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Israel's Income Support System in a Comparative, Cross-National Perspective • The Impact of the Income Support Law on Social Service Departments: Expectations and Realities • Changes in the Characteristics of Income Support Recipients over a Decade: The Potential for Work • Selected Issues in the Delivery of Home Care Services to the Elderly after a Decade of Implementing Israel's Long-Term Care Insurance Law • A Tough Life for Victims: Crime Victims and the Israeli Justice System • Health Inequality in Israel During the 1990s • Psychosocial Counseling and Preparation for In Vitro Fertilization in Selected Western Countries and in Israel • Organizational Aspects of Coalition Activity in a Social Change Campaign.

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FOREWORD

This is the seventh special English-language edition of *Social Security*. As in the past, this publication includes a number of selected articles published over the last three years in the regular Hebrew language volumes of the journal that have been revised and translated for this English-language edition. *Social Security* deals with a wide range of issues relating to social welfare and social security in Israel and abroad. This scope is reflected in the articles included in this special edition of the journal as it is in the regular issues of *Social Security*. By translating into English articles that appeared recently in the journal in Hebrew, we hope to avail non-Hebrew readers with a better understanding of the issues that are at the forefront of debate and concern in the Israeli welfare state.

Earlier versions of the first three articles in this publication were published in a special issue of *Social Security* devoted in its entirety to the Income Support program, Israel's social assistance scheme. Publication of the issue marked two decades since the Income Support Law was passed in the Knesset, Israel's parliament. The first article, by Abraham Doron and John Gal, examines the Israeli income support system in a comparative cross-national perspective. Data on social assistance programs in other welfare states provides the authors with a useful foundation upon which to examine the Israeli program. Issues such as the degree of coverage, modes of operation, responsibility levels, work incentives, take-up levels, program generosity, the impact of the program on poverty levels, and program costs are discussed in the article. The findings indicate that while the Israeli program has a number of country specific characteristics, the fact that it was enacted after most of the similar programs in other countries were already in operation, enabled it to adopt many of the characteristics prevalent in social assistance schemes in European welfare states, and particularly those in the British program.

A study of the implications of the adoption of the Income Support Law upon local social service departments is presented in an article by Idit Weiss. One of the goals of the law was to separate the provision of financial assistance from that of personal social services, both of which had previously been the responsibility of social workers in local social service offices. Weiss examines the development of the local social welfare services in the two decades since the implementation of the separation process. While she finds that the policy did indeed lead to a change in the socio-demographic profile of the client population

of the social services and enabled social workers to focus more on provision of social treatment and to enhance their level of professionalization, the findings also indicate that financial limitations, a lack of sufficient manpower and an increase in the number of involuntary clients due to new legislation endanger these achievements.

The final article devoted to issues concerning the Income Support Law, by Brenda Morginstin and Miriam Shmelzer, focuses upon the characteristics of the recipients of the program and, in particular, the work potential of members of this group. Morginstin and Shmelzer identify and characterize target groups of income support beneficiaries with the greatest work potential. They find that the 1990s saw major growth and differentiation in the population of Income Support recipients due to employment fluctuation and a mass immigration to Israel. Thus, by 2000, this population had become a large and heterogeneous group comprising immigrants and veteran Israelis, young and old, and conventional as well as single-parent families. The authors discuss the implications of these developments in the context of attempts by decision-makers to introduce a welfare-to-work program.

The Long-Term Care Insurance Law is the subject of an article by Hillel Schmid and Allan Borowski. The authors examine a number of organizational and structural dilemmas concerning this law was first implemented a decade and a half ago. In particular they focus upon issues arising from the policy of contracting out services to nongovernmental organizations, a crucial element in the law. Schmid and Borowski also discuss the status of home care workers, the strategic behavior of service providers, problems related to the monitoring and control of the standard of services, the impact of the law on the institutionalization of the elderly, and the burden of care borne by primary informal caregivers.

The well-being of victims of crime and their treatment by the Israeli justice system is dealt with in an article by Uri Yanay. The author points out that while much attention is devoted to criminal offenders in the Israeli legal system, their victims are not a part of the pubic discourse. Moreover, the physical, mental and financial well-being of victims of crime has not been secured. In most cases, the victims of criminal acts are little more than court witnesses in cases of legal proceedings. Yanay points out that, though victims of crime do have the right to bring a civil suit against the offender, they often do not have the means or the emotional stamina to do so.

A major piece of social legislation dealt with in this issue of *Social Security* is the 1995 National Health Insurance Law, which guarantees universal access

to health services. The law stipulates that every citizen has the right to health insurance regardless of financial ability and it replaced the prior system of income-linked membership of health plans. Amir Shmueli and Revital Gross seek to assess the degree to which the law has indeed made the health system more equitable. They find that equality in access, availability, utilization of services and satisfaction have increased since enactment of the law. However, inequality in adjusted income-related ill health has persisted. The authors' conclusion is that it may be necessary to address directly income-related inequality in order to achieve greater equality in health.

Infertility treatments - one of the components of the health basket in the National Health Insurance Law - and the role of psychosocial counseling are the subject of an article by Ruth Landau. While the volume of In-vitro fertilisation (IVF) is relatively great in Israel and is supported by the state, psychosocial counseling is not considered as vital. Indeed, despite the recommendations of the public-professional committee on IVF and the direction emerging from the legislation on this subject, social workers and psychologists are usually not part of the IVF team. The author notes that this diverges from the dominant trend in other welfare states and suggests that the psychosocial needs of IVF patients in Israel be thoroughly examined and principles concerning the inclusion of psychosocial counseling in the health basket be determined.

The final article in this issue deals with organizational aspects of coalition activity in a campaign seeking social change. It presents the findings of a study that analyzes the participation of 23 voluntary organizations in a campaign coalition which sought to influence the recommendations made by a policy setting commission of experts established to propose tax reform and changes in social security benefits. The campaign was eventually successful and the government announced that it rejected the commission's recommendations. The author of this article, Roni Kaufman, offers an analytical framework to describe the coalition structure and the participation of voluntary organizations in the campaign.

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ISRAEL'S INCOME SUPPORT SYSTEM IN A COMPARATIVE, CROSS-NATIONAL PERSPECTIVE

By Abraham Doron and John Gal*

The article looks at the Israeli income support program, the country's primary safety net, from a comparative perspective. Employing qualitative and quantitative data on social assistance programs in other welfare countries, it examines issues such as the degree of coverage provided by the programs, their mode of operation, the level of responsibility, work incentives, take-up levels, the generosity of the programs, their impact on poverty, and their cost. Despite differences between the various programs, there is much similarity between them. Because of the later implementation of the Israeli program, various characteristics of existing programs could be adopted, and also the number of individuals of the target population not covered by it remained relatively small.

Introduction

The income support system of Israel constitutes the safety net of last resort for ensuring the subsistence of groups suffering from severe hardship who cannot maintain themselves without public support. A safety net consists of financial support for individuals and families who have either no income whatsoever or income that is insufficient to ensure their existence. The assistance provided by the safety net is always contingent upon means testing. All developed countries acknowledge the need for a safety net, and all maintain such systems. However, this is only one of the many programs in the broad-based social security system. In Israel, it is referred to as "income support"; elsewhere, it is known as "public assistance", "social assistance", "welfare payments", or the like.

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Unless otherwise noted, the primary data and findings cited in this article are taken from a cross-national study of income support systems in OECD countries carried out by Eardley and others and published in 1995 (Eardley et al., 1995). This comprehensive survey of income support assistance in all the OECD member countries is based on surveys conducted by local experts in each country and an in-depth, summarizing discussion, which compares the countries and draws general conclusions.

Income support programs take on varied forms in different countries. The manner in which they operate often reflects the historical development of the safety net in that country, relates to the role and importance of these programs within the broader social security system, and to some extent the overall economic-political system of the country (Ditch and Oldfield, 1999). However, the program designed to provide the safety net of last resort reflects not just political decisions about the nature of the welfare state, but to a large extent the macro-economic management of the economy. Hence, the generosity of the system is influenced not just by political decisions, but also by economic constraints.

The role played by the safety net depends, of course, upon the existence of other welfare measures that provide in-kind services to the population or to large parts of it. The availability of universal health care, education, low-cost housing for the disadvantaged, food subsidies, and similar programs have great significance for the role played by the safety net and its effectiveness in addressing the problems of the needy. The provision of cash benefits as income support becomes even more important when other welfare provisions are limited or non-existent. An examination of income support in isolation from other forms of assistance thus provides only a partial picture about the functioning of the safety net to ensure the welfare of needy population groups (Atkinson, 1992; Ditch, 1999).

Despite the differences, safety net systems in various countries are quite similar to each other. The similarity stems from the fact that they address the same problems that beset policymakers as they make decisions about issues related to the provision of means-tested cash assistance. Although a discussion of the political, social, and economic processes that led to adoption of a safety net in various countries would be important and interesting (Bar, 2000), the goal goal here is more modest.

This article examines several key issues that reveal the similarities and differences between safety nets in several welfare states, and compares these with the income support system or safety net employed in Israel.

The main issues examined are: the nature and scope of coverage of the safety net, how the system functions, responsibility for the system on a national level, structured incentives to work, the take-up of income support benefits, the generosity of the system and its effect on poverty, and its cost as a proportion of the Gross Domestic Product. Although these issues will be treated separately below, in practice they are fully integrated and inseparable.

1. Nature and Scope of Coverage

The main issue that every income support program must address relates to the nature of the program and the scope of its coverage: Is the safety net a broad, inclusive program that covers all needy individuals and families, or is it a categorical program with distinct schemes to address different groups separately? If the coverage is accomplished through separate schemes, do these exclude any segments of the population from coverage? Hence, there are two issues here: (a) whether the safety net covers the entire needy population or only part of it; and (b) whether it relates differently to diverse groups within the needy population.

2. How the System Functions

The issue here is how the system operates and how efficient is it in allocating its resources to ensure a safety net for the population in need. Both these issues touch upon administrative efficiency in meeting the goals of providing assistance. The key concern in this context is whether people who are not eligible for income support do in fact receive it; or the converse – those who are eligible are not receiving it. The question is whether such phenomena are the result of incorrect decisions in awarding or rejecting claims.

A related issue concerns the effect of the burden of proof placed on the individual who applies for support, and the cost to the applicant for submitting a claim, as well as the cost to the system for processing the claim and allocating the benefit. The critical concern here is whether the process of application has a built-in deterrent factor, or are individuals given help in applying for support.

The effectiveness of the system as reflected in its administration has an impact on three levels: the willingness of needy individuals to claim benefits; the chances of getting an allowance; and the effect of the safety net as a whole on the well being of population groups in need.

3. Level of National Responsibility

This concerns the issue of who bears responsibility for operating the safety net system – the central government, the local authorities, or a combination of the two. Another aspect is the degree of centralization in operating and supervising the system. This is partly a function of the historical legacy of the evolution of the safety net in each country, and partly of governmental structure. In countries with a federal system or a tradition of strong local authorities, the degree of autonomy and authority of each arm of government holds special significance,

and this is true in particular for programs of income support. Additional political significance accrues to this issue in an age of claims about the failings of "Big Government" and the desire to delegate its tasks to local authorities.

4. Incentives to Work

The issue here is how to maintain the incentives to work within the system. The question is, what level of benefit would suffice to ensure a means of subsistence, but still maintain a gap between the level of income support and the income obtained from low wage employment. Incentives to work are particularly important in circumstances of high unemployment, depressed salaries among unskilled wage-earners, the growth of temporary or part-time jobs, and competition for low-wage jobs with foreign workers, documented or not. Again, the problem is dual: Income support payments close to the level of low wages can create an unemployment trap, i.e., make it not worthwhile to seek work. On the other hand, reducing benefits by the amount of income earned from work, and imposing taxes and social security contributions on such income, or denying the right to services to which income support recipients may be entitled, could create a poverty trap from which it would be very hard to extricate oneself (Evans, 1998).

5. Take-up of Income Support Benefits

Take-up refers to the extent to which people in need of and potentially entitled to income support actually apply for it. Measuring the take-up of these benefits concerns, first and foremost, people in need who are not claiming support. Another dimension concerns people who do apply for support, but for one reason or another did not get the benefits to which they are entitled. Non take-up of benefits is a problem that persists with regard to all kinds of means-based support, but it is of special significance with regard to the safety net because low levels of take-up mean that those eligible will remain at levels of living below an acceptable minimum living standard.

6. The Generosity of the System and its Effect on the Poverty Level

This subject concerns various aspects regarding the level of support and its generosity. One such aspect is whether the level of support is considered sufficient in political terms, i.e., does it appear acceptable to the public and its willingness to sustain it.

Another aspect is whether the current support enables a minimal level of subsistence and meets basic, measurable social needs. Again, the issue is whether the minimum is based on standard of living indices that truly reflect the capacity to fulfill needs. Another concern is whether the amount is sufficient to afford its recipients reasonable participation in the life of their community and prevent their exclusion from it (Veit-Wilson, 1998).

A final pertinent consideration with regard to the generosity of the allowance relates to its effect on the extent of poverty. One of the main objectives of the entire social security system is to prevent economic distress and poverty. Safety net programs are an inseparable part of the social security system. The rationale of the safety net is wholly based on its effectiveness in preventing individuals and their families from falling beneath the poverty line, as defined at the time by the country.

7. Cost of the Safety Net

What are the costs of safety net programs as part of the total social security expenditures and in proportion to the GDP (Gross Domestic Product)? There are wide disparities between countries in the size of their outlay for income support. For most, however, the cost of the safety net programs takes up a relatively small portion of the total outlay on social security. Because of the differences in structure of the safety net in various countries, it is difficult to determine which programs are included in the safety net and to conduct a meaningful cross-national comparison of costs. Nevertheless, this measure can give some notion of the nature of the safety net in various countries and the functions it serves. The comparison is also important in light of the pressure to reduce public spending on social security. Such pressure could have a damaging effect on public willingness to allocate funds to sustain the safety net, and could affect the scope, coverage, and generosity of the system, as well as its efficiency.

These issues will be discussed below, with a view toward exploring the similarities and differences among the eleven countries studied, and Israel, in particular.

Nature and Scope of Coverage

What is the nature and scope of coverage of the income support programs in the different countries? The differences in how countries organize their safety net systems are quite extensive, which makes a cross-national perspective very complex. Few countries operate one inclusive program that covers

all needy individuals and their families. In general, the preference is for separate schemes that focus on specific segments of the population. And yet, most common in a number of European countries is one central, basic program, which constitutes the primary safety net for the entire population, supplemented by several smaller, distinctive schemes, which fill specific functions in the framework of the income support system.

In Britain, for example, the primary, central safety net program is "Income Support Benefits". This is supplemented by two separate schemes, which provide support for specific population groups. These are "Family Credit", intended for working families, and "Job Seekers Allowance", for the unemployed. Income Support is the oldest and broadest of the programs, and replaces the "Supplementary Benefits" program that preceded it. The present program covers all residents over the age of 16 who are not able to work or who work only partially and whose income from work or other sources does not reach the set amount. The "Family Credit" program replaces the former "Family Income Supplement" for working families.

The special role of these specific schemes is to supplement the income of working families with children (both wage earners and the self-employed) with low incomes where at least one parent is employed for a set number of hours a week, and whose total family income does not reach the defined level. "Job Seekers Allowance" is a relatively new program instituted in 1996. The function of this program is to maintain the work incentives for the over-18 unemployed who are capable of working, actively looking for a job, willing to accept any employment offered, and have no income above the defined amount from other sources.

The goal of these three schemes is to provide a safety net for the entire needy population of Britain. In this sense, the existing safety net is fully integrated. Receipt of an allowance from each program is conditioned upon an income or means testing, though the severity of this test varies. The variations in means tests reflect the different objectives of each scheme and its role in the safety net.

Norway also has one central social-economic assistance program that is anchored in the 1991 Social Services Law. This safety net program covers all permanent residents of Norway from age 18 and over who do not have the resources to meet their own basic needs or the needs of those dependent upon them. Assistance seekers who are able to work must be registered in the local employment office and be willing to accept jobs they are offered. In addition

to this central assistance program, Norway has two supplementary, secondary, categorical schemes: Transitional Allowance, intended for single-parent families, and Income Supplements, for those receiving low old-age or disability pensions who have high housing expenses. All the programs are conditioned on means testing.

The safety net in Germany operates in a similar manner. The basic income support program is the "Sozialhilfe", entrenched in federal law. This program provides a system of last resort for ensuring subsistence to all residents of Germany – those who cannot ensure their survival independently, whose family is unable to provide assistance, and in cases in which recipients are not eligible for any social security allowance that would provide for their subsistence. The right to receive an allowance is contingent upon means and work testing. In addition to the "Sozialhilfe", "Arbeitlosenhilfe" is available – a special program of help for the unemployed who exhausted their unemployment benefits or were never entitled to them. This allowance, too, is based on means testing, but one that is somewhat less strict than for the general income support program.

In addition to this model of one central, basic program that provides universal coverage, a number of countries, especially in the Mediterranean basin, use only categorical income support schemes. These are intended for special population groups such as the elderly, the disabled, families with children, or the unemployed. In Italy, for example, there is no national income support program. The existing safety net is based on several categorical income support schemes intended for the elderly or the disabled. In addition, there are local welfare programs run in cooperation with church-based aid agencies and other voluntary organizations. The safety net as it exists covers only some of the population in need, and excludes other groups from coverage. Thus, large numbers of needy people are forced to rely on their families or voluntary welfare agencies for relief (Eardley et al., 1995). Lodemel and Shulte (1992) have called this "an incomplete, differentiated poverty regime", i.e., an incomplete regime that is differential or categorical.

