community Housing	469 (7)	36 (1)	51 (2)	286 (23)	950
Private		1,327 (17)	912 (20)	1,461 (30)	2,187
Family		70 (7)	48 (6)	58 (7)	
Foster Care		179	160	143	250
Other		40			
Total	1,164	3,483	4,260	5,302	6,439

Note: The figures in brackets signify the number of institutions and the figures with no brackets signify the number of residents.

> that we have fought to live up to the age-old Jewish tradition of caring for the weak and helpless. Let us persist in our endeavor to assist these people, with the help of additional factors; and with God's help, we can and will succeed (Kurtz, 1975, p. 502).

Reorganization and Formulation of Ideology, 1977-1985

1. The Background

In 1972, a special committee was charged with reorganizing welfare services for the retarded in an operative unit with autonomy in matters of budgeting and personnel management. Providing the retarded population with multi, integrated services demanded more administrative independence, as did additional changes being planned at the time.[4] The committee proposed to transfer authority from various divisions in the Ministry to a new, senior, autonomous department, which began operating in 1978.

In effect, only responsibility for personnel management was transferred to the new division. Administration, finance, professional training and construction all remained under the authority of the various Ministry departments, who expressed opposition to the transfer idea (Hovav, 1987).

The reorganization occurred after a number of committees reported dissatisfaction with the Service's level of functioning. Parents of retarded

4. Ministerial autonomy involves independence in personnel management and financing. An autonomous division is usually less dependent in these matters on other divisions in the Ministry.

children, represented largely by A.K.I.M., were also pressing for a revolution in the organizational approach.

In January 1976, the director of the Ministry of Welfare appointed a committee to examine private residential homes. The committee was to write a report which could potentially effect change in the system. An important outcome of the report was the adoption of a declaration concerning the rights of the mentally retarded. The report emphasized the following tasks: furthering the education and treatment of retarded individuals in order to allow them to reach their full potential; referring retarded individuals with suitable mental abilities to employment and vocational training services; and developing medical and para-medical services. An A.K.I.M. member of the committee was crucial in the formulation of these recommendations (Ministry of Welfare, 1976).

The committee recommended that cooperation between parents, homes and the division for the retarded be enhanced. The committee further recommended to simplify selection and placement processes and to centralize placement; to develop productive employment possibilities; to conduct a careful examination of manpower needs and the ways to train retarded individuals accordingly; to advance treatment facilities; to make parents active partners in residential processes; and to tighten supervision on private homes.

While the committee was writing its report, Bank Mikelson visited Israel. Mikelson headed welfare services for the retarded in Denmark and was known worldwide for his efforts to reach normalization of care for the retarded and for his call to move the focus of care from residential solutions to community services. In a comprehensive report published in 1977, Mikelson protested the situation in Israel and suggested a number of ways to improve welfare services for the retarded. He spoke of abandoning the original construction plan accommodating 432 people per home, claiming that this figure was far too high to allow for adequate treatment. He also considered the Dimona and Hevrat Ne'urim homes to be inappropriately distanced from normal community centers. He urged the Division to more effectively cooperate with the various educational, health and welfare services and recommended the establishment of a special governmental bureau to deal with retardation and physical disability. He encouraged building up the role of the municipalities in providing services for the retarded, developing alternatives to residential treatment, and working to return care for the retarded to the community.

Mikelson emphasized the importance of developing the professionalism of home workers; raising the number of workers per resident; raising the workers' status; and encouraging volunteer work. He pointed out the need to educate the

public concerning mental retardation and methods of treatment. Mikelson also recommended that home administrators and other senior workers in the Division study the work being done abroad and bring their conclusions back home.

As a result of the committee's and Mikelson's work, the A.K.I.M. Center prepared three reports in 1976-1977. The first was intended for members of the Knesset (Israel's Parliament), in anticipation of the upcoming elections. The second presented data on existing services and points for improvement. The third report analyzed Division work in 1976-77 (Hovav, 1987).