Another form of categorization that can include or exclude segments of the population from safety net coverage is based on criteria of age. The systems in France and Luxembourg, for example, limit eligibility in their main income support programs to individuals aged 25 or 30 or older. Thus, young people in these countries are not protected as the young are in countries with universal income support. In countries like Belgium, Denmark, Finland, and Sweden, on the other hand, unemployed young people are eligible for non-contributory

unemployment benefits, even though these usually amount to less than regular unemployment benefits (Ditch, 1999, p. 126).

In some countries, exclusion from the safety net is accomplished by making eligibility conditional upon criteria of nationality, citizenship, or residency. This carries special meaning for the character of the safety net and the scope of its coverage, especially in light of the policy of free movement among countries of the European Union and increased immigration to the EU from other countries. As a result, several EU countries have made income support conditional upon several years of residence or registered residence in a local authority. The most stringent residency requirements are in France and Luxembourg. In these countries, income support eligibility is conditional upon three years of residence and continuous employment, or residence during ten of the previous twenty years. In contrast with these stringent criteria, some EU countries – Belgium, Germany, Ireland, Italy, Holland, and Portugal – have no residency requirement whatsoever, other than registration in a local authority (Ditch, 1999).

With regard to the nature and scope of coverage, the situation in Israel resembles that of European countries with one basic, central program that constitutes the safety net for the entire population, and several small, categorical programs that fill supplementary, specialized functions. The primary safety net program in Israel is "Income Support", which has been in force since 1982 (Doron and Kramer, 1992, pp. 40-53). One supplementary scheme addresses the specific needs of a single population group. The general "Income Support" program covers all residents over the age of 18 who are unable to work or work only partially, and whose income from work and other sources does not reach the specified level. The separate scheme is for support payments to women and their children who are entitled to alimony payments by a court decision or to child support payments.

Jointly, these two programs are meant to ensure a safety net for the entire needy population in Israel. In this sense, there is full integration of the safety net and no specific groups are excluded. The only ones excluded from the net are those who do not fulfill the requirement of 24 months of continuous residence in Israel, such as foreign workers (Yanay and Borowski, 2000). This residency criterion does not apply to new immigrants who entered Israel under the Law of Return. Receipt of an allowance for both programs is based in all cases on means testing and generally also upon work testing.

How the System Functions

Operating an income support program and providing allowances are very complex tasks. Although scholars who examined these programs found significant country-by-country differences – from how they organize the programs to how they administer them – they did not find any income support program that was simple in its operation. Aspects common to all countries concerned their efficiency and effectiveness with respect to the process of submitting a claim and its handling, systems of payment, mechanisms to prevent abuse of the system or fraud, how to deal with over-payments or erroneous payments, relations with other institutional bodies relevant to operating the program, and how to deal with appeals about claims that were denied, or claimants who regard themselves as harmed by the decision.

1. Submitting and Handling a Claim

In most of the countries studied, an individual must initiate filing a claim. The claimant must appear at the offices of the operating service, fill out a claim, and submit it to the service official. Britain is an exception: the preferred method for filing a claim in Britain is by mailing it. In France and Germany, too, one may file a claim by mail, but the claimant is generally invited for an interview in the service offices. In some countries, an official is required to interview the claimant on the premises of the service or in the claimant's home. In several countries, such as Belgium, the interview is conducted as a welfare investigation by a social worker. Outreach activities meant to encourage or ease the filing of a claim for assistance are carried out in Australia to improve access to the service for the homeless, minority groups, and those living in remote areas.

In most cases, an individual who requests income support must prove his or her identity, age, social security number if relevant, residency status, citizenship, and possibly other information. As part of proving citizenship or permanent residency, a common requirement is proof of the duration of previous residence in the country. In addition, claimants must provide proof of the resources available to them, or the lack thereof. The burden of proof placed on the claimant differs from country to country. In countries that have computerized databases – such as a registry of car ownership – and where income support agencies have access to these, the data can be useful not only to the service, but also to the claimant, as it eases the burden on the individual to provide the required information.

Means testing lies at the heart of the process of each claim for income support. This test presupposes a series of political and administrative decisions about the

resources available to the claimant. These include decisions about who are the household members with whom resources must be shared, and what portion of the resources of other family members should be included in the budget of the household unit applying for support. Other issues relate to types of income and the extent to which they should be taken into consideration in calculating income for determining eligibility, or some forms of income that are disregarded in this respect. With regard to savings or property, for example: Should claimants be expected to exhaust all their savings before becoming eligible, or can they maintain certain amounts without damaging their eligibility for support – what Alcock and Pearson have described as "the savings trap" (1999). Savings of up to £3,000 a couple are disregarded for purposes of determining eligibility in Britain. Savings of £3,000-8,000 will somewhat decrease the amount of the allowance. In Sweden, however, claimants must use up all their savings before becoming eligible for income support.

Countries have different rules about forms of income such as social security allowances. Benefits intended to cover special expenses due to disability or restricted movement are not generally considered income, or are only partially counted as income. In Britain, for example, special pensions to war widows or for holiday grants are not counted. Other pensions, such as reparations to victims of Nazi persecution, are partially counted.

In Israel, as in other countries, the claimant or claimant's spouse must submit the initial application for income support. Claimants are asked to provide comprehensive information that includes personal data about themselves and their spouse, children, work history, current employment, and education. For the means test, each claimant must provide information about their own sources of income and those of their spouse from work or other sources (pension or allowances), and details about savings accounts, property, and vehicle ownership. Claimants are also required to provide a cause for filing a claim and information about other community agencies in whose care they are. All these sources of income are taken into consideration in adjudicating the claim. Not calculated are child allowances, grants to demobilized soldiers, and several other forms of income. Claimants are asked to provide evidence such as bank statements to corroborate the information they provide, and to declare that this information is complete and correct. The information provided by the claimant is crosschecked by the social security system with data from other databases, such as the Ministry of the Interior and the Motor Vehicle Registration Bureau.

2. Forms of Payment

Various methods are used to make income support payments. In most countries, long-term allowances are paid into the bank account of the claimant or made by bank credit. Cash is provided only in cases of one-time payments, emergency payments, or short-term allowances. In several countries, the payment is made by way of vouchers for a defined period, including money orders that can be redeemed on specific dates in the Postal Bank. Some countries continue to make payments by way of a check mailed to the claimant's home. In exceptional cases where there is suspicion of attempted fraud, the claimant is required to show up at the service offices to collect the allowance personally. Most support payments are given for a period of a month, but several countries, such as Ireland, pay weekly, and payments in Britain are biweekly. In Israel, the payment is generally monthly and transferred directly into the bank account of the recipient.

3. Prevention of Abuse

The issue of preventing fraud or abuse of the income support program is high on the agenda of policymakers and officials in many countries. Efforts to prevent abuse stem from the need to ensure that the limited resources available to prevent economic hardship will reach the people and families who are in real need of assistance. Concern over prevention of fraud in the income support program is also a function of the need to maintain political trust and support for the safety net. The danger is that trust may be eroded if abuse of the system becomes widespread.

In some countries, the issue of preventing abuse has recently become the focus of attention and a priority in the political discourse. This discussion inexorably fueled the ongoing debate about the value of the welfare state, and formed part of the critique against it. Britain's Labor government, led by Tony Blair, placed the subject of abuse prevention – "rooting out fraud", as he put it – high on the agenda of its welfare policies. To that end, Blair instituted three strategies: improved detection, more effective deterrence, and better prevention (Department of Social Security, 1998).

The primary method to prevent the payment of support allowances to those ineligible to receive them is the initial screening and means testing. Procedures to prevent payment to those who are ineligible, but are already receiving them include:

- The obligation of the support recipient to report any change in his or her financial situation, and any additional income;
- A routine, periodic check of continued eligibility for support;

- The requirement to re-submit a claim for assistance at set intervals;
- Short-interval checkups to ensure that unemployed recipients of benefits continue to search for work.

Beyond these routine administrative measures, some countries have adopted a more active policy to prevent the abuse of funds. In Australia, for example, advanced technology is employed to locate and crosscheck data about income flow among select groups of support recipients. In other countries, more use is made of the information obtained about income or employment of recipients. In Britain, for example, any information suggesting abuse that reaches the social services offices is investigated. German officials, on the other hand, ignore anonymous tips, and use information obtained only if there is a clear suspicion of fraud. Other countries seek to deter abuse by initiating prosecution of offenders. Japan and Britain take these steps not just to punish the wrongdoers, but primarily to deter potential offenders.

The problem of preventing abuse has also preoccupied the Israeli income support system. In Israel, as elsewhere, routine measures are taken to prevent abuse. So far, data from Israel do not suggest that abuse of the system is a problem that merits special attention. In fact, data about the abuse of unemployment insurance suggest that incidence is particularly low (Toledano, 1996). Measures employed to prevent abuse include periodic comparisons of the information given by recipients with other databases and the requirement that those on long-term assistance submit a yearly declaration. In addition, each local branch of the National Insurance Institute has an investigative unit that monitors eligibility. Even anonymous tips about the abuse of assistance are investigated by this unit.

4. Handling Overpayments

Procedures for recovering overpayments are similar in most countries – most demand the return of overpayments resulting from the claimant's filing of incomplete or inaccurate information. In these cases, collection is usually undertaken by deductions from future payments. Even in these cases, however, deductions are generally made from a small part of the allowance, to avoid undermining the living standard of the recipients. Although overpayments due to administrative errors are supposed to be returned, this is generally not implemented. In Iceland, for example, the rule is not to recover overpayments. In some countries, overpayments can be recovered from the estate of the recipient after his or her death. There is no information available about whether this is actually done. In Israel, too, there are procedures for

processing overpayments. Overpayment due to incorrect information provided by the claimant is generally deducted from other benefits paid to the person.

5. Cooperation between Relevant Agencies

Efficient operation of the safety net requires coordination and cooperation between the agencies involved in providing these services. Above all, coordination is required with the social security institutions in order to determine whether the claimant is eligible for an allowance in an existing program and, if so, to ensure that he or she realizes this right. Coordination is sometimes required with the tax authorities in order to get a full picture of the income and other resources available to the claimant. Cooperation is required with the Employment Service to carry out work testing and to monitor the possibilities of job placement or placement in a training course that will improve the marketable skills of the benefit recipient. Cooperation can also be necessary with health, welfare, and other agencies in the community to get a better understanding of the causes that led the individual into poverty or to deal with the problems of the individual or family in need of the safety net. The more agencies involved in the process, the more difficult the coordination, which can lead to inefficient functioning of the system. Coordination problems appear in the income support systems of many countries (Weiss, 2000. Reprinted in this issue of *Social Security*). Lack of coordination among agencies often causes delays in providing assistance, duplication, and an increased burden of proof on the individual, who is sometimes asked to provide similar proof from several agencies, which may lead to conflicting interpretations. The direct and indirect harm caused by such lack of coordination falls not just on the individual filing a claim, but on the entire system, increasing the cost of its operation.

6. Handling Appeals

Major differences exist among the countries with regard to a claimant's right to appeal a decision. Appeal options range from an internal review within the service itself to a quasi-judicial tribunal in the form of appeal committees, ombudsmen, special courts such as Labor Courts, and even the regular legal system. In some countries, the number of appeals is high and it increased during the 1990s. This is true, for example, of Canada, where a period of budget cuts made it more difficult to get assistance. In other countries – Finland and Switzerland, for example – there are few appeals, perhaps

due to the lack of faith in the structure and operation of the appeal system. Some countries, including Germany, Belgium, and Holland, expanded the appeal options to special courts or the regular legal system, in acknowledgement of the advantages of ordinary courts in matters of justice.

In most countries, filing an appeal, even to a special court, does not usually incur any costs with the exception of appeals to a regular court. Some countries make available legal aid to those filing an appeal to the various authorities. In Israel, a claimant who feels that his or her case was dealt with in an improper way has the right to appeal to the Labor Court.

Level of National Responsibility

Systems of income support in various countries can be structured according to a centralized, integrative model or a decentralized, local model (Alcock, 1996, pp. 192-195). The centralized model takes the form of a nationwide system of income support integrated with the broader social security system. In this system, the procedures, eligibility criteria, and the amount of allowance are uniform throughout the country, and governed by policy set by the national government. Funding comes from the central government.

Responsibility for the decentralized model of income support is characteristically borne by the regional or local authority, and its integration with the national social security system is more tenuous. In this system, the procedures, eligibility criteria, and amount of allowance can differ based on local circumstances in the absence of a uniform, national policy that defines the functioning of the safety net throughout the country. Funding of the decentralized system comes from the local authority or is shared between the local and national authorities.

These are the two models in their pure form. Each has its advantages and disadvantages, and the choice of which to use reflects the historical development of the safety net in each country, as well as political preferences and values. Many hybrid variants exist that combine elements of both.

Countries with a federal structure, such as the United States, Canada, or Germany, tend to have decentralized models of income support, with responsibility divided between regional and local authorities. Not all federal systems employ this model, however. Australia, for example, adopted the centralized, integrative model despite its federal structure. On the other hand, some countries with a unified governmental structure, such as Norway, Finland, and Sweden, have decentralized, localized systems.

Britain is a clear case in which the safety net reflects the centralized, integrative structure. In Britain, income support policy is integrated with overall welfare and social security policies, all of which are set by the Department of Social Security and implemented by a nationwide Benefits Agency. The Benefits Agency, which is responsible for implementing social security payments, including social insurance and other benefits, is also responsible for paying the income support allowances throughout the country. The Benefits Agency maintains a network of regional branches, which uniformly implement safety net payments throughout Britain.

The systems in Sweden and Finland, on the other hand, take the form of the local, decentralized model. The Social Welfare Ministry in the Finnish central government was originally supposed to set the general policy guidelines for income support regarding eligibility criteria and payment procedures. In the 1990s, however, these general guidelines were partially cancelled by the local authorities, which were then charged with implementing the policy. Hence, the local level retained a great deal of discretion and freedom to act. The burden of funding the income support program is divided between the central and local governments. Major differences exist in the safety net available to the needy population in different local authorities because of policy differences and the economic capacity of each local government. As a result, some local authorities are more lenient than others in awarding income support.

Although in Sweden income support policies are set by national legislation, in practice they are implemented at the local level. The decisions that determine the eligibility criteria and the amount of support are made by the local authorities under the general guidance and guidelines of national policy. Within the national guidelines, however, local authorities retain considerable discretion and freedom to maneuver. The local authorities bear the brunt of income support programs, which are funded by local income taxes. In both Sweden and Finland, a price is clearly paid for implementing the income support programs at the local level, as there is only loose integration with the broader system of social security. The lack of integration leads to higher administrative costs as a result of duplication, lack of uniformity, and delays in processing claims. The advantage that these and other countries see in the decentralized model is the capacity to integrate the functions of the safety net with the personal social services, thereby ensuring individual treatment by social workers. In addition, the Swedish authorities regard local control of income support as an important way to oversee the public expenditures related to this support (OECD, Vol. 1, 1998, p. 109).

The more extreme case of the local, decentralized model exists in Switzerland. Although there, too, countrywide guidelines outline the principles of income support, implementation is entirely in the hands of the 26 cantons. Furthermore, responsibility within the cantons is entrusted to the lowest level of local government. As a result, more than 3,000 different income support programs operate in Switzerland, equal to the number of local authorities. The source of funding for these programs is also the local authority. As a result of the joint canton-local responsibility, complex rules of local residency evolved to determine the responsibility of each canton in bearing the costs of income support for its residents. In parallel, a complicated system of inter-cantonal accounting developed to cover the cost of aid to people who move from one canton to another.

The problem of most countries that employ the local, decentralized model of income support – among them Austria, Italy, France, and Spain, in addition to those already mentioned – is that the demand for support is highest in regions and on authorities least able to bear the costs. This quandary does not contribute to closing the gaps between regions or enhancing social cohesion. It is also a factor in the internal political tension in some of the countries.

By contrast, Israel abandoned the local, decentralized model in the early 1980s and adopted an integrated, centralized model. The Israeli safety net is anchored in the Income Support Law of 1980 and is implemented by the National Insurance Institute. The Institute is also responsible for running the entire social security system. Income support allowances are provided in accordance with uniform, national rules throughout the entire country by local branches of the National Insurance Institute. This avoids the political and social tensions that are inevitable when operating the safety net according to a local, decentralized model.

Incentives to Work

In all countries, income support policies are motivated by a desire to encourage integration of recipients of these allowances into the workforce and thereby end their dependence on the safety net. Therefore, the first rule in most countries is to ascertain the work and employment capacity of the claimant as a condition for receiving income support. This means the claimant is obligated to show up and register as a jobseeker in the Employment Service, thereby ensuring that he or she is actively searching for work. In addition to relying on this measure, all countries expect that those applying for support will do their best to find work in every way available. Usually exempt from the work test are those suffering from

disabilities that limit their ability to work, those over or approaching retirement age, and single parents with young children.

In most countries, income support recipients who do not meet the work requirement in the periodic review of their cases can expect the application of sanctions – which range from complete loss of the right to benefits to suspension of the allowance for a defined period. Another type of sanction recently adopted in the United States as part of the new "welfare-to-work" legislation is a time quota, which limits the total length of time throughout one's life that an individual is entitled to receive income support (Doron, 2000). Apart from the punitive sanctions, some countries award positive benefits to help people return to work, become self-employed, or become small business owners. Most of these come in the form of a supplement to the benefit payment, extension of the allowance period, small grants, and loans for developing a small business.

The governments of many countries have also instituted policies that seek to actively help people leave income support by enhancing their job-seeking and marketable skills. One policy adopted in Israel is a program that encourages income support recipients to upgrade their education, or participate in vocational training courses to broaden their range of opportunities for integrating into the workforce (Katan, 2000).

An important element in maintaining the incentive to work while receiving income support relates to the level of these allowances, i.e., what is the earnings replacement rate provided by the income support payment? Support payments that are close to the level of wages for jobs typically held by the recipients may reduce the incentive to find a job and break out of the income support cycle. Yet research data suggest that recipients of income support generally want to work and break out of the cycle. Most people are unaware of the earnings replacement rates of the allowances they receive. In fact, people want to find work because it improves their social status, satisfies the social need to be employed, and also expands their opportunities for social contacts (OECD, 1998).

The issue of incentives is also related to other benefits, financial or in-kind, that countries provide to income support recipients as part of the safety net. These include rent support, medical help or assistance in covering medical expenses, reductions in local authority taxes, property tax and other direct taxes, discounts for the use of public transport, the provision of school supplies for children, and other. In Britain, for example, benefits include allowances for heating in the winter, free school lunches for children, educational services, milk and vitamins to pregnant women and young children, and free prescriptions, eyeglasses, and dental work. For those with a limited capacity to earn a living, going to

work, when it involves the loss of these benefits, may create disincentives, as low salaries do not compensate for their loss (McKay and Rowlingson, 1999, pp. 165-181). Research indicates, however, that few are aware of the practical meaning of such negative incentives (Marsh and McKay, 1993; Bryson and Marsh, 1996).

In most countries, income-support recipients who also take up some paid work are allowed to retain part of the wages they earn. In other words, the net income that recipients earn at work is not entirely deducted from the allowance they receive. The usual method is through "disregarding" job-related expenses, such as the cost of transportation to and from work, or union dues. In other words, the deduction from the income-support allowance is less than 100%, because a full deduction would create a negative incentive to work, thereby creating a poverty trap.

It has been found that the more generous the income support payment – meaning that the earnings replacement rate is also higher – the stricter the means test and the greater the deduction of earnings from the allowance. Scandinavian countries provide very high levels of income support allowances: In Sweden and Finland, for example, income support for a couple with two children, including a grant for housing, reaches the average wage level (99% and 98%, respectively – OECD, 1998). However, these countries also employ very rigorous means testing, and almost no form of income is exempt in calculating the allowance (Eardley et al., 1995; Ditch, 1999).

Incentives to work in Israel resemble those of other countries (Gal and Doron, 2000). Work testing is conducted upon application for support, and repeated periodically. Means testing is carried out with similar frequency. In theory, income support legislation allows recipients to retain some of their income from work after deducting work-related expenses. In practice, however, this is more complex as the law sets a relatively low ceiling of total income that is allowed within the safety net. This ceiling actually prevents a great many people from retaining some of their wages (Gal and Doron, 2000). Thus, in Israel, too, it is hard to escape the problems of negative work incentives that permeate the income support system.

Take-up of Income Support Benefits

One important criterion of the effectiveness of the entire safety net is the scope of take-up – the extent to which people for whom it is intended actually exercise their right to income support (Craig, 1991; Atkinson, 1995). Take-

up is generally very high and approaches 100% for social security programs based on social insurance principles or non-contributory programs in which the eligibility criteria are clear and simple – such as age, marital status, or the demographic characteristics of the claimant. On the other hand, take-up of benefits based on means testing or income is generally lower: Some of those potentially eligible for support do not take advantage of their rights. A variety of reasons could explain this, such as the lack of, or incorrect, information about one's rights, frequent changes in the eligibility criteria, the reluctance some feel to ask for such help because of the need to prove hardship, or bureaucratic procedures that deter people from filing claims. Few evaluations have been carried out about the extent of the potentially eligible population who do not exercise their right to income support, but, in most of these countries, it reaches at least 20% (Van Oorschot, 1995, p. 25).

Despite the significant number of people who do not exercise their right to receive income support, the phenomenon has not been sufficiently studied by scholars or the relevant government bodies in most countries, with the exception of Britain (Corden, 1995). Dutch researcher Wim Van Oorschot asserts that three main factors influence the take-up level: the structure of the allowance, how payments are made, and how the potential claimant responds to these variables. He concludes that lack of take-up of income support becomes problematic when the program contains a long list of complex rules, the eligibility criteria are vague or insufficiently clear, the program is directed toward stigmatized social groups, or the initiative for application is left entirely to the potential claimant (2001).

An additional factor that adversely affects the level of take-up of these rights is the stigma associated with receiving income support. Being unable to support oneself in a society that places a premium on material acquisition and financial independence can foster a sense of inadequacy among those for whom the safety net is intended. The intensity of this feeling differs in each country, of course, but it exists even where income assistance enjoys broad public support and full legitimacy, such as Australia and New Zealand. When income support recipients are identifiable as a distinct social group, they become subject to prejudice and stigma.

In Britain, where considerable attention has been given to the issue of low take-up in safety net programs, improvements have been noted in recent years with regard to income support. This can be attributed partially to improved procedures, higher allowances that made it more attractive to apply for them,

advocacy groups working to increase the take-up of rights, and the effort made to inform and encourage the public to apply for benefits. Another explanation offered for higher take-up rates is the increased number of those earning below the minimum required for subsistence, who have no choice but to apply for an allowance. Despite this, estimates are that, in Britain, the number of families whose income falls below the level ensured by safety net assistance has only grown (Evans, 1998).

Information available in other countries – Austria, Belgium, France, Holland, and Scandinavia – also suggests that they have a problem of potential recipients not exercising their rights to safety net programs, but this has not been studied sufficiently in these countries. Evaluating the lack of take-up is particularly difficult in countries where safety net programs are based on a high level of individual discretion, such as Switzerland and Austria.

Although the problem of low take-up of income support rights presumably exists in Israel as well, here too it has not been the subject of empirical examination by scholars or the National Insurance Institute, which operates the program.

The Generosity of the System and its Effect on the Poverty Level

One of the most important elements in the safety net concerns the level of benefits provided to those in need. The key issue in this context is whether the allowance is sufficient to ensure a minimal subsistence level. The goal of the entire safety net – its focus on those who lack the minimum income required for subsistence and basing the allowance on strict means testing – is measured by whether or not the allowance does indeed ensure a minimal standard and level of living. Another question is whether the allowance is sufficient to raise those who live on it above the poverty line, which is the accepted measure of poverty.

The real level of income support allowances is related to four factors that are closely interrelated:

- The amount of the basic allowance to the single recipient;
- The equivalence scale, which sets the structure of the allowances, i.e., defines the relationship between the amount given to an individual and to families of different sizes, or single parents.
- How the allowance is updated;
- Additional payments for needs not covered by the basic allowance.

Differences in who has responsibility for operating the income support program – from direct national responsibility through regional responsibility, as in the provinces of Canada, the states of the

United States and Germany, and the cantons of Switzerland; to local responsibility – inevitably lead to differences in the level of benefits. And yet, despite the different systems of operation, in more than half of the OECD countries, the amount of the allowance is defined centrally by the national government, in one way or another. Even in countries where the program is decentralized and locally run, but follows national guidelines, differences between the allowance amounts are not great. Only when the responsibility for operation is exclusively local, such as in the United States, can large differences be found in the level of assistance provided. Nevertheless, one can find several similar patterns for setting the amount of benefit.

In some countries, such as Sweden and Finland, the pattern for setting the basic allowance, and the structure of the scale for families of different sizes, are based on family expenditure surveys. The income required for a family to maintain a subsistence level of living according to these surveys serves as the basis for setting the allowance, as this is intended to reflect a community standard of living that is "modest but sufficient". Since the differences in these countries between low-income wages and the median income is small, there is some overlap between this community-based budget and the net income of those earning a low wage. This means that there is little or no difference between the ensured level of income through income support and the potential level of income that can be earned by work.

In other countries, such as Britain and Australia, the level of benefits is not set by expenditure surveys or community standards, as in Scandinavia, which makes it hard to define the community standard of living that is "modest but sufficient". In these countries, differences between low-level wages and the median wage are much larger. The earning replacement rates of income support allowances tend to fall near the bottom of the wage-earning ladder (see Table 1 below). This means that the allowance is a smaller part of the net earnings than in countries where the differences are smaller (OECD, Vol. 1, 1998, pp. 62-64).

Virtually all countries periodically update the level of benefits. In many countries, this takes place annually, usually by linking payments to the Consumer Price Index. In Australia, Sweden, and Finland, the benefit is updated annually by law. In Britain, the law mandates that the minister responsible must update the allowances annually based on price fluctuations. Several countries, such as Belgium, eliminated the cost of cigarettes, alcohol, and gasoline from the price index used to update the allowances. Other countries, such as Japan and Germany, tend to link the update to the expenditures of those in the lower

Table 1. Earnings Replacement Rates of Income Support Allowances as a Proportion of the Average Wage in Various Countries and by Type of Family

	Single Person	Couple + 2 children	Single parent + 2 children
Australia	32.4	60.3	45.0
Finland	42.3	80.1	61.2
Sweden	54.0	82.8	66.6
Britain	46.8	60.3	52.2
Israel[1]	20.0	42.0	47.5
Israel[2]	25.0	49.5	47.5

Source: OECD (1998), Vol. 1, p. 42
Notes: These figures are calculated after deducting the part of the allowance intended to cover housing assistance.
With the exception of Israel, average wage is based on the average wage of a full-time employee in the production sector of the economy.
The average wage in Israel is calculated according to the average wage per employee post as calculated by the National Insurance Institute.
1. Income support allowance at the regular rate.
2. Income support allowance at the increased rate.

quarter or third of the distribution of income scale. Some countries, such as Australia and Denmark, base the update on the wage index in the economy.

Two separate levels of income support exist in Israel – regular and increased rate of allowance. The increased allowance is equivalent to the minimum income assured to recipients of social assistance benefits in 1974, while the regular allowance is set at 80% of the increased allowance. In practice, this means that an individual eligible for increased allowance is paid an amount equivalent to 25% of the average wage, while an individual entitled to a regular allowance is paid an amount equivalent to 20% of the average wage. The higher rate of allowance is intended for those expected to need long-term help, while the regular allowance is intended for those for whom it is reasonable to assume that they will return to the workforce within a short period. A supplement of 50% of the average wage is added for a spouse, and 5% for every child. Income support allowances are updated regularly in Israel according to fluctuations in the average wage.

The increased scope of poverty in industrialized countries also raised the issue of the contribution of income support systems to preventing poverty and extricating individuals from income levels that keep them beneath the poverty

line. The debate revolves around the extent to which the allowances provided in various countries keeps the recipients of income support in economic hardship and poverty. In Scandinavia, the discussion also concerns whether cash assistance alone is sufficient for addressing the needs of a multi-problem family, when inadequate income is just one aspect of their distress. However, the focus of the debate is whether income support systems enable those who live off these allowances to participate reasonably in the life of their community, and prevent their exclusion from it.

7. Cost of the Safety Net

It is difficult to find comprehensive data about the cost of income support in various countries. In countries with the local, decentralized model of income support, these statistics do not exist. In other models, the definitions of what constitutes income support are not uniform, and therefore the data are sometimes not comparable. Thus, as is always the case in cross-national comparisons and national expenditures, with regard to income support, too, it is hard to determine the cost of the safety net in various countries.

Despite these difficulties, Eardley et al. (1995) collected comparative data about the income support expenditure as a percentage of the Gross Domestic Product (GDP), and also the national social security expenditures. Data in this study are based upon estimates provided by the various countries or upon OECD estimates. Estimates from these sources are not always identical. Nevertheless, the comparative data from this research are the best that exist. These are presented in Table 2.

As indicated by Table 2, the cost of safety net programs in most countries is a relatively small portion of the total expenditure on social security programs. In this table, Britain leads both in the proportion of the GDP and the proportion of social security expenditures. This reflects the tendency of Britain and other English-speaking countries to focus on selective, means or income tested benefits, unlike other European countries which emphasize universal non-means tested payment within their social security systems.

Summary and Conclusions

This article sought to examine the safety net program for the needy population in Israel – income support – in light of the characteristics of safety net programs in other welfare states. To that end, we looked at several key issues in these programs. These include the type and extent of coverage, how they operate, the

Table 2. Income Support Cash Expenditures as a Percentage of the GDP and the National Expenditure on Social Security (1992)

	% of GDP[1]	% of National Expenditure on Social Security[2]
Austria	1.2	6.7
Belgium	0.7	3.0
Britain	2.9	33.0
Denmark	1.4	7.8
Finland	0.4	2.1 (1991)
France	1.2	6.4
Germany	1.8	11.9 (1990)
Holland	2.2	10.9
Israel	0.5[3]	5.0[4]
Norway	0.7	4.8
Sweden	0.5	6.7

Source: Eardley et al. (1995), Vol. I, pp. 33-36.

1. The expenditures do not include housing assistance.
2. The expenditures do include housing assistance.
3. Calculations based on data from Kop, 1994, pp. 17-19.
4. Income support out of the total National Insurance Institute expenditures on social security (National Insurance Institute, 1992, p. 21).

centralization or decentralization of the program, incentives to work, constraints on take-up of rights, the generosity of the allowance and its effect on poverty, and the program costs.

An examination of these aspects of income support in various welfare states reveals many similarities among the programs. And yet, in each country, the programs have distinctive features, and reflect diverse ways that each country chose to build its safety net. Differences stem from the specific developments in each country, the concrete problems with which each had to contend, the dominant policy tradition, and the characteristic social and political system of each. Nevertheless, the similar goals and functions of these programs, as well as the cross-national learning that takes place in this field, have led to a surprising resemblance among the income support programs in the welfare states.

Income support was one of the last social security programs to be instituted in the Israeli welfare state, and was put into place after most such systems already existed in other welfare states. This is evident from a number of parameters in the Israeli system. Since most of the social security needs of Israel's population

are covered by insurance or categorical programs not requiring a means test, income support serves as a safety net only for a residual group not eligible for other programs. It is not surprising, therefore, that the cost of this program, in proportion to the expenditure on social security in general, is relatively small. The late adoption of the Israeli program enabled policymakers to learn from the experience of other countries. Thus, in addition to the local factors that shaped this program (Bar, 2000), the Israeli programs sought from the outset to address some of the problems that beset these programs in other countries.

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THE IMPACT OF THE INCOME SUPPORT LAW ON SOCIAL SERVICE DEPARTMENTS: EXPECTATIONS AND REALITIES

By Idit Weiss*

The extent to which the objectives and expectations of policymakers were realized following enactment of the Income Support Law and implementation of the separation policy during the last two decades are examined in the article. After focusing on the debate over separation and clarifying the objectives of policymakers in this field, the author discusses the goals of the separation policy and the anticipated changes in the social welfare departments of municipalities. After the research questions and methods are described, the findings of the study are presented in detail, followed by a final section of conclusions.

Introduction

The 1980 Income Support Law brought about far-reaching changes in personal social services and the social security system in Israel. It culminated a process of separation between the provision of financial assistance and personal social services that was first initiated by municipal social service departments in the early 1970s. On enactment of the law, responsibility for income support shifted from the local departments to the national government, thereby terminating a policy that existed since a social welfare department was first established by the pre-state National Council (Vaad Leumi) in the 1930s, that combined provision of cash benefits with personal social services (Brick, 1982; Doron and Yanay, 1988; Doron and Kramer, 1992).

Through separation, policymakers sought to overcome crucial shortcomings in the operation of social service departments (SSD for short). This study examines the extent to which the objectives and expectations of policymakers were indeed realized during the two decades following enactment of the Income Support Law and implementation of the separation policy. The first section of this study will focus on the debate over separation and clarify the objectives of policymakers in this field. A discussion of the goals of the separation policy

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and the anticipated changes in the SSDs will then follow. After the research questions and methods are described, the findings of the study will be presented in detail, followed by the final section, comprising the study's conclusions.

The Pros and Cons of Separation

Prior to enactment of the Income Support Law, the issue of separating personal social services from provision of cash benefits was the focus of debate among policymakers and social workers alike. A brief description of the underlying rationale of the different positions in this debate follows (Burns, 1962; Hamilton, 1962; McEntire and Haworth, 1967; Hoshino, 1971, 1972; Jaffe, 1973; Piliavin and Gross, 1977; Doron and Ziskind, 1978; Wyers, 1980; Yanay and Doron, 1987; Doron and Yanay, 1988; Doron and Kramer, 1991; Brock and Harknett, 1998):

1. Arguments for Separation

(a) Economic distress need not originate in psychological difficulties or personal pathology: This claim emphasizes the role of social factors in explaining the source of economic distress. It rejects assumptions that psychological problems engender economic hardship and belittles claims that economic distress necessarily leads to personal distress. As such, there is clearly no justification to link cash benefits to individual psychosocial treatment.

(b) Personal social services and provision of cash benefits require distinctive kinds of professional expertise: Income support seeks to contribute the financial resources necessary to provide the individual or family with essential subsistence needs and thus requires a bureaucratic administrative system based on uniform and universal criteria. By contrast, personal social services seek to assist individuals in coping with personal and social adjustment difficulties and assume differential treatment of individuals. Given the substantive differences between these two types of assistance and the diverse types of expertise required by professionals in both, each should be provided by a separate specialized agency.

(c) Separation will lead to greater individual freedom of choice with regard to receipt of social care: When social care and economic assistance are distinct from one another and financial aid is not contingent on acceptance of social care, service users will enjoy greater freedom of choice in deciding whether or not to apply for social care. Separation will also allow individuals greater latitude in explaining the source of their economic distress and in defining the types of services they require. Moreover, if

individuals receiving social care do so out of free choice, treatment is likely to be more successful.

(d) Separation will decrease the stigma associated with both types of services and will thus increase their accessibility and take-up rate: If financial distress is not perceived as a personal pathological condition and social care is not only offered to the poor, these services will inevitably be less stigmatized. Consequently, it is to be expected that access to these services will be wider and the take-up rates of benefits and services greater.

(e) Separation will enable social workers to devote more time and effort to the provision of personal social care: Provision of financial assistance is a time consuming endeavor and imposes a heavy burden on social workers, thereby reducing their ability to fulfill their professional role effectively in providing social care. Once financial assistance is no longer a function demanded of social workers, they will devote more time and effort to provision of social care and improvement of their professional skills and methods. This may encourage more professional and skilled personnel to work for SSDs and consequently further the development of the departments and their services.