Examination of welfare services for the retarded in Israel uncovered the following primary defects: treatment was outdated and lacked long-term planning; resources were more heavily channeled towards residential care than towards community care; residential homes were large and physically inadequate; there existed a clear preference for residential solutions over community care; residential homes housed the retarded, but did little to educate or rehabilitate them; personnel was not sufficiently professional; the law of mandatory education did not apply in homes for the retarded; and coordination with the Ministry of Health was flawed. Municipal authorities and the community were not sufficiently aware of their role in caring for the retarded (see Aharoni, 1989, chapters 5-7).

Undoubtedly, the call for reorganization in Israel had its seeds in revolutionary trends worldwide. These included enhanced public involvement in care for the retarded; transfer of individuals receiving residential care to community services, through use of health and social security resources; normalization and integration of the retarded in community services; and a move towards individualized care with special emphasis on recreational and vocational needs.

2. The Reorganization Process

The reorganization process, which stretched from 1977 to 1980, set the following objectives: analysis of the existing situation in order to uncover the system's flaws; preparation of a long-term master plan; creation of a united working front comprised of the Division's senior staff and home administrators; building an organizational infrastructure which would encourage improved administration and cooperation with other services and with parents (in the form of individuals, parent committees and the A.K.I.M. Center).

As part of the reorganization process, cooperative workshops were conducted on various levels in the Division. Meetings were held with the Special Education Department in the Ministry of Education, and the newly

organized Division was encouraged to cooperate with other services in the Ministry of Labor and Social Affairs. It is important to note that the reorganization had the full backing of the Ministry administration.

Major defects of all systems were analyzed (Hovav, 1987), and a long-term working plan was prepared (Ministry of Labor and Social Affairs, 1978; Avisar, 1979a), Improvement was apparent in the following areas.

(1) The Division clearly defined its target population (Ministry of Labor and Social Affairs, 1979; Schwartz, 1982).

(2) A community-oriented approach encouraging development of community services was adopted (Ramot, 1979, 1986; Portowitz and Rimerman, 1983).

(3) Information concerning retardation in Israel was gathered for purposes of analysis and long-term planning (Henrietta Szold Institute, 1985; 1990).

(4) Supervision of residential homes was tightened; poorly functioning private homes were closed and replaced by newer, improved homes. Requests for placement grew in number due to improved conditions (Hovav, 1986; Nadan, 1978).

(5) Ministerial cooperation was enhanced in an attempt to formulate policy concerning criminal acts committed by retarded individuals and concerning mandatory education for the retarded.

(6) Laws were passed concerning guardianship, disability allowance, marriage, and payment for productive employment.

(7) Emphasis was placed on educating the public.

(8) Administrative reorganization was achieved.

After the major defects were defined and the process of reorganization completed, the Division set five primary goals, in accordance with the Welfare Law (Law Regulating Care for the Retarded), 1969:

- Caring for and rehabilitating members of the retarded population in Israel;
- Providing services for families with retarded members;
- Gathering and training personnel for working with the retarded;
- Locating retarded populations with special needs;
- Prevention of retardation.

The goals were then broken down into specific objectives and operative goals (Ministry of Labor and Social Affairs, Division for Welfare Services for the Retarded, 1979), In addition, options for applying normalization, integration and individualization were examined (Ramot, 1979).

The following changes took place as a result of the newly formed Division policy:

- Similarly to other categories of disabled individuals, the mentally retarded now came under the authority of the Social Security Rehabilitation Division.

- A special unit formed as part of the Division for Treatment Programs and presented a number of programs geared to individualistic treatment.
- Community housing was expanded.
- Attempts were made to transfer individuals placed in residential homes back to the community.
- Emphasis was placed on sex education (Avisar, 1979b).
- Efforts were made to develop productive employment opportunities (Ben-Ari and Ramot, 1984).
- Emphasis was placed on the rights of the retarded community.
- Voluntary and parent organizations were encouraged to play a more active role in caring for the retarded, as were universities throughout Israel.