2. Arguments against Separation

The debate over separation also brought to the forefront a number of arguments that emphasized the importance of combining provision of income support and personal social care and the drawbacks expected to result from their separation (Chaiklin and Landau-Frank, 1973; Jacobs, 1973; McEntire and Haworth, 1967; Oliphant, 1974; Wickenden, 1976; Piliavin and Gross, 1977; Wyers, 1980):

(a) Poverty originates in personal difficulties and thus effective amelioration requires personal social care: In contrast to the social explanations of poverty on which the rationale for separation is based, this claim underscores individualistic explanations of poverty. The basic assumption is that people who seek social assistance suffer from psychosocial deficiencies that deprive them of the ability to function independently, and this is the primary cause of their economic distress. Consequently, these individuals require psychosocial care that focuses on individual difficulties, thereby enabling them to escape the poverty cycle. Social care is also required to help these individuals cope with the individual and family implications of poverty and deprivation.

(b) Separation legitimizes individual dependence on society: It is claimed that separation legitimizes reliance on public financial support, leading to a culture of dependence. To encourage the rebuilding of a sense of independent functioning, recipients of public financial assistance should be required

to accept social care and thus improve their ability to fulfill their social functions.

(c) Adverse effects on access to services and the take-up of rights: Separation forces individuals to apply to separate rather than unitary institutions to attain the services they require. Under such conditions, more people are likely to fall between the cracks, accessing one service but not the other. Moreover, separation requires service users to maintain contact with several service providers and by doing so forces them to reveal their individual needs and difficulties to a greater number of people. This may deter individuals in need from seeking help. Separation may also adversely affect take-up rates of rights, because financial assistance is handled by bureaucrats who lack formal training in helping relationships and are thus more likely to adopt a bureaucratic or technical approach to service provision, possibly deterring individuals in distress from seeking the assistance they require.

(d) Separation will distance social work from populations in distress: As a result of separation, individuals in need will, in the first instance, not apply to a social work agency. As a result, the social work profession forfeits a major avenue through which it can access this population, offer it services and engage in prevention of distress.

(e) Separation will lead to the loss of an intervention tool: Financial assistance *can serve as a gateway to helping relations and be an effective incentive for* personal change. By relinquishing this tool, social workers will lose a useful means to further psychosocial treatment.

(f) Separation will cause social work to relinquish its professional contribution to the determination of conditions for qualification for financial assistance: Professional considerations play a major role in the determination of eligibility for financial assistance. Issues pertaining to the duration of assistance and the level of benefits are not merely technical questions, but rather require the professional expertise and input of social workers.

(g) Reduced social service resources: Separation will necessarily lead to a situation in which most resources will be allocated to the administration responsible for provision of financial assistance, with much smaller allocations for SSDs. Furthermore, it will limit opportunities to press for increased SSD budgets as a different agency is responsible for the key mission of providing subsistence support.

The Goal of Separation and Anticipated Changes in SSD Operation

Calls for the separation of social services grew increasingly vocal in Israel

during the 1960s and early 1970s, not least because numerous shortcomings in the operation of the SSDs appeared to impede any effective response to the needs of the population and the fulfillment of the social mission of the departments. Critics asserted that an integrated system, in which social work agencies provided both financial assistance and psychosocial treatment, was the source of these shortcomings (Hamilton, 1962; Jaffe, 1973; State of Israel, Ministry of Welfare, 1975). Two state commissions established at the time to investigate the functioning of the SSDs buttressed these claims. The Katan Commission (State of Israel, Ministry of Welfare, 1975) found that the SSDs lacked a clear cut definition of their goals, that too much of their time was devoted to the provision of material assistance instead of engaging in preventive social work and psychosocial treatment, and finally that there was a lack of services open to the community at large. On the basis of these findings, the commission concluded that the existing structure of the SSDs prevented them from responding adequately to the needs of diverse population groups. Similar conclusions were reached by the Salzberg Commission, which found that the welfare service system could not and did not provide sufficient response to the population's needs (State of Israel, Ministry of Welfare, 1975).

The principle of separation thus gained increased support in the 1970s and achieved a relatively broad consensus (Brick, 1982; Yanay and Doron, 1987). Through separation, policy makers sought to exert an influence on the functioning of the social services and to deal with their flaws. It was anticipated that the process of separation would achieve the following goals (Jaffe, 1973; Doron and Ziskind, 1978; Bar, Marcus and Shoham, 1980; Brick, 1982; Yanay and Doron, 1987; Doron and Yanay, 1988; Korazim et al. 1988): (1) Providing social workers with more time for psychosocial treatment and further the development and improvement of social care; (2) Increasing the availability of the departments for potential applicants; (3) Improving the quality of the personnel in the social services and reduce turnover; (4) Instituting new work procedures based on systematic social care planning; (5) Integrating SSDs within the community.

In addition, separation was expected to be complemented by tighter ongoing cooperation between the National Insurance Institute (NII), which was to be responsible for financial assistance provision and the SSDs which would provide social care (Doron and Yanay, 1988). This cooperation was seen as crucial in overcoming any anticipated difficulties in take-up of benefits and access to personal social services (Doron and Ziskind, 1978).

Research Questions and Methods

This study aims at evaluating the degree to which three principal objectives sought by decision makers on adoption of the separation policy were indeed achieved. As such, three questions are examined:

(a) Did effective working relationships between SSDs and NII income support units indeed emerge following separation? More specifically, were the ties between these agencies the subject of specific policy directives that determined the nature of this relationship and the distribution of labor between the two agencies? What were the goals of this policy and to what degree is it actually implemented?

(b) Did separation lead to a significant transformation of the socioeconomic profile of SSD clients and were the services offered by the departments indeed designed for a wider and more diverse population within the community?

(c) Did the new policy lead to major changes in the types of practice undertaken by social workers in SSDs? Was there a major decline in the time devoted to determination of eligibility for, and provision of, material assistance and was there a consequential increase in the involvement of social workers in the provision of social care?

Diverse data sources were employed in the study. These included a content analysis of various official documents, among them regulations governing the activities of social workers in the SSDs,[1] SSD reports and procedures, NII directives and the minutes of official meetings; Semi-structured interviews were conducted with SSD officials and social workers in four major cities in central Israel; Semi-structured interviews were also conducted with the Head of the NII Income Support Division, as well as directors and claimant clerks at the income support departments in the four cities studied.[2]

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1. Regulations and directives of the Director-General of the Ministry of Labor and Social Affairs.
2. Ten interviews were conducted with department directors and social workers: The director of the Children and Families Division of the Central and Southern District office in Tel Aviv, the director of the Family Office at one of the Department offices in Tel Aviv, a general social worker and intake worker at the Family Office of the Central District Department in Tel Aviv and two Regional department directors in Tel Aviv. Eight interviews were held with NII officials and claimant clerks: The National Director of the Income Support Division, the liaison official for contact with the Ministry of Labor and Social Affairs, the regional liaison official, Income Support Office Directors in Tel Aviv, Rishon Lezion, Rehovot and Kefar Sava and a claimant clerk in one of those cities.

Contact between SSDs and NII Income Support Units

While one of the primary expectations of the separation process was the development of structured contact and coordination between NII claimant clerks and SSD social workers (Doron and Ziskind, 1978; Doron and Yanay, 1988), very little research has been undertaken to assess and evaluate patterns of cooperation between these two agencies following separation. This chapter will examine these relationships with regard to policy and practice.

1. NII Policy with Regard to SSDs

Work regulations formulated at the time the Income Support Law took effect and subsequently updated periodically are indicative of the NII's policy with regard to SSDs. In the most recent version of these regulations (NII, 1995), the importance the NII ascribes to such contacts is specified in Section 10.2.2.1. Similarly, in interviews, officials of the Income Support Division emphasized the significance of interorganizational ties and noted that the management team includes a senior official responsible for liaison between the division and the Ministry of Labor and Social Affairs. The relevant section of the regulations stipulates two reasons for contact with SSDs, indicating that these departments are both a tool for promoting applicants' well being and a vast reservoir of useful information. Claimant clerks are required to open two major channels of communication with SSDs: One to ensure provision of social care for claimants and the other to obtain information for investigation purposes. However, these channels are accorded differential emphasis in NII policy. Social care is only mentioned in a single paragraph of the regulations. This requires that claimant clerks mediate between claimants and SSDs if they believe that they indeed require such services. This is to be accomplished by providing the relevant department's address, explaining the department's assistance options and by informing the department of the referral. However, an examination of whether this policy can indeed ensure social care for benefit claimants revealed three major problems:

(1) Clerks are allowed to exercise personal discretion in determining whether to initiate mediation.

(2) Claimant clerks are not professionally trained to identify problems and lack the skills required to conduct diagnostic interviews, and there are no regulations to inform their discretion.

(3) Claimant clerks are not obligated to monitor the referrals to SSDs to ascertain that the relevant individuals did indeed apply to the department and receive the required services.

The resulting lacunæ may deter NII beneficiaries from applying to SSDs despite their need for social services. One such lacuna is reflected in the handling of substance abusers. According to the NII, a substance abuser applying for income support is to be referred to the Institute's Diagnostic Center. However, there are no regulations that guarantee SSD treatment once diagnosis has been completed and rehabilitation is recommended. Evidence of this lack of coordination between the two agencies is apparent in the NII's decision to appoint an interdisciplinary team to assess and improve NII-SSD cooperation regarding treatment of substance abusers. This team found that community treatment personnel have no access to Diagnostic Center data and sought to rectify this shortcoming by stipulating procedures for cooperation, such as informing SSDs about referral of clients and ascertaining whether they *actually sought treatment.*[3]

A second goal of NII policy with regard to contact with SSDs is the obtaining of information about claimants. Most sections of the regulations regarding contact with SSDs do in fact deal with procedures for soliciting such information (Paragraph 5.1.5 of the chapter on separated couples; Paragraphs 4.19.3 and 4.19.4 of the Chapter on abandoned children; Paragraph 1 of the chapter on narcotics addicts and alcoholics; Paragraph 4.5.6 on the homeless). Clearly, SSDs are perceived as a source of information and as a mechanism for verifying claimants' particulars during assessment of their eligibility for benefits. The vast importance of this goal is evident in a statement by the National Director of the NII Income Support Division: "Our chief objectives in applying to the departments are verification of claimants' declarations and prevention of system abuse."

2. Ministry of Labor and Social Affairs Policy Regarding NII–SSD Contact

A reading of the social work directives concerning treatment of special population groups, such as alcohol and narcotics abuse victims undergoing rehabilitation (Sections 3.2 and 3.27), domestic violence victims (3.28), abandoned children (3.31) and the homeless (3.33) can shed light on the manner in which the Ministry of Labor and Social Affairs perceives the links between SSDs and NII income support units. Joint procedures were developed to determine handling of these four population groups by the two agencies. These consist primarily of directives mandating reciprocal reporting between them, as social workers constitute the final authority for determination of several key eligibility criteria

3. Minutes: Meeting of August 30, 1999.

(such as ascertaining whether an applicant is indeed "homeless" as claimed). Furthermore, these directives are intended to enable social workers to ensure that members of these groups have *full* access to their rights within the social security system, either by way of direct contact with claimant clerks (as in the case of the homeless), or by referral of applications to the NII.

However, the proportion of income support beneficiaries belonging to these specific groups is in fact very small. Of a total of 114,309 of income support beneficiaries in July 1999, only 1.5% were substance abusers in rehabilitation, 0.2% were abandoned children and fewer than 0.1% were homeless (NII, 1999). Thus the directives pertaining to cooperation and guidelines for exercising of rights apply to only a very small percentage of NII cases. By contrast, there is no policy governing contacts between the systems regarding other income support beneficiary groups, such as the long-term unemployed, low wage earners, working mothers and substance abusers not undergoing rehabilitation.

3. NII–SSD Contact in Practice

Our interviews reveal that NII claimant clerks seldom applied to the SSDs to secure social care for income support applicants. While clerks concerned by applicants' distress generally informed them about SSDs (by providing addresses or telephone numbers), they only rarely took any of the additional steps required by the regulations, such as updating SSDs regarding referrals (most interviewees were unaware of the existence of a standard form to inform departments about referral of people for treatment). The clerks also reported that activities aimed at ensuring social care for income support applicants, including provision of SSD addresses, are not carried out routinely due to a lack of motivation, awareness or time. Only rarely would claimant clerks call and inform departments about people who need assistance. Furthermore, virtually no higher-level mediation, such as follow-up of referrals to SSDs, was undertaken to ascertain that claimants indeed applied for and received the relevant services. Some interviewees did not regard these activities as within their domain: "We're not social workers, we're clerks." Moreover, personnel at some of the branches examined noted a downward trend in mediation, indicating that such activities were far more common in daily NII practice during the initial period after the law took effect. They attributed this to the vast increase in income support claims and the heavy burden imposed on clerks, rendering it impossible for them to assess claimants' distress and initiate referral for social care.

Social workers interviewed for this study also reported that the NII rarely takes any steps to guarantee social care for income support applicants. One

department director told us: "The NII is not a referring body but one that requests information." In practice, while some SSD clients did indicate that they were referred by income support claimant clerks, these referrals were not accompanied by direct NII-SSD contact. Social workers interviewed underscored two negative consequences of this situation: First, it resulted in a lack of information on the reasons for the claimant clerks' decisions to refer applicants for social care. In the words of an intake social worker:[4] "I have no information on why they referred people to me, what they are asking for and what their impressions were." Second, referrals are not accompanied by any explanation of realistic options for SSD assistance. Individuals referred to the departments by the NII tended to have erroneous expectations regarding the opportunities for material assistance. An intake worker noted: "At present, referrals give rise to expectations that we are capable of solving all problems that the NII could not." This gave rise to frustration and anger among applicants and led to tension in their relationship with social workers.

The small number of NII applicants referred to SSDs for social care contrasts sharply with the number of direct requests by claimant clerks for information needed to determine claimants' eligibility. While in the initial period following adoption of the law information was solicited for all applicants who claimed to be registered with SSDs, requests are now issued only in cases of demand for urgent assistance or for verification of data before commencing investigation.[5] One clerk informed us: "In some cases, it is impossible to prove that a couple is separated, so I ask the social worker to confirm it and verify that the woman does not maintain a common household with the man who lives in her house."

Attitudes of social workers towards requests for information from NII claimant clerks differ. Social workers at one of the departments said they were uncomfortable about being used as "NII investigators" or "data verification tools", even though waivers of confidentiality accompanied NII requests. This was particularly the case when it became clear that the information was liable to hinder approval of income support. One director exclaimed: "We want to tell the NII: 'Send an investigator and find out for yourself! Why [use] us?'". Nevertheless, social workers reported that they complied with requests for information on applicants.

By way of contrast, some departments actually initiated the handing over of information to the NII when misuse of benefits was suspected. Many

4. Social workers at SSDs whose functions include receiving new applications.
5. At the same time that they fill out their claim forms, applicants for income support benefits also fill out a general waiver of confidentiality to be used by the NII in requesting information about claimants from various bodies, including SSDs.

interviewees did not report any discomfort due to requests for information, as they regarded the NII as an assistance-providing organization acting on behalf of common interests. A social worker noted, "There is no suspicion and no competition. Why shouldn't we provide information?"

Close working relations have developed between the SSDs and the NII regarding the income support rights to be exercised by claimants. All social workers interviewed expressed considerable satisfaction with these contacts and reported numerous appeals to claimant clerks requesting that they assist applicants in filing claims, expedite handling, inform them of available benefits and the like. In practice, this assistance is tendered to all income support applicants and not only to those belonging to the four target population groups mentioned explicitly in the social work directives. Social workers indicated that the clerks were eager to help and cooperated closely. One director said she felt that "we can think things through together, racking our brains to determine how we can help the same people." Other directors interviewed reported that joint staff meetings and visits were conducted to consolidate work ties with claimant clerks.

Most of the social workers interviewed did not report any difficulties or problems resulting from their loss of influence in determining eligibility for benefits, possibly a result of the close_working relations that developed regarding the exercise of rights. Only a single director reported that social workers occasionally felt helpless because of their inability to control resource allocation, especially when department employees sensed that certain families suffered serious distress even though they did not meet the criteria stipulated in the Income Support Law.

Some claimant clerks maintained that social workers were unfamiliar with the Income Support Law and consequently may have misled applicants. For example, social workers advise women to claim child support from their husbands and thus become eligible for income maintenance. However, such measures may spark or intensify domestic violence. One NII clerk said: "I had to contact social workers and insist that they stop these support claims, explaining that they may endanger women and that benefits may be approved in any case." Lack of knowledge about the law may also lead social workers to make impossible demands, such as requests for approval of benefits under extraordinary circumstances. One clerk noted, "Once, before separation, they were the law and they knew it best. Now that we've been separated, the law no longer belongs to them. They've been cut off."

Another channel of communication, less emphasized by policymakers, is

demonstrated in the handling of immigrants in one of the cities studied. The work relations that developed concerned the processing of benefit claims in which social workers served as mediators, explaining the immigrants' requests to claimant clerks and informing applicants of the implications of their claims. In some cases, for example, women asked to have their income support benefits split between themselves and their husbands, whereupon claimant clerks asked social workers to help them reach a decision by explaining the effect this step could have on marital relationships and discussing the matter with them thoroughly. Referrals to social workers are initiated by the claimant clerks themselves and not based on any official work regulations governing cases of this type.

In sum, activities undertaken to ensure social care of income support claimants are of a partial and limited nature. Most appeals by claimant clerks to social service departments are for purposes of obtaining information. In contrast, forthright steps were taken to ensure full utilization of NII rights, involving close cooperation between the two services.

Changes in the Demographic Profile of SSD Clients

In the 1970s, prior to separation, the majority of SSD clients were poor families requiring assistance to cover basic subsistence needs (Doron and Kramer, 1991). Priority in provision was generally granted – explicitly or otherwise – to the most needy of these families (Riger-Shlonsky, 1970). One of the goals of separation policy was to broaden the profile of populations treated and to extend services to more diverse population groups on the basis of a variety of needs, not necessarily financial hardship (Brick, 1982; Korazim et al., 1989).

The interviews undertaken for this study clearly indicate that over the past two decades, the target populations of the SSDs have indeed changed. Two principal trends characterize this process:

First, the implementation of separation has led the SSDs to offer more services intended for the general population. These include marriage counseling centers, day centers for the elderly, family day-care centers, single parent centers, centers for children of divorced parents, social work at junior high schools, and various therapy groups, such as "siblings of retarded children." Eligibility for these services is not contingent on financial status. However, for-fee services based on individual income testing are becoming increasingly common. Thus, extension of services to the general population has proceeded hand in hand with a form of privatization that reflects the rising proportion of service costs covered by fees remitted (see also Katan, 1996).

Second, the demographic profile of population groups receiving services has changed. This has taken the form of an increase in the proportion of middle-class clients (Korazim et al., 1988). Many interviewees noted that the marriage counseling and single-parent centers in particular attract clients from a variety of socioeconomic strata, including those of the middle class (see also Spiro et al., 1998). Various explanations have been offered for these trends:

(1) Separation led to a substantive change in the social work staff's perception of the SSDs goals and functions. The departments are increasingly considered to be professional agencies responding to a wide variety of crisis situations and of individual and family needs. This inevitably led to the development of new services addressing a broader range of problems.

(2) Separation has led to the extension of community work within the SSDs. Thus, social workers found themselves working with a wider spectrum of community groups, such as neighborhood activists, neighborhood committee members, service providers, etc. (Itzhaky and York, 1998).

(3) Elimination of the material assistance component lessened the stigma attached to some of the SSD services. One director remarked that "even municipal council members with difficulties contacted us when they needed treatment for the elderly or had divorce problems. They came to us for service. People have internalized the idea that even those who are not poor may apply to us."

(4) Greater utilization of social services by middle class clients may also be linked to the development of a greater awareness of consumerism and citizens' rights among members of the middle classes. As such, social services are regarded as legitimate sources of assistance in times of need. "Middle class people come and say: 'we are citizens and we have rights. One of them is the right to social services'", noted one of the directors interviewed.

(5) Over the last two decades, SSDs have become increasingly aware of the need to market their services and to engage in outreach to the general public and to other institutions within the community. This has led to growth and diversification of department clientele.

However, the changes in the demographic profile of SSD clientele cannot be linked exclusively to separation. The adoption of laws that offer statutory services (the Long Term Care Law, 1986) or protection (the Prevention of Domestic Violence Law, 1991) has led to an increase in the number of SSD clients and their diversification (Katan, 1996; Shnit, 1996; Weinblatt et al., 1999; Katan and Loewenstein, 1999). Interviewees emphasized that over the past decade, this legislation led to a rise in the proportion of middle-class

families treated for problems such as domestic violence, in interventions on behalf of neglected children and youth and in the number of elderly persons requiring nursing care (see also Shnit, 1996; Katan and Loewenstein, 1999). Another change resulting from the increase in legislation is a rise in involuntary SSD clients. Thus, while legislation did indeed lead to growth in middle-class clientele, many such individuals were compelled by law to seek treatment at social service departments. Interviewees maintain that the increase in legislation and the growing burden imposed on SSDs (see also Katan, 1996; Shnit, 1996; Shnit, 1998; Katan and Loewenstein, 1999) led to neglect of voluntary clients. One director remarked: "I don't have enough personnel to deal with individuals who apply voluntarily, such as an elderly man whose wife died or a woman in need of support because her husband is ill."

Preventive work has also been almost entirely neglected due to the impact of legislation on the SSDs. One director noted that: "when we receive an application reporting an adolescent in distress whose situation does not require the intervention of a welfare officer, I put her on the waiting list. Two months later, she's already at substantial risk and a welfare official has to intervene." Indeed, even individuals at risk are often placed on waiting lists. Interviewees claimed that the neglect of these client groups runs counter both to their conception of the goals of the departments and to the aspirations of policymakers who instituted separation with the goal of expanding SSD beneficiary circles.

A sizable proportion of the directors interviewed reported that this situation creates dilemmas in defining SSD target populations: "We suffer from work overload. I often find myself pondering questions of who is to benefit from our services and who is to be rejected." These dilemmas also relate to the allocation of time between population groups referred to the departments by force of law and those who apply voluntarily. Among elective clients, social workers must ask themselves whether to give priority to those who lack financial means and have no other treatment alternatives, or to provide service according to need, irrespective of financial situation. In practice, most directors report giving preference to groups for which intervention was required by law. In cases of voluntary application, priority was given to people unable to receive services elsewhere. One director noted: "Today, I am guided by the principle that the little time we have is to be devoted first to the weaker population that cannot acquire services privately and has no therapy alternative." Some interviewees noted the growing tendency towards rejection of voluntary applicants in general and those from higher socioeconomic strata in particular.

With regard to the demographic characteristics of the clientele of the

SSDs then, it would appear that separation did indeed lead to a change in the sociodemographic profile of population groups handled by the SSDs and to a consequent increase in the number of middle-class applicants, reflected primarily in a number of unique services developed by the SSDs in recent years. Nevertheless, the rise in percentage of middle-class clients cannot be attributed exclusively to separation. The adoption of legislation that requires the SSDs to offer certain services or to intervene on behalf of specific groups at risk has brought about greater variation in the range of SSD clients, as well as a rise in percentage of involuntary applicants. The heavy burden now imposed on the departments has led them to limit treatment according to sociodemographic criteria, especially regarding elective services. Thus, despite the intention to develop services for the entire population and broaden the sociodemographic characteristics of SSD clientele, recent trends indicate that services are being limited to narrower population segments only.

Change in the Place of Financial Assistance in Social Service Department Work

Before separation took effect, SSDs devoted considerable time to allocation of material resources. Research indicates that approximately 40% of social workers' time was dedicated to providing financial aid (Jaffe, 1973; Doron and Kramer, 1991). One goal of separation was the introduction of a change in SSD social work practice so as to reduce the amount of time devoted to the provision of material assistance.

SSD directors interviewed noted that separation did indeed lead to major changes in the nature of the work undertaken by social workers in the SSDs, among them a decline in the time dedicated to material assistance (see also Korazim et al., 1988; Spiro et al. 1997). New services developed after separation, such as marriage counseling centers, did not require any resource allocation. Nevertheless, the Income Support Law did not entirely eliminate this function and the SSDs still retain responsibility for the provision of material assistance in response to special needs (see Social Work Regulations, Section 3.16). As such, the provision of financial aid has not entirely disappeared from the repertoire of SSD social workers. The extent of involvement in provision of material assistance depends on the specific function that social workers fulfill and the nature of the localities in which they work. Interviews show that intake, follow-up and general social workers are likely to become highly involved in the practicalities of resource allocation, including application processing, determining eligibility, tending to the technicalities of assistance

provision, handling rejected applications, mediation and referral to other services and institutions (such as the NII, Ministry of Housing, municipalities) for material assistance of various types and solicitation of contributions and funds. This increased involvement originates in the numerous applications for comprehensive services that entail various kinds of material assistance, such as basic equipment, day care for children, housing assistance, dental care, etc.

The time social workers spend dealing with material assistance may also be derived from data on activities of the departments examined. For example, 29% of all households dealt with by the Tel Aviv social services in 1998 received financial aid, indicating that nearly one third of all clients required social work that concerned material assistance. An analysis of the problems affecting these households indicates that the proportion entailing material assistance of various types ranges between 16% in some parts of the city to 27% in others (Tel Aviv-Yafo Municipality, 1999). In Rishon Lezion, it was found that 18% of applicants suffer from problems that can be defined as economic (Ahimor, 1995). The director of a local SSD estimated that approximately 30% of applicants suffer economic distress that demands involvement of social workers in the provision of financial assistance. At the Kefar Sava SSD more than a quarter of all families receiving care required financial aid. Thus, while these findings do show that separation reduced SSD responsibility for financial assistance, social workers engaged in intake and other functions remain highly involved in provision of such assistance.

Through separation, policymakers sought to relieve SSDs from having to deal with subsistence support, thereby enabling social workers to focus on social care. All the interviewees emphasized that separation did achieve its objective in this respect. Elimination of the financial assistance component freed social workers for professional social work and development of new professional services, provided them with a powerful impetus to become more professional and improve their knowledge and skills and enabled them to engage in provision of more social care to a variety of distressed population groups. As one director indicated: "Separation offered greater opportunities for professional work. It provided the social workers with more time and options for working differently with applicants." Interviewees who worked in social welfare services before separation described their previous situation in harsh terms such as "nightmare" and "trauma" and termed the present situation a "genuine revolution", "breakthrough" or "dramatic change."

At the same time, interviewees concurred that the introduction of extensive social legislation over the last decade had a major impact on practice because it

was not accompanied by a concurrent increase in personnel. As a result, social workers were unable to devote sufficient efforts to social care and the treatment of voluntary clients. One director noted that "today, most social work in the departments is a consequence of the new laws. While the Income Support Law relieved us of the function of providing financial assistance, the additional laws imposed a heavy work burden on us. Social workers are now involved in investigations and dealing with crisis and not in providing social care." This trend is reflected in all aspects of SSD work. Most of the departments examined in this study reported that social workers at the marriage counseling centers devote the bulk of their time to mandatory activities, including submittal of expert opinions to the courts in child custody cases, leaving very little time for actual treatment of couples and families or follow-up of adherence to court orders. Shnit (1996) maintains that social workers are less capable of conducting intensive investigations and monitoring implementation of court decisions due to these developments. In addition, the vast increase in the number of applications to SSDs resulting from enactment of the Long-Term Care Law has had a profound effect on social work with the elderly. Interviewees claimed that the extensive work involved in planning long-term care treatment programs for the elderly has led to a decline in social care provision for the elderly clients themselves and their families, such as guidance and support when families experience difficulty caring for elderly relatives, whether or not they are self-sufficient (see also Shnit, 1998; Katan, 1999).

In summary, separation sharply reduced the involvement of social workers in resource allocation, leading to the development of new social services. However, the SSDs are still responsible for provision of material assistance to clients with special needs. In some localities, moreover, intake and follow-up social workers are very much engaged in resource allocation. Although separation freed social workers to engage in the provision of social care, legislation enacted over the past decade imposed a heavy burden on social workers, so that SSDs again find it difficult to provide sound, adequate social care.

Conclusions

This study examined the degree to which policymakers' expectations regarding the separation of social care and income support were indeed fulfilled over the two decades since the Income Support Law was adopted. Three expectations were given particular attention:

(1) Effective cooperation between the NII and the SSDs;

(2) Growth and diversification of SSD clientele;

(3) Decline in the time spent by social workers in the provision of material assistance and an increase in the provision of individual and family social care.

The findings indicate that close links between the NII income support units and the SSDs emerged particularly in cases in which the NII sought data on clients. The NII regarded the provision of data on clients as the primary purpose of contacts with the social services. Clearly, this goal had less to do with an attempt to improve the well being of individual claimants or to increase take-up of benefits and more with an effort to limit fraud and abuse of the social security system. In practice, there are no specific guidelines with regard to actions of claimant clerks to ensure social care for claimants that require it. Indeed, the limited number of referrals to SSDs is undertaken at the discretion of claimant clerks alone. Under such circumstances, the marginal attention accorded to social care in NII policy and practice is liable to increase the risk that applicants who require social care will not actually seek treatment.

In contrast, the two agencies cooperated closely regarding the take-up of NII rights, an issue emphasized in both the formal policy of the Ministry of Labor and Social Affairs and the practice of both services. In short, the expectation that cooperation between the two agencies would be close and would thus enhance effective utilization of services by those needing them was only partially realized.

An examination of the population groups treated by SSDs shows that separation, as expected, indeed led to a change in the sociodemographic profile of service beneficiaries and to an increase in the middle class clientele. This change is reflected primarily in innovative services developed after separation and to a much lesser extent in comprehensive regional services. Change in the sociodemographic characteristics of SSD service users increased in momentum over the past decade following the expansion of protective and statutory social legislation. Nevertheless, the failure to accompany this expansion of legislation with an increase in SSD personnel has led to three additional consequences not consistent with the original expectations regarding separation policy: (1) An increase in non-voluntary clients, (2) a decline in the volume of voluntary clients and (3) a growing tendency to provide voluntary services primarily to individuals suffering economic distress.

Prior to separation, recipients of social care were a "captive audience" compelled to accept social care as a condition for obtaining material assistance (Spiro et al., 1998). The situation remains similar today but the causes differ. The introduction of protective laws has created a new type of "captive" SSD client forced into mandatory professional-client relationships with social workers.

This reality gives rise to an interesting question: Did the newly adopted laws provide social workers with the means to attract a new clientele to replace the "captive" clientele lost with the implementation of separation?

As expected, separation indeed led to a decrease in the time devoted by social workers to the allocation of resources and a substantive change in SSD social work practice. By reducing social worker involvement in the provision of material support, separation required social workers to redefine their professional mission and focus their activities on provision of social care. This, in turn, led to the development of new social services designed to respond to a wide variety of needs and problems. Nevertheless, SSD intake and follow-up social workers involved in comprehensive and regional service work still devote much time to provision of material assistance. In some of the localities examined, social workers were as critical of this situation as they were regarding resource allocation issues before separation took effect. Over the last decade, the growth in social legislation has threatened the achievements of separation because the time freed by eliminating responsibility for resource allocation is largely taken up by the provision of mandatory social care. One implication of this situation is the neglect of other types of care, including preventive work. Today, two decades after separation was first introduced, social work is in nearly the same position it was before the policy was adopted, remaining unable to provide sound and adequate personal social care.

The findings of this study clearly demonstrate that adoption of the Income Support Law – and with it the separation of income support and social care – indeed exerted a major influence on personal social services in Israel. Separation led to a change in the sociodemographic profile of population groups receiving services from social service departments and enabled social workers to provide social care to a variety of population groups requiring such services. However, an acute lack of personnel required to provide services required by laws adopted during this period threatens to undermine these achievements.

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CHANGES IN CHARACTERISTICS OF INCOME SUPPORT RECIPIENTS OVER A DECADE: THE POTENTIAL FOR WORK

By Brenda Morginstin* and Miriam Shmelzer**

During 1990-2000 the number of individuals receiving Income Support benefits im Israel more than tripled while the total population of working age grew only by 25%. Whereas during the first half of the decade the increase was primarily in the number of immigrants, after 1997 the rate of increase was higher among veteran Israeli residents. A significant increase was noted in the number of single parent families and individuals who are defined as unplaceable. Three large distinct target groups of individuals under age 50 are identified for job-placement programs: (1) Married men and women with children; (2) Single parents, primarily women; (3) Single men and women. These groups must be differentiated in order to design effective programs which will take into consideration the work capacity, specific needs, required education and training, as well as the social support services which are necessary in order to realize work potential. Especially important to married women and single parent families will be subsidized child day care programs. In planning job-placement programs it is crucial to guarantee a reasonable standard of living, expand social support services and maintain an accessible safety net under the Income Support system.

Introduction

A number of Western countries have introduced programs aimed at integrating Income Support recipients into the labor force, especially those groups affected by long-term unemployment. In Israel, the Minister of Labor and Social Affairs appointed a Commission, headed by Professor Yossi Tamir, for Reform of Income Support Policy. This Commission was mandated with planning an experiment for establishing Employment Centers in four geographic regions, which will provide work promotion services, adopting an approach that recognizes the need for intensifying commitment to work and increasing the likelihood of employment among long-term unemployed Income Support recipients. The model proposed by the Tamir Commission calls for more directed

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work-placement interventions on the part of relevant authorities, supported by a range of training programs and supportive services adapted to the needs of single persons and families who will benefit from case management throughout the program. The overall objective is to help individuals dependent on income support benefits find their place in the world of employment.

Income Support (IS) recipients do not constitute a homogeneous group in terms of likelihood of work integration. Any new employment policy needs to identify which subgroups are most likely to benefit. This study seeks to characterize target groups of Income Support recipients with the greatest work potential, underscoring differences among these groups as translated into the program's employment objectives and required supportive services and benefits.

From a relatively small group of former welfare recipients in 1982 when IS was first established as a new program in Israel, by the year 2000 it had become a large and heterogeneous group comprising immigrants and veteran Israelis, young and old and conventional as well as single-parent families.

This study describes the changes in size and characteristics of the population receiving IS benefits during 1991-1999, and attempts to identify beneficiary groups having work potential. In general, the IS program guaranteed a minimum income to low-income families during this period which was characterized by employment fluctuations and a mass influx of immigrants to Israel which changed the composition of IS recipients.

Space limitations preclude attention to job market conditions affecting employment policy and work potential. Whereas the present study focuses on general characteristics of the total IS population, subsequent research will require analyzing local markets so that the specific programs be based on intensive assessment of job markets in the designated regions in which the employment centers are to be established: local unemployment rates, the types and levels of employment offered, wage levels, foreign labor statistics, etc,

Background

Israel's social security system guarantees a minimum income for population groups in severe financial distress due to lack of employment, low wages, disability or other social factors, as reflected in three laws:

- The Income Support Law, that ensures a minimum income for people of working age and provides a supplement to old-age pensions received by elderly persons who have no other sources of income.
- The Alimony-Guarantee of Payment Law, that ensures compensation for

divorced and separated women granted alimony by the courts who have not received due payment from spouses legally responsible for payment.