3. Primary Areas of Change

During this period, Israel exposed itself to substantial external influence and made an active attempt to experiment with innovative ideas. Universities became involved in research and development programs; for example, a Research Center for Human Rehabilitation and Development was established in Haifa University, in conjunction with the Philadelphia University Rehabilitation Center (Ganigar, 1981), Bar Ilan University in Ramat Gan (near Tel-Aviv) founded a Program for Developmental Disabilities.

- Community services, and especially community housing, were expanded (see table) (Ramot, 1986).
- Opportunities for productive employment were developed.
- Emphasis was placed on the development of recreation opportunities (Reiter and Levi, 1980).
- Emphasis was placed on the sexual needs of the retarded population.
- The rights of the retarded community were stressed.
- Residential homes improved in the following ways:
- Homes continued to undergo a process of internal improvement and development (see table 1 above).
- The Division enhanced cooperation with parent committees and the A.K.I.M. Center in planning and executing the 30% disability allowance fund.
- Poorly functioning homes were closed and replaced by new improved homes.
- Training programs were expanded.
- The law of mandatory education was extended to include residential homes for the retarded.
- Senior staff members received training in institutional personnel management. Cooperation between senior staff members and workers' committees was encouraged.

- Emphasis was placed on gathering data and on writing master and treatmental plans (Avisar, 1979a).
- Resources external to the Ministry were secured: For instance, the Leman Fund; the Joint Distribution Committee (Gross, 1985); the Municipalities Fund (currently known as the Shalem Fund); and the Guardian General. Volunteering was encouraged.
- A large number of Division and university publications were published during this period (Aviad, 1983; Ben-Ari et al., 1986; Ben-Atar, 1981; Pienski, 1982; Zeider, 1984; Lipschitz, 1983; Sofrin, 1981; Aminadav, 1986; Planitzki, 1980; Kenig, 1985; Shalev, 1983; Viden, 1980; Rimerman, Reiter and Hovav, 1986).

The desire to analyze and solve core defects in the system is characteristic of this period. These objectives were achieved by clarification of theoretical issues, physical development, additional acceptance towards organizations inside Israel and abroad, cooperation with parents of retarded children, and by administrative reorganization and new initiative. Professional administrators, the academic world and parents united to accomplish common goals.

Development and Expansion, 1985-1994

1. General Policy

In 1986, the Division was renamed the Division for the Welfare of the Mentally Retarded and in 1993 it was renamed again: the Division for the Care of Mentally Retarded Persons. The change in name was accompanied by a changing conceptualization of the Division's target population, now more widely defined. For instance, the Division now stressed that it was responsible for retarded individuals ranging from infancy to advanced maturity. The Ministry also officially stated that its responsibility was not only towards the retarded, but also towards their families.

A report written up by the Legislative Committee for Individuals with Mental Retardation - better known as the Professor Shnit Committee - made a major contribution to policy formation in the Ministry. The report dealt with the following issues (Israel Joint Distribution Committee, 1993):

(a) The definition of mental retardation.
(b) The use of birth prevention and sterilization.
(c) Housing for the mentally retarded.
(d) Education.
(e) Employment.
(f) Recreation.

Assisted by the J.D.C., the committee published its recommendations in 1993. Although they were but partially adopted, these recommendations lay the

foundations for policy formulation in the 90s, especially in the area of employment.

Towards the beginning of 1993, Mrs.Ora Namir became Minister of Labor and Social Affairs, and a turnover occurred in the Division's senior staff. During this period, the Division came out with a clear policy concerning a number of issues:

(a) The waiting list for residential homes would be abolished. This would lead to a situation of more offer than demand, which in turn would allow families to pick and choose the home best suited for their children and would generate competition between homes.

(b) Community services would be improved upon, encouraging parents to leave their retarded children in the care of the community for as long as possible.

(c) The municipalities would assume responsibility for community housing, placement in residential homes and diagnosis.

2. Community Housing

The Division encourages community housing in normal community environments. Housing units are built to both suit the tenants' special needs and give the feeling of a home atmosphere. In 1994, the Division redefined the population intended for community housing, describing it as any person who may benefit from living as part of the community.

This definition excluded retarded people with extreme behavioral dysfunctioning, for professional reasons, and those in need of chronic care, for both professional and financial reasons. The decision to bar community housing from these populations aroused considerable opposition among professionals and parents.