- The National Insurance Law-Disability Insurance, that grants disability pension eligibility to persons whose earning ability declined by 50% as a result of physical, mental or emotional handicap.

This article focuses on the growth in the number[1] of income support recipients of working age under the Income Support Law and the changes in definitions of eligible groups.

Prior to the Income Support Law, enacted on January 1, 1982, assistance was provided as welfare payments, with no entitlements guaranteed by law. Under the new law persons ineligible for other National Insurance Institute (NII) benefits, such as unemployment or disability pensions, became entitled to income support, financed by the State Treasury. Enactment of the Income Support Law in 1982 continued a legislative process for unemployment, disability and child allowances that began in the 1970s and which sought to guarantee minimum incomes for specified groups defined according to age, family status, disability or unemployment. The Law replaced a series of welfare programs and benefits, stipulated eligibility criteria and mandated disbursement by a single authority, the NII. Furthermore, it established a common minimum income level for the various programs, guaranteed by the State, thereby instituting a major change in the country's social service system (Morginstin, Shamai and Haron, 2000).

As indicated, Income Support benefits for people of working age (20-59 for women, 20-64 for men) are intended to protect people from adverse economic conditions when they are unable to earn minimal livelihoods for themselves and their families. These benefits constitute a final safety net that guarantees a minimum subsistence level[2] for three principal groups:

- Unemployed persons not entitled to unemployment compensation or who have exhausted rights under the Unemployment Insurance Law.
- Individuals unable to work and who cannot be placed in jobs – primarily because of advanced age, poor health or social problems – but who are not eligible for disability pensions.
- Working people earning low wages entitling them to income supplements.

Eligibility for IS benefits is contingent on an employment test and family income criteria. Benefits are provided to families whose income is below the

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1. Data in this study may refer either to recipients only or to families, i.e. recipients and their spouses.
2. At the time of this study, the minimum subsistence level for a single individual was 25% of the average wage)

ceilings determined by the NII. If of working age, both husband and wife are subject to the employment test and are required to report weekly to the Labor Exchange and accept any job offered them, remaining eligible for benefits only if no jobs can be found. The law exempts certain categories from this employment criterion: individuals who are determined to be permanently or temporarily unplaceable due to poor health or age; mothers of children up to age seven; narcotics addicts and convicts.[3]

Enactment of this Law (in 1982) was preceded by intensive discussions regarding its purpose (Doron and Ziskind, 1978). As planned, the system fulfills an important role in guaranteeing family income, especially during times of economic downturn and unemployment, when large groups of working people may be vulnerable to dismissal and economic distress. The Law was envisioned primarily as a response to temporary economic distress and unemployment and not as a source of long-term benefits for people who leave the labor force permanently – a function largely intended to be assumed by the Disability and Old-Age programs.

Besides the employment test, there is also an income test, which defines as income earnings from work, pensions, rent, dividends, savings and capital gains. Both husband and wife must meet the employment and income criteria, according to which the family's eligibility and the benefits to which it is entitled are determined. To create an incentive for work, there is an income disregard of 13% of the average wage for single persons and 17% for those with dependents. For each family type there is an income ceiling. A household whose income exceeds the ceiling is no longer eligible for a benefit. If it falls below the ceiling, the individual or family is entitled to benefits equal to the difference between that ceiling and its actual income. Vehicle owners are automatically ineligible for benefits. Because of the special structure of these ceilings, whose levels are determined as the sum of the specific benefit level (according to family size) and the disregard, the effective tax rate on any amount exceeding the disregard is 100%, except for single-parent families, for whom the rate is 60%. Effectively, no ceiling exists for single-parent families which can thus attain a relatively high overall income from work and benefits (see Table 1 and Figure 1).

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3. All criteria as well as benefit and income levels in this article refer to the program as it existed prior to 2003. Under the Economic Reform Law of 2003 the category of unplaceable was abolished, mothers of children over age two became subject to the employment test, and income disregards as well as benefit levels were reduced.

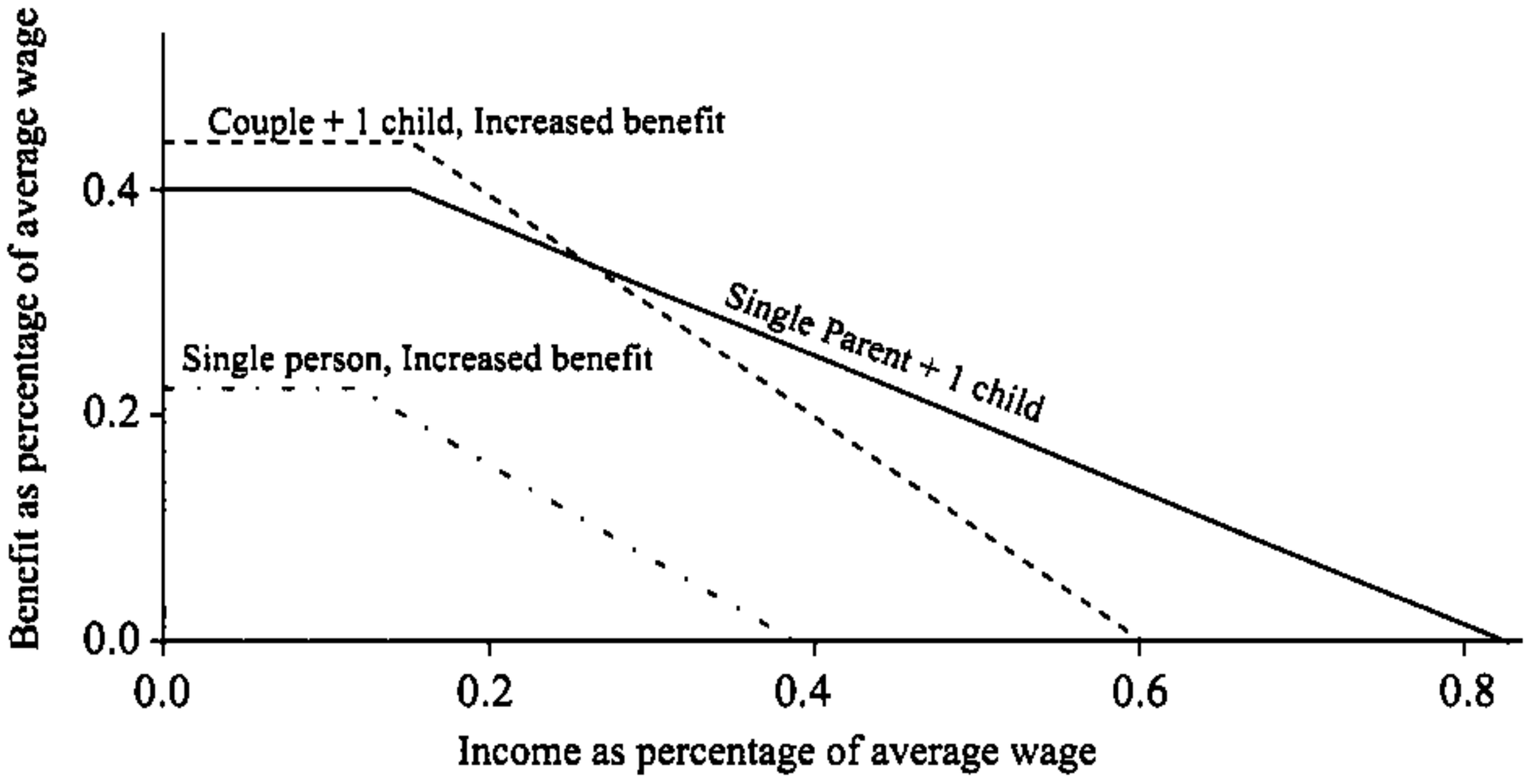
Table 1. Income Support Benefit Rates and Ceilings as a Percentage of Average Wage,* 2000

	Percentage of Average Wages	
	Benefit	Ceiling
Single person	25.0	38.0
Single parent + 1 child	42.5**	83.3
Single parent + 2 children	52.5**	100.0
Couple	37.5	54.5
Couple + 1 child	43.5	60.5
Couple + 2 children	49.5	66.5

* In January 2000, the average wage, calculated according to the provisions under Section 2 of the National Insurance Law, was NIS 6,347.

** Less one benefit point.

Figure 1. Income Support Benefits as a Function of Income



Three benefit rates apply:

(a) *Standard benefit rate*: provided to individuals during the first two years in the IS program, at 20% of the average wage for single persons, 30% for couples, 36% for couples with one child and 42% for couples with two children.

(b) *Increased benefit rates*: Provided to individuals after two years in the program or who are 46+ years old: 25% of the average wage for single persons, 37.5% for couples, 43.5% for couples with one child and 49.5%, for couples with two children.

The underlying assumption behind the determination of these two rates is

that the first two years in the program are temporary and the incentive to remain therein should be minimized.

(c) *Special benefit rate*: For single-parent families: 42.5% of average wage less one benefit point[4] for a single parent with one child and 52.5% less one benefit point for those with two children.

Eligibility for Income Support benefits accords eligibility for other benefits and concessions, such as exemptions or discounts on municipal taxes, television license fees and on public transportation fares; lower health insurance rates; housing assistance; lower rates at day-care centers and other benefits. The experience in Israel, as in other countries, indicates that the monetary value of these benefits constitutes a powerful additional incentive to remain within the IS program, since exit into work incurs a marginal tax rate higher than 100% (Achdut, 1976; Gal and Doron, 2000).

All recipients of IS benefits are categorized according to a qualifying condition, i.e., eligibility category. These may be divided into two major groups: categories for those considered in the labor force, including seeking employment and low wages; and categories for those unable or not expected to participate in the labor force, including unemployability (unplaceable) due to age, social, mental or physical condition, single parent mothers of young children and a number of additional other small categories. The principal eligibility categories for income support benefits include: job-seekers for whom no work has been found, and individuals who are unplaceable because of poor health, social problems or age (55-59 for women and 60-64 for men), mothers of children up to age seven, narcotics addicts or alcoholics, and persons with temporary illness.[5]

Changes over the Past Decade

Many changes were introduced in Israel's Income Support program over the past decade, as reflected in substantive amendments to the law and significant changes in the number and composition of the recipient population. These changes took place primarily in response to the large wave of immigration from Eastern Europe and Ethiopia that, on the one hand, expanded Israel's human resources significantly but also brought in many people who had difficulty

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4. The benefit point paid in child allowances for the first child was NIS 171 in January 2000. The structure of benefits for single-parent families developed following a decision to relate to such families in the same manner as couples, as well as a series of amendments to the Law that raised benefits (these amounts changed in 2003).
5. See changes in benefit categories under the Economic Reform Law, 2003.

finding jobs, including the elderly, the indigent and those with language or occupational problems. Moreover, that same period was characterized not only by high immigration but also by fluctuations in the level of unemployment with an initial rise in unemployment at the beginning of the decade, considerable reduction from 1993 to 1996 and steady increase thereafter. Furthermore, the job market in Israel, as in other developed countries, underwent various changes due to globalization, privatization and technological developments.

During this difficult decade the IS program fulfilled an important social welfare function by assuring minimum subsistence income, especially for immigrants in their first years of settlement in Israel and those who arrived at an advanced age for whom economic integration opportunities were limited from the outset. The program had a vital role in enabling immigrants to enjoy at least minimal subsistence conditions during their early years in Israel.

Below, we detail the principal changes in the IS program which had direct implications on the increase in number and the characteristics of income support recipients:

1. Changes in Legislation

Several changes in legislation affected the number of IS recipients over the past decade, usually by extending coverage or making it easier for people to enter and remain within the program:

(1) *Mothers with Children:* In 1992, eligibility criteria for these benefits were changed to include mothers of one child under seven. Formerly, only mothers of two children under ten or one under five were eligible for benefit increments.

(2) *Single Parent Families Law*: This law, enacted by the Knesset in 1992, constituted a highly significant change by defining which families belong to this category and by increasing their IS benefits markedly. Until April 1992, such benefits were no different from those to which single persons with children were entitled. Thereafter, the benefits were increased by about 37% to the rate received by widows with children, as defined in the Amendment to the Income Support Law. Additional benefits for single-parent families were approved as well, such as housing priority, entitlement to day care for children, etc.

(3) *Duration of Stay in Israel Entitling Immigrants to Benefits*: In April 1992, the Income Support Law was amended to entitle immigrants to benefits after twelve months residence in Israel (instead of the previous 24) to assist those no longer eligible for Ministry of Absorption assistance who had not yet joined the labor force. The amendment eased criteria for entering the IS program, substantially increasing the number of recipients within a few years of its enactment.

(4) *Reduction of Poverty and Income Disparities Law*: This law, enacted in two stages (1994 and 1995), introduced important changes in the Income Support Law (Achdut et al. 1994; 1995). It increased benefit rates considerably, especially for single-parent families, but also for other families with children. Similarly, eligibility for increased benefits was extended not only to people in IS for 24 months but also those aged 46 and over. Another change raised the system's age threshold from 18 to 20 (except for extenuating circumstances).

2. Immigration

The decade of the 1990's was characterized by a large wave of immigration that brought many immigrants to Israel with no source of income. It began in late 1989, peaked in 1990 and 1991 with an annual influx of nearly 200,000 immigrants and stabilized thereafter (Table 2).

Table 2. Number of Immigrants Arriving in Israel Annually, 1990-1998

	Number of Immigrants	
Year	Arriving	Cumulative Total
1990	199,500	199,500
1991	176,100	375,600
1992	77,100	452,700
1993	76,800	529,500
1994	79,800	609,300
1995	76,400	685,700
1996	70,900	756,600
1997	66,200	822,800
1998	56,700	879,500

Source: Central Bureau of Statistics, *Statistical Abstract of Israel* (relevant years)

During their first year in Israel, immigrants from distressed countries are entitled to a series of basic services and benefits known as the *Absorption Basket*, provided by the Ministry of Absorption, including a monthly stipend, housing concessions, household equipment, loans and the like. These benefits are relatively generous and are granted to immigrants so that they can make all appropriate arrangements for life in Israel, including learning of Hebrew, while hopefully finding their place in the labor force as well.

To facilitate integration of the great influx of immigrants, a special arrangement was instituted in 1992 that shortened the waiting period for eligibility for income support from two years to one. The required bureaucratic procedures were shortened as well to ensure a smoother transition from the Ministry of Absorption to the NII for immigrants who could not find employment. This measure was essential to guarantee a minimum standard of living under the benefit program applying to the general population instead of providing a separate system of benefits through the Ministry of Absorption (Eliav et al., 1995; Arad, 1996). It is possible, however, that such concessions were introduced too early for the immigrants to have obtained sufficient job-seeking experience.

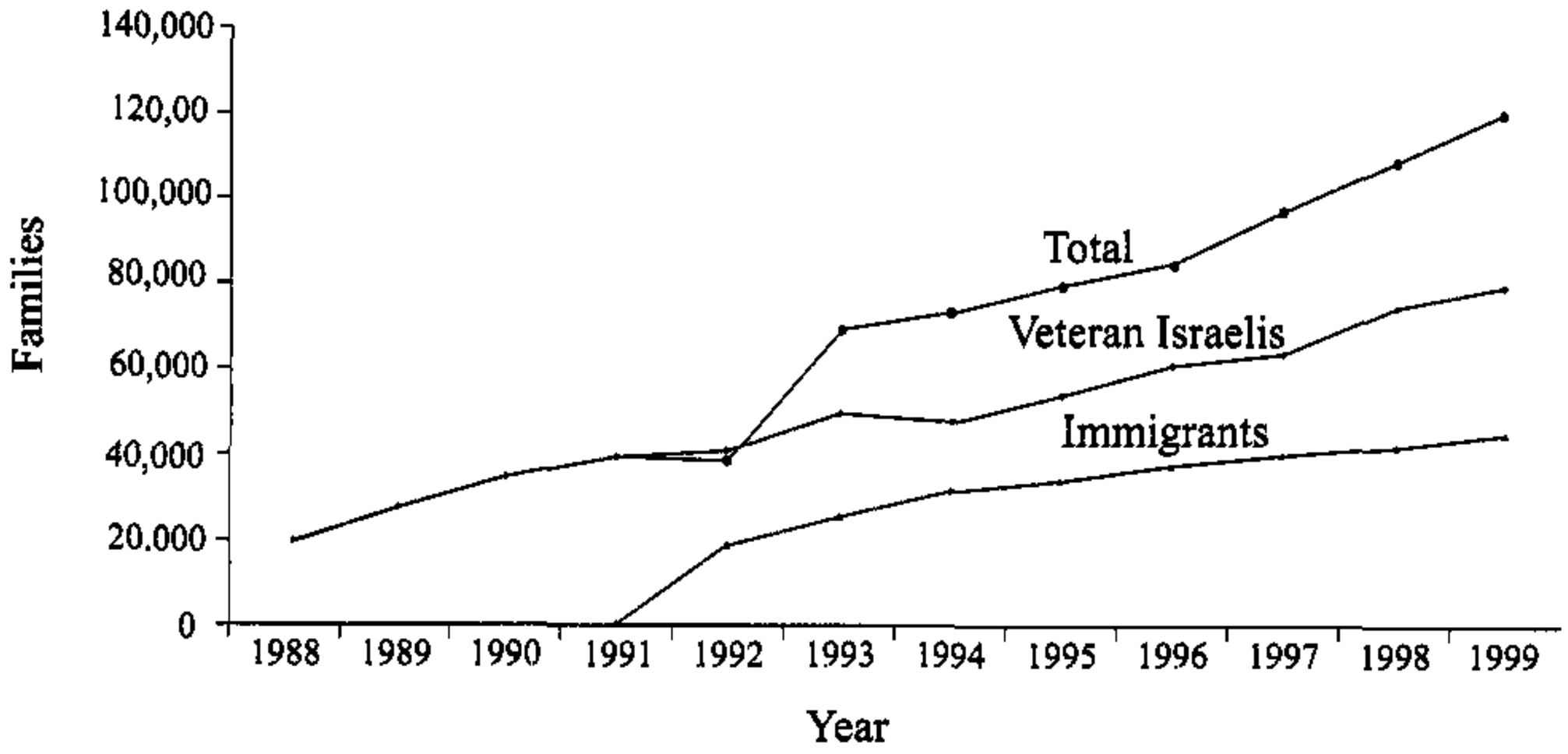
Before the laws were amended, immigrants were required to spend two years looking for work before becoming eligible for IS benefits. Thereafter, the law reduced the period to one year only and entitled immigrants to a basic service package. Those who have not yet joined the labor force become eligible for income support benefits according to standard eligibility criteria (employment test – as defined by the Labor Exchange – and income test).