In 1993, 598 retarded people were benefiting from community housing; this number rose to 950 in 1994, and a 1995 report to the Minister of Labor and Social Affairs predicted that by the end of the same year, 1,150 retarded individuals would be living in the community. Investment in community housing eased the demand for placement in residential homes.

In the early 1990s' the Division located more than 500 retarded people suitable for community housing and then removed approximately 160 from residential environments to community housing.

3. Employment

During this period, the Division reformulated its employment policy, although changes had been occurring prior to 1985. New models of employment were opened for the retarded, initiated by local organizations (the Jerusalem-

centered "Elwyn" organization and the "Chimes" organization in Tel-Aviv) and supported by social security.

The goal was to create a wider spectrum of employment options, while emphasizing the ends of the spectrum: on the one hand - day care centers, and on the other, group and individual placement in jobs in the free market.

In 1993, 1,948 retarded people were employed in "Ma'as" workshops and 245 people held positions in the free market; in 1994 "Ma'as" employees numbered 2,293, and an additional 356 retarded individuals were employed in the free market (Ministry of Labor and Social Affairs, 1995).

4. Diagnosis

During this period, the field of diagnosis moved towards professional flexibility. The second amendment to the Law for the Welfare of the Retarded, 1975, determined a three-year interval between two diagnoses. The Division now set more realistic, flexible intervals: a 21-year-old retarded person would undergo more diagnoses than a 40-year-old; from the age of 18, vocational evaluation would be the focal point of diagnosis, under the assumption that at 21 the youth would leave school and enter the work market if able. Diagnosis committees were reorganized so that at the end of 1994, five fully staffed diagnosis committees were operating in Israel.

In 1993, 300 new diagnoses and 180 repeat diagnoses were conducted. These numbers rose to 800 and 400 in 1994, respectively, and were expected to stand at 800 and 1,000 in 1995 (Ministry of Labor and Social Affairs, 1995).

The approach during this period required that responsibility for diagnosis be transferred to external organizations by means of a tender and not kept within existing frameworks. The result was a wider range of diagnosis options (mainly the diagnosis committees as defined by law) and wider distribution throughout the country. A Diagnosis and Promotion Unit was established as part of the Division, for administrative purposes.

5. Residential Homes

Policy at this time prevented the opening of large homes. A number of private residential homes were opened, each housing a maximum of 120 people. In 1993, 5,171 retarded individuals were being treated in homes; this number rose to 5,242 in 1994 and according to prediction, approximately 5,500 would be residing in homes for the retarded in 1995. As the alternative for community housing gains popularity, residential homes find themselves with more and more empty spots.

Special attention was devoted to the following three issues:

(a) Physical accommodations: Existing structures were renovated and expanded. Standards were set for furnishing, clothing and equipment, and the ratio of one worker to twelve residents was reduced to a ratio of one to ten.
(b) Setting of supervisional standards, to which the J.D.C.'s Brookdale Institute was partner.

In 1988, "Elwyn", a Jerusalem-based public organization, assumed responsibility for the government-run Kfar Hashvedi home. The transfer was achieved despite objections of the workers' union and its political representation. Shortly after, a second home, "Bnei Zion", was transferred from governmental to private hands. Additional, though unsuccessful, similar attempts were made later.

6. Community Services

In order to enable families to keep retarded members at home, emphasis was placed on developing community support services. For instance, an increasing number of day-care centers remain open until six o'clock in the afternoon. Another example is the weekend and holiday service, which allows parents to leave a retarded child in a professional care center for a period of fifteen days a year. Alternative settings for children under 3 exist as well. In certain cases, the weekend and holiday services allow children to remain up to forty five days a year. In 1993, 3,000 children benefited from this service; this number rose to 5,000 in 1994, and the predicted figure for 1995 is a total of 6,000 children.

7. Interactions between Residential Homes and the Community

An important tendency during this period is the attempt to blur the distinction between residential and community care. This involves opening residential home services to the community at large and allowing home residents to take part in community services.