In contrast, the system created a more difficult situation for immigrants by limiting their rights to unemployment compensation during this period. Until 1992, immigrants were required to work only three months, as compared with six months thereafter, in order to be eligible for an unemployment benefit. Seeking to introduce a work incentive, a law enacted in 1993 applied the same mandatory work period to both immigrant and veteran Israeli applicants for unemployment compensation. Some apprehension has been expressed regarding this measure, as it may direct immigrants towards the IS program when they might otherwise remain in the labor force and receive unemployment compensation. In other words, immigrants who worked for only three months now apply for IS benefits instead of requesting unemployment compensation while seeking employment for an additional three months. As indicated, this change in regulations was reflected in the IS program's massive absorption of immigrants beginning with 1992.

3. Increase in Number of Income Support Recipients

The number of families of working age receiving IS benefits has increased steadily over the past decade. In 1990, the average number of families per month entitled to such benefits was about 32,000; by 1999, it had more than tripled to over 118,000 and by April 2000 it reached 129,000. The average number of individuals entitled to these benefits increased from 47,300 in 1990 to 150,500

Figure 2. Number of Families Receiving Income Support Benefits: Immigrants and Veteran Israelis, 1990-1999



in 1999 (including men aged 60-65 receiving IS benefits through the Old Age and Survivors'.Branch (OAS) of the NII).[6]

Between 1993 and 1995, when the unemployment rate began to decline, the total number of IS recipients increased as a result of the continued absorption of immigrants in the IS program. Furthermore, during that same period, criteria for eligibility were tightened. *Table 3* shows that between 1993 and 1996, most of the growth in number of recipients resulted from the number of immigrants *entering the system. Thereafter, growth was primarily due to an increase in* veteran Israeli recipients. This latter growth clearly reflects the effect of increased unemployment in 1998-1999 on the veteran population of Israel. Among immigrants, the growth rate declined somewhat over the last few years.

The proportion of IS recipients out of the total population increased at a rate even higher than that of population growth rate during the same decade. Looking at recipients as a percentage of the adult population of working age (men aged 20-64, women 20-59), we note that this percentage doubled from about 2% in 1991 to 4.4% in 1998, while the population grew by about 25% (Figure 3). In other words, the growth rate among income support recipients was four times that of the general working age population.

6. For technical reasons, a special group of immigrants, consisting of married couples in which the wife is 60 years old or the husband 65, receives IS benefits under the Old Age and Survivors' Branch of the NII. Such persons are not legally eligible for Old-Age pensions since the men are still of working age and the women are not entitled to such pensions at all. As we lack additional information about this group, the men in this category are only taken into account in those tables displaying IS recipients as a percentage of the working population. All tables state explicitly whether or not the group is included in the data shown.

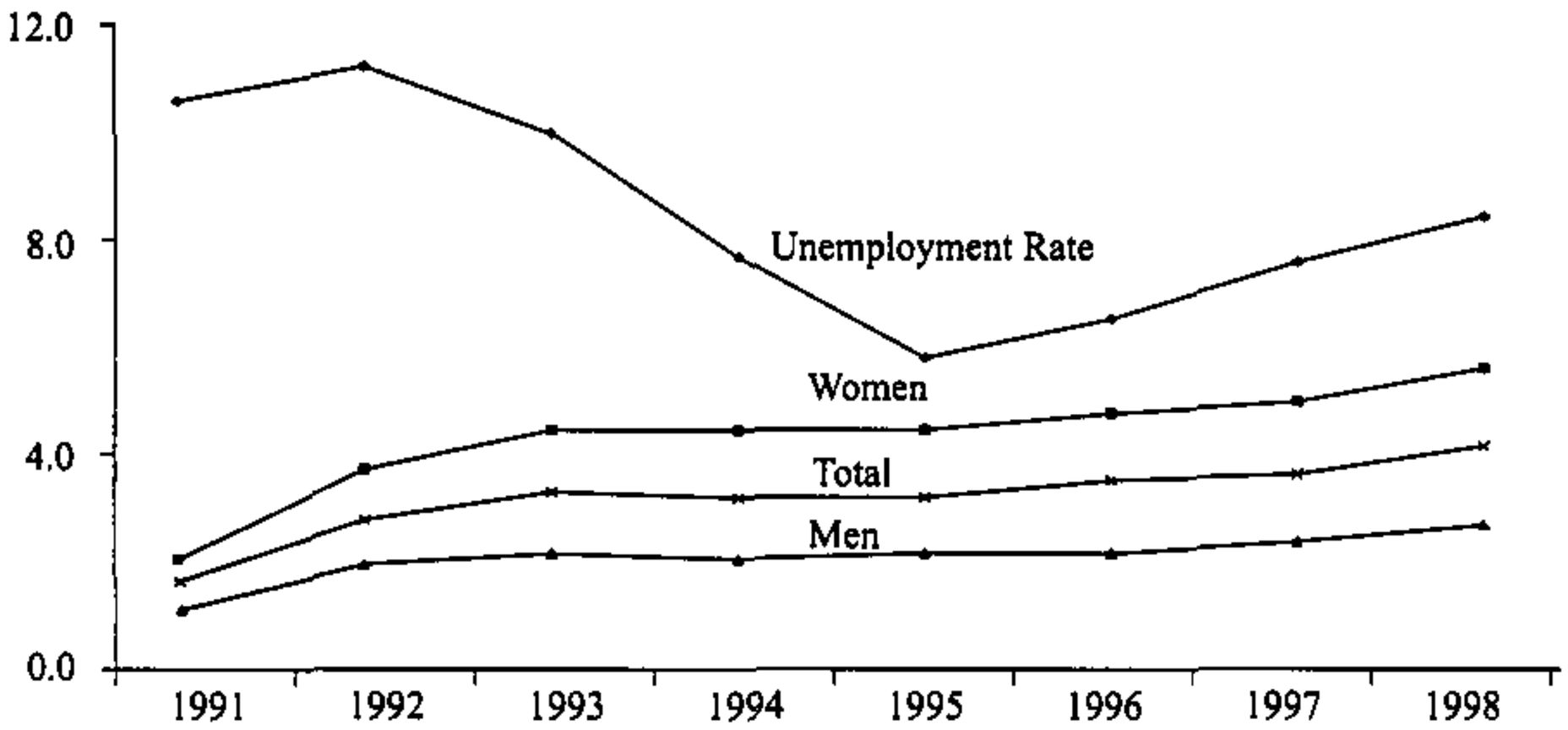
Table 3. Number of Families* Receiving Income Support Benefits, 1985 and 1990-1999

	Number of Families			% Change		
Year	Total	Veteran Israelis	Immigrants	Total	Veteran Israelis	Immigrants
1985	24,564					
1990	31,818			29.5		
1991	34,725	34,250	475	9.1		
1992	59,372	42,156	17,216	71.0		
1993	71,774	45,910	25,864	20.9	19.8	28.9
1994	73,388	44,899	28,489	2.2	3.4	12.5
1995	77,991	45,867	32,124	6.3	1.2	12.8
1996	84,334	47,307	37,027	8.1	5.5	11.6
1997	92,633	51,868	40,765	9.8	9.6	10.1
1998	104,570	60,891	43,679	12.9	17.4	7.1
1999	118,556	69,617	48,839	13.3	16.8	8.5

* Monthly average.

Note: Includes couples aged 60-65 who, for administrative reasons, receive IS benefits from the Old Age and Survivors' Branch of the NII (about 4,000 families in 1999) and are not included among IS recipients in NII statistical and quarterly publications.

Figure 3. Unemployment Rate and Percentage of Working Age Population* Receiving Income Support Benefits,** 1991-1998



* Men aged 20-64, women aged 20-59.

** Individuals, not families. Between 1995 and 1999, IS recipients include male married immigrants aged 60-65 who received income support benefits under Old Age Insurance for administrative reasons.

The percentage of women receiving IS benefits is higher than that of men, reaching 5.8% of all women of working age in 1998 as compared with 3.0% for men. The increase over the past few years may well be a result of entry into the program of a large number of single mothers, partly as a result of the demographic composition of the vast wave of immigration as well as the enactment of the Single-Parent Families Law in April 1992 that expanded the Income Support rights of such families.

The figures only partially reflect fluctuations in the unemployment rates. In 1992, parallel to the increase in the extent of unemployment, there was also a massive ongoing influx of immigrants into the program, causing a sharp rise in number of IS recipients. This trend persisted through 1996, despite the subsequent decline in unemployment rates.

4. Income Support Trends

Considering all the above changes, it is not surprising that the characteristics of IS recipients at the end of the decade differed from those of their counterparts at the beginning of the decade (Table 4). In 1999, about 40% of recipients consisted of immigrant families. The percentage of single-parent families increased from 29% in 1990 to 37% in 1999 and the percentage of female recipients from 60% to 66%. Furthermore, in 1999 recipients spent more time in the program, rising from an average of 21 months to 32 months. During the same period, the percentage of families receiving increased benefits rose from 52% to 79%, even though, as indicated, the program was originally conceived as a temporary safety net for people with low income who are not entitled to other NII benefits such as unemployment compensation or disability insurance.

Table 4. Characteristics of Income Support Recipients, 1991 and 1999 (monthly average)

Year	Number of Families	Average No. Months in Program*	% of Immigrant Families**	% of Single-Parent Families	% of Families Receiving Increased or Special Benefits***	% of (single) Women among Recipients
1991	34,370	21.3	0.3	28.8	51.6	60.4
1999	114,170	32.0	39.0	36.8	79.2	66.1

* Number of months in which benefits were received since last entry into the IS program.
** Families that immigrated to Israel since 1990.
*** Special benefits: For single-parent families.
Note: Figures do not include immigrants receiving IS benefits under Old Age Insurance.

The percent of IS recipients in 1998 (Table 5) rises with age, as expected, from 1.6% for ages 20-24 to 7.4% for ages 55-64, reflecting a decline in labor force participation and a rise in unemployment. The rate is higher for women in every age group (except the oldest), with differences especially marked among the younger groups (ages 20-34) because of the relatively large number of female immigrants among the recipients.

Table 5. Percentage* of Income Support Recipients Among the Working Age Population – by Age, Gender and Resident Status in Israel (monthly average)

	1988					
	Total	20-24**	25-34	35-44	45-54	55-64***
Total	4.2	1.6	3.6	4.8	4.6	7.4
Veteran Israelis	3.0	1.3	3.0	3.9	3.2	3.3
Immigrants	11.0	3.4	6.9	9.3	12.4	25.1
Men:						
Total	3.0	0.6	1.9	3.1	2.8	9.0
Veteran Israelis	2.3	0.6	1.9	3.1	2.4	4.0
Immigrants	7.3	1.0	2.1	3.2	5.2	33.0
Women:						
Total	5.4	2.5	5.3	6.4	6.2	6.1
Veteran Israelis	3.7	2.1	4.2	4.7	3.9	2.8
Immigrants	14.2	5.7	11.2	14.7	18.9	19.1

* Figures refer to individuals (not families), including men aged 60-64 receiving income support benefits under Old Age Insurance.

** According to estimates of the labor force of this age; the 18-19 age group was not included because the number of recipients is negligible. Figures represent the percentage of IS recipients (claimants and their spouses) relative to the total labor force of the relevant age group.

*** Women aged 55-59.

The percentage of recipients among immigrants is higher than that among veteran Israelis for each age group. Among those of working age, 11% of immigrants, as compared with 3% of veteran Israelis, receive IS benefits. Differences between immigrants and veteran Israelis become more marked with age. Some 3.3% of veteran Israelis and 25% of immigrants aged 55-64 are eligible for benefits. The difference between men and women is especially prominent: The difference between immigrants and veteran Israelis is evident primarily among older men, whereas among women it may be discerned in all age groups.

As indicated, there appears to be a clear pattern of failure to integrate in the labor force among older male immigrants and a particularly strong dependence on the IS program during the decade preceding retirement age. This finding points to an "early retirement" trend among immigrants close to retirement age, due to the difficulty of finding work. From a policy viewpoint, it is uncertain whether this trend can be reduced for men aged 45-54, for whom employment opportunities remain scarce. Similar findings were noted among male immigrants from the Former Soviet Union in 1995 as well (Habib, Morginstin and Zipkin, 1998).

Among women as well, differences between veteran Israelis and immigrants in all age groups were similar in 1995 and 1998. It is more difficult for women of all ages to find jobs than it is for men. Furthermore, there are more single mothers receiving IS benefits (and more single-parent families in general) among immigrants than among veteran Israelis, probably because the special criteria applying to them provide them with high benefit rates and allow them to enter and remain in this system at relatively high levels of earnings (see detailed explanation and analysis below).

5. Average Duration in Income Support Program

There are three principal patterns of duration in the IS program: Some recipients enter the program, then exit and do not return; others receive benefits, leave the program and return intermittently while still others enter and remain on a long-term basis. For purposes of analysis, we defined duration as the number of months during which one has received benefits since last entry into the program.

Differences in average duration are evident among the various groups (Table 6). For all types of families, including those comprising veteran Israelis, the average stay has increased.. It is surprising to note that this trend is characteristic of single persons, many of whom are young and could have been expected to find jobs more quickly The figures were particularly high for single immigrants – an average of 34 months, as compared with 26 months for single veteran Israelis. This development is of special concern because single persons constitute more than a third of income support recipients (Table 7).

Table 6. Number of Months* in Income Support Program: Monthly Average – by Gender, Family Structure and Age (families)

		1999		
	1991	Total	Veteran Israelis	Immigrants
Total	21.3	31.6	30.1	34.2
Gender:				
Men	20.4	28.0	27.6	29.2
Women	22.5	33.4	31.7	36.0
Family Structure:				
Single Person	15.8	28.9	26.1	33.5
Single Parent with Child	25.7	36.3	35.5	37.1
Couple	20.5	31.3	30.7	31.8
Couple with Child	22.7	29.9	29.7	30.8
Recipient's Age:				
20-29	14.0	18.5	16.8	23.2
30-39	22.9	29.7	28.8	32.2
40-49	24.6	39.7	34.1	36.0
50-55	35.8	36.2	36.8	35.5
55-59		39.9	40.5	39.3
60+**		40.4	43.1	38.9

* Number of months during which benefits were received since last entry into program.

** Not including immigrants receiving IS benefits under Old Age Insurance.

Table 7. Income Support Families in Israel by Status and Family Structure, 1991 and 1999 (monthly average)

			1999		
Family Structure		1991	Total	Veteran Israelis	Immigrants
Total:	Number	34,370	114,170	69,617	44,553
	%	100.0	100.0	100.0	100.0
Single Person		31.8	34.7	35.3	33.7
Single Parent with Child(ren)		28.8	36.8	29.8	47.7
Couple		3.6	6.0	4.3	8.7
Couple with Child(ren)		35.8	22.5	30.6	9.9

Duration of stay in Income Support increases with age. Between 1991 and 1999, this figure for people aged 50 and over rose from 26 to about 40 months.

Immigrants have longer duration rates than veteran Israelis. At more

advanced ages, there is no marked difference between veteran Israelis and immigrants,most of whom entered the program shortly after immigration to Israel . In another pattern observed, some immigrants do succeed in finding jobs when they first arrive in Israel but are subsequently dismissed, whereupon they enter the IS program.(Habib, Morginstin and Zipkin, 1998).

6. Recipients of Increased Benefit

Between 1991 and 1999, the percentage of IS recipients receiving the higher benefit rose from 52% to 79%, due to an increase in duration and changes in legislation that determined eligibility for increased benefits for two groups: single-parent families, which are entitled to a special rate from the outset (42.5% of the average wage[7] for a single parent with one child), and single persons or families in which one spouse is 46+ years old.

7. Family Structure and Age

The slight rise in the proportion of women from 60% in 1991 to 66% in 1999 is partly explained by the rise in percentage of single-parent-families (37%) among IS recipients. Most of the growth in single parent-families was among immigrants (see *Table 7*): the percentage of single-parent families among immigrants is 48%, as compared with 30% among veteran Israeli families. In contrast, the percentage of conventional families – couples with children – remains higher among veteran Israelis: 31% vs. 10% among immigrants.

IS recipients – claimants and their spouses – were older in 1999 than in 1991 (Table 8): About 55% of recipients were over age 40 in 1999, as compared with 42% in 1991. Immigrants are older than veteran Israelis, a finding that underscores the employment problems faced by people who come to Israel at an advanced age. Some 43% of immigrants are aged 50 and over, as compared with 22% among veteran Israelis. As explained earlier, the immigrant group is actually even older than reflected in these statistics, as they do not include those receiving IS benefits under the Old Age Insurance program.

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7. Less one benefit point.

Table 8. Individuals* Receiving Income Support, by Age, 1991 and 1999 (monthly average)

		1999		
Age	1991	Total	Veteran Israelis	Immigrants
Total: Number	47,394	146,505	93,707	52,798
%	100.0	100.0	100.0	100.0
age:				
up to 29	24.9	17.7	20.2	13.1
30-39	33.1	27.4	30.9	21.0
40-49	20.7	25.1	26.2	23.0
50-55	9.3	13.5	11.6	16.9
55-59	7.0	8.5	6.6	12.0
60+**	5.1	7.9	4.5	13.9

* Claimants and their spouses.
** Not including immigrants receiving IS benefits under Old Age Insurance.