The most outstanding operation of this kind is taking place in the city of Herzeliya, where professional interaction between the local community and the experienced Levtzeler Home is being cultivated.

8. The Role of Parents and Family

During this period, the role of parents and family in caring for retarded members was again stressed, and especially the role of family in cases of residential care.

Parent involvement was encouraged on all organizational levels: the individual level, the level of parent committees, and on the level of Israel's umbrella parent organization.

The supportive role of family in cases of community care was discussed as well.

Summary

Welfare for the retarded person in Israel underwent significant change since 1948. The following points sum up the major changes:

(a) Organizational change: The system moved from inclusion in the Child and Adolescent Welfare Service to the status of senior Division in the Ministry. Reorganization reflected a growing understanding of the urgency to provide quality services for the retarded.

(b) Welfare services for the retarded and their families grew and expanded. This held true for residential care, community housing, support systems for the family, and educational settings in cooperation with the Ministry of Education.

(c) Parental organization grew and parents became actively involved in treatment.

(d) Residential treatment shifted from a budget-oriented approach to a professional-oriented approach, reflected in the move to smaller residential settings.

(e) Public and private factors became gradually more involved in residential care and in diagnosis, shifting the center of responsibility away from governmental factors.

(f) Community housing was developed and normalized as an alternative to residential care. Municipalities became more actively involved in caring for the retarded.

(g) Legislation in the areas of residential care, diagnosis and policy regarding criminal acts.

(h) The free market was opened as an employment option for the retarded, and emphasis was placed on productivity in sheltered settings.

(i) Mental retardation became the subject of academic research and instruction.

(j) Israel exposed itself to influence from abroad and became involved in a process of worldwide cooperation and exchange of ideas.

(k) The early view of retardation conceptualized retarded individuals as children, reflected in the inclusion of welfare for the retarded in the Child and Adolescent Welfare Service. Over the years, the retarded came to be viewed as people; this was reflected in the separation of services for the retarded and in a new definition of retardation: the retarded were no longer defined in terms of mental age, but in terms of individual functioning and social adaptability.

Welfare services for the retarded have developed considerably since the establishment of the state of Israel. Yet the discrepancy between goal and

reality still exists. The Israeli administrative mechanism is still challenged by the need to adapt to swiftly changing ideologies and trends.

In the future, Israel will be called upon to deal with more integration in the community, more individualized treatment, and more technology-aided education. Care for the retarded will continue to grow more professional and a theory of mental retardation will emerge as the result of research efforts. Israel now faces two main challenges: to keep up with these universal tendencies, and to maintain its unique humanistic approach to caring for the retarded population.

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LIST OF PARTICIPANTS

Zippi Amit	Faculty of Management, University of Tel Aviv, Tel Aviv, Israel.
Dov Chernichovski	Ben Gurion University of the Negev, Be'er Sheva, Israel, and the National Bureau of Economic Research, USA.
Abraham Doron	The Paul Baerwald School of Social Work, the Hebrew University of Jerusalem, Jerusalem. Israel.
Tami Eliav	Research and Planning Administration, The National Insurance Institute, Jerusalem, Israel.
Tali Etgar	Elem - Youth in Distress in Israel, Jerusalem, Israel.
Dalia Gordon	Research and Planning Administration, The National Insurance Institute, Jerusalem, Israel.
Charles W. Greenbaum	The Martin and Vivian Levin Center for the Normal and Psychopathological Development of the Child and Adolescent, the Department of Psychology, the Hebrew University of Jerusalem, Jerusalem. Israel.
Meir Hovav	Ministry of Labor and Social Affairs, Jerusalem, Israel.
Joseph Katan	The Bob Shapel School of Social Work, Tel Aviv University, Tel Aviv, Israel, and the Center for Social Policy Studies in Israel, Jerusalem, Israel.
Avi Ramot	JDC - Brookdale Institute of Gerontology and Human Development, Jerusalem, Israel.
Carmel Shalev	Ethics Unit, the Gertner Institute for Health Policy Rsearch in Israel, Tel Hashomer, Israel.