8. Eligibility Categories

As mentioned above, all applicants to IS become eligible for benefits according to a number of eligibility categories, or qualifying conditions. Between 1991 and 1999, we find a change in the distribution of recipients according to eligibility category (Table 9). In 1999, some 60% of recipients were entitled to benefits according to labor market factors – job seekers, unplaceability or low wages – as compared with 50% in 1991. The most significant change is the growth in percentage of recipients who were defined as unplaceable due to social, behavioral or health problems (not including age or addiction). The relative size of this group doubled from about 13% in 1991 to 25% in 1999, with a high rate of unplaceable persons among veteran Israelis (26%) and immigrants (23%) alike. Another group that is defined as unplaceable comprises older individuals: men over 60 and women over 55. Their percentage rose from 5% in 1991 to 9% in 1999, and reached 16.2% for immigrants as opposed to 4.5% for veteran Israelis, not including those receiving IS benefits under the Old Age Pension program (about 4,000 married men).

Table 9. Individuals Receiving Income Support, by Resident Status in Israel and Eligibility Category* (monthly average)

		1999		
	1991	Total	Veteran Israelis	Immigrants
Total: Number	47,394	146,505	93,707	52,798
%	100.0	100.0	100.0	100.0
Unemployed**	22.9	19.0	21.8	13.9
Unplaceable	12.6	25.0	26.3	22.6
Age***	4.8	8.7	4.5	16.2
Low Wages	13.0	14.8	10.9	21.8
Mother with Child	35.2	26.1	28.4	22.1
Addiction	7.6	3.1	4.3	0.9
Other	3.9	3.3	3.9	2.4

* Claimants and their spouses.
** Including job seekers and vocational training.
*** Not including immigrants receiving IS benefits under Old Age Insurance.

Two principal categories identify Income Support recipients as belonging to the labor force: Job seekers (unemployment) and low wages. No major changes took place over the past decade regarding the percent of unemployed persons: 23% of all recipients in 1991 as compared to 19% in 1999 consisted of people who were unable to find work during the preceding month and continue to report to the Labor Exchange weekly – as required – and receive income support benefits if no work is found for them. In this respect, there is a difference between veteran Israelis and immigrants – 22% vs. 14%, respectively – primarily due to differing age structure.

Some 15% of IS recipients are working people who are entitled to supplements as long as their income remains below the defined ceiling. Once again, significant differences are evident between immigrants and veteran Israelis (22% vs. 11%, respectively are eligible for an annual supplement). The extent to which the employment test (e.g., requiring that recipients search for full-time work) is rigidly applied to this group is unclear, depends primarily on local job market conditions and whether the individual is working full or part-time.

In 1999, 26% of IS recipients were mothers with children, as compared with 35% in 1999; 3% were eligible for other reasons, such as ex-convicts, those serving community service sentences, abandoned children, pregnancy, illness, hospitalization, care of a disabled person and the like. The percentage

of recipients eligible due to narcotics or alcohol addiction declined from 8% in 1991 to 3% in 1999.

The percentage of women receiving benefits as mothers of children in 1999 appears relatively low, considering that some 40% of all recipients are single-parent families, most of which are headed by single mothers. However, not all single-parent families are eligible for that specific reason. Analysis of the distribution of eligibility criteria according to family structure reveals that about 16% of veteran Israeli single-parent families and 37% among immigrants were defined as low wage earners. Another 11% were job seekers and 12% unplaceable (Table 10).

Table 10. Individuals Receiving Income Support in Israel, by Family Structure, Eligibility Category and Resident Status, 1999 (monthly average)

	Total		Unemployed	Unplaceable	Unplaceable Due to Age	Low Wages	Mothers with Children	Other
	Number	%						
Total	146,505	100.0	19.0	25.0	8.7	14.8	26.1	6.4
Single Person	39,317	100.0	30.7	32.3	15.7	88.1	0.0	13.2
Single Parent with Child	42,112	100.0	10.5	12.3	1.0	26.5	46.9	2.7
Couple	13,723	100.0	11.5	40.5	35.2	6.5	0.0	6.3
Couple with Child	51,353	100.0	18.9	25.6	2.7	12.6	35.1	5.2
Veteran Israelis	93,716	100.0	21.8	26.3	4.5	10.9	28.4	8.2
Single Person	24,418	100.0	37.4	31.3	7.0	6.4	0.0	17.9
Single Parent with Child	20,865	100.0	11.2	15.0	0.8	16.1	53.3	3.6
Couple	5,985	100.0	14.3	46.5	23.5	5.5	0.0	10.2
Couple with Child	42,439	100.0	19.2	26.1	2.2	11.6	35.3	5.7
Immigrants	52,798	100.0	13.9	22.6	16.2	21.8	22.1	3.3
Single Person	14,899	100.0	19.6	33.9	30.0	10.9	0.0	5.6
Single Person with Child	21,247	100.0	9.9	9.7	1.2	36.7	40.7	1.7
Couple	7,738	100.0	9.3	35.8	44.2	7.3	0.0	3.4
Couple with Child	8,914	100.0	17.8	23.2	4.9	17.3	34.1	2.7

If we consider those in the category of unemployed (job seekers) as the primary target group with potential for job placement, we find this category among all family structures. The largest subgroup of unemployed is that of single persons, primarily veteran Israelis. However, all other types of families include this eligibility category: single parents, couples and couples

with children. On the other hand, the largest subgroup of recipients who are categorized as unplaceable, the second target group for labor force integration, is found among single persons and couples. For this group, we may assume that placement attempts will be more difficult because of poor health and social problems asociated with this eligibility category.

However, age, like family structure, is a decisive characteristic in determining work potential. The distribution of recipients by eligibility category for 1999 indicate that 58% of the unemployed are under age 40, about 30% between 40 and 49 and only 14% are 50 and older. Immigrants receiving income support benefits because of unemployment are older than their veteran Israeli counterparts: 25% are over age 50 as compared with 9% in the latter group.

One prominent feature of the unplaceable group is the relatively small percentage of younger people (up to age 40). About 32% of veteran Israelis and 20% of the immigrants in this category are aged 40-50 and the remainder are older. Among those receiving low wage supplements we also note that nearly half the veteran Israelis and 37% of the immigrants are under age 40 (Table 11).

Table 11. Individuals Receiving Income Support by Eligibility Category and Age, 1999 (monthly average)

	Total	Unemployed	Unplaceable	Low Wage Supplement	Mothers with Children
Total: Number	146,505	27,786	36,563	21,698	38,267
%	100.0	100.0	100.0	100.0	100.0
Age:					
20-29	17.7	27.8	3.8	7.9	34.9
30-39	27.4	30.1	11.3	33.5	44.7
40-49	25.1	28.8	28.8	38.2	18.5
50-55	13.5	9.7	33.9	14.2	1.6
56-60	8.5	2.3	13.6	3.9	0.3
60+	7.9	1.3	8.6	2.2	0.0

As expected, most mothers with children are young: 35% are under age 30 and 45% under age 40, with immigrant mothers generally younger than veteran Israelis.

It is worth noting that there is some degree of interchangeability among the various eligibility categories (Morginstin, Haron and Zipkin, 1997). An IS recipient may be eligible for benefits under different categories while in

the system: He may begin receiving benefits under one category and continue eligibility under another, either by leaving and reentering the system or by moving to another category while receiving benefits. For example, some of those whose current eligibility category was unemployment had previously been categorized for a lengthy period of duration as unplaceable and only subsequently were transferred to the unemployed category (i.e., requiring them to accept any job offered them by the Labor Exchange). The implication of this interchangeability may be that even some of those currently determined unplaceable still might have employment potential. Younger unplaceable recipients are categorized as such primarily because of health and social problems whereas older individuals will find it difficult to obtain work One can assume that the target group for work integration among the category of unplaceable are individuals aged 40-55 who comprise 63% of this category and who are inherently employable. For this group, current job market conditions as well as placement difficulties induced the Labor Exchange to move them from job seeker to unplaceable category. Obviously, the respective job placement strategies for these two groups will be very different.

In itself, the large number of single IS recipients is particularly surprising, reaching over 39,300 in 1999. Table 12 shows that veteran Israeli single persons are much younger than their immigrant counterparts: 50% are under age 40 (men and women), as compared with 25% of immigrant men and 11% of immigrant women in this category.

Table 12. Single* Income Support Recipients, by Resident Status in Israel, Gender and Age, 1999 (monthly average)

	Veteran Israelis		Immigrants	
	Men	Women	Men	Women
Total: Number	10,680	13,738	4,928	9,971
%	100.0	100.0	100.0	100.0
Age: 20-29	24.4	33.1	14.2	8.0
30-39	25.9	17.3	11.5	3.2
40-49	25.0	19.2	12.0	15.9
50-55	10.9	16.3	12.2	33.8
56-59	5.3	11.2	8.7	26.9
60+	8.6	2.2	41.4	12.1

* Not married, without children.

Income from Work

As described above, IS recipients may work and earn wages up to a specified ceiling (if there are no other relevant income sources) determined according to family structure. In practice, as indicated, no such ceiling applies to single-parent families, enabling them to earn relatively high incomes and remain eligible for benefits.

Table 13 displays the percentage of working IS recipients with income from work, grouped according to various parameters. This percentage is particularly high among immigrants, especially women: About 15% of veteran Israeli recipients work, while the parallel figures are more than twice as high for immigrants (32% for all immigrants and 37% for women). The highest percentages are found among single-parent families: 27% for veteran Israelis and 51% for immigrants. Moreover, for each type of family structure, the percentage of working individuals among immigrants is twice as high as that of veteran Israelis. Apparently, immigrants exhibit a greater tendency to combine employment with dependence on the income support system.

Table 13. Percentage* of Income Support Recipients in Israel with Income from Work, by Gender, Family Structure and Resident Status, 1999 (monthly average)

	Total	Veteran Israelis	Immigrants
Total: Number	146,505	93,707	52,798
% with income from work	21.3	15.3	31.8
Gender:			
Men	15.5	14.8	17.4
Women	24.2	15.6	36.9
Family Structure:			
Single Person	13.1	9.4	19.3
Single Person with Child	39.0	26.8	51.0
Couple	11.4	7.6	14.3
Couple With Child	15.6	14.2	22.4

* *Figures represent the percentage of individuals (claimants and their spouses) with income* from work out of the total number of IS recipients in each subgroup.

On the one hand, the high percentage of working individuals among single-parent families attests to the positive work incentive when there is no income ceiling restriction. However, it also indicates the relative ease with which working single parents may enter and remain within the IS program. The liberal

income criterion, combined with social and employment difficulties resulting from single-parent status – and of course the increasing number of such families in Israel – have yielded a marked increase in the size of this group within the program.

Analysis by age group also reveals higher percentages of working recipients among immigrants than among veteran Israelis. At younger ages (30-49), this difference is more than twofold. It is surprising, however, to note the low percentage of working people among those under 30 – only 13%. The highest percentage is found among persons aged 40-49, and declines thereafter in direct proportion to age (Table 14).

Table 14. Percentage* of Income Support Recipients in Israel with Income from Work, by Age and Resident Status (monthly average)

	Total	Veteran Israelis	Immigrants
Total Number	146,505	93,707	52,798
up to age 29	13.2	10.5	20.4
30-39	25.5	18.1	45.1
40-49	28.7	19.3	47.6
50-55	21.6	14.1	30.8
56-59	12.7	9.2	16.1
60+	9.8	6.9	11.4

* See note Table 13.

Recipients eligible for reasons other than low wages may also work, including the unemployed, mothers of young children and even those categorized as unplaceable (*Table 15*). Different intervention and support programs will be required to enhance job placement efforts for these varying groups.

Table 15. Percentage* of Income Support Recipients in Israel with Income from Work, by Eligibility Category and Resident Status (monthly average)

	Total	Veteran Israelis	Immigrants
Total: Number	146,505	93,707	52,798
% with income from work	21.3	15.3	31.8
Unemployed	6.7	4.4	13.0
Unplaceable	4.4	2.1	7.9
Low Wages	100.0	100.0	100.0
Mother of Children	12.7	9.0	21.3
Other	5.4	3.2	9.3

* See note Table 13.

As expected, most recipients who work earn wages at levels close to the respective disregards (NIS 825 per single person and NIS 1,079 per couple in March 2000). Furthermore, there is a correlation between income level and income ceilings set for each type of family structure (see Table 16).

Target Groups

To determine which groups among veteran Israelis and immigrants currently dependent on Income Support constitute target groups for job placement, and assess their magnitude, we analyzed data according to gender, family structure, age and resident status in Israel. Data are for March 2000.

Assuming that work potential is strongest among people under age 50, we identify three major target groups (Table 17):

(a) Married couples – primarily veteran Israelis but including some immigrants as well: approximately 20,000 couples (40,000 individuals).

(b) Single mothers (veteran Israelis and immigrants): approximately 40,000.

(c) Single men and women among veteran Israelis: 20.000.

As noted previously, women constitute 74% of all immigrants receiving IS benefits (as compared with 65% of veteran Israeli recipients). The largest groups are single mothers aged 20-49 and smaller groups of single and married women (with children) up to age 50. Three large target groups of women are discerned among veteran Israelis: Married women with children, single mothers and a sizable group of unmarried women. The situation differs among immigrants, for whom the principal target group consists of single mothers.

Table 17 shows that there are no large groups of younger immigrant men that

Table 16. Income Support Recipients with Income from Work, by Wage Level, March 2000

Family Structure		1-1,000	1,001-1,500	1,501-2,000	2,001-2,500	2,501-2,658	2,659-2,797	2,798*	2,799-2,938	2,939-3,100	3,101-3,500	3,501+	Ceiling
Total	100.0	19.1	20.8	15.5	10.8	3.6	3.1	1.4	4.9	4.7	8.1	8.1	
Single Person	100.0	45.6	32.0	18.3	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2,412
Single +1	100.0	12.4	18.8	15.6	12.4	4.9	3.9	0.5	4.8	5.0	10.2	11.5	5,288
Single +2	100.0	16.1	21.3	16.4	12.8	4.1	3.3	0.3	3.6	4.0	6.6	11.4	6,347
Couple	100.0	35.1	28.2	14.4	8.6	2.1	2.4	0.4	2.8	3.0	3.0	0.0	3,459
Couple +1	100.0	15.9	20.7	15.5	14.6	3.9	4.3	2.1	6.9	6.5	7.3	2.4	3,840
Couple +2	100.0	7.6	12.9	12.2	11.8	4.1	4.2	5.1	10.6	8.5	13.9	9.1	4,392

* minimum wage

Note: Disregard for single person = 13% of average wage: NIS 825; Disregard for couple = 17% of average wage: NIS 1,079 – March, 2000.

Table 17. Income Support Recipients in Israel, by Status Gender, Family Structure and Age, January-March 2000

		MEN					WOMEN				
		Total	Unmarried	Single + children	Couple	Couple + children	Total	Unmarried	Single + children	Couple	Couple + children
Total	160,823	55,804	17,688	1,469	7,590	29,057	105,020	25,525	42,945	7,574	28,976
Veteran											
Israelis	105,859	41,288	12,230	858	3,626	24,574	64,570	15,383	21,288	3,607	24,293
Age: 20-29	21,802	6,266	3,136	68	285	**2,778**	15,536	**5,168**	**4,310**	414	**5,644**
30-39	32,225	12,122	3,029	221	243	**8,629**	20,103	**2,660**	**8,230**	171	**9,042**
40-49	27,722	10,995	3,061	335	234	**7,366**	16,727	**2,865**	**6,698**	513	**6,.651**
50-55	12,616	5,042	1,372	136	582	2,953	7,574	2,590	1,670	1,100	2,214
56+	11,493	6,864	1,633	99	2,283	2,843	4,631	2,099	379	1,411	743
Immigrants	54,965	14,515	5,458	611	3,964	4,483	40,449	10,142	21,657	3,967	4,683
Age: 20-29	7,246	1,167	828	15	19	305	6,080	800	**4,290**	33	957
30-39	11,619	1,926	663	122	27	1,115	9,692	334	**7,797**	36	1,525
40-49	12,784	2,337	697	246	118	1,277	10,447	1,650	**7,146**	261	1,391
50-55	10,098	2,192	721	132	549	790	7,906	3,790	2,048	1,429	638
56+	13,218	6,892	2,550	95	3,251	996	6,324	3,568	376	2,208	172

Note: Numbers in bold type denote the largest groups of recipients aged up to 49 years.

could be considered target groups for job placement. The largest group consists of married men aged 30-50. There is also a relatively small group of unmarried men up to age 50. Among veteran Israeli men, the largest group of recipients consists of married men aged 20-50. The group of unmarried men aged 20-50 is also large among veteran Israelis but not among immigrants.

It is important to differentiate among these three target groups not only by age but also their principal eligibility category. Table 18 clearly indicates that there are over 40,000 married men and women aged 20-50, i.e. some 20,000 families, in about half of which the husband is classified as unemployed (job seeker for whom the Labor Exchange did not succeed in finding work) and the wife is eligible as mother of young children.

Table 18. Target Groups* for Job Placement, by Eligibility Category, March 2000

	Total Number	%	Unemp-loyed	Unplace-able	Low wages	Mothers with children	Addiction	Other
Veteran Israeli men:								
Unmarried	9,226	100.0	43.4	23.8	2.5	-	21.6	8,7
Married	18,773	100.0	46.7	23.3	20.4	-	6.0	3.5
Veteran Israeli women:								
Unmarried	10,693	100.0	56.9	21.1	9.9	-	2.4	9.7
Married	21,337	100.0	5.5	9.5	2.8	80.2	0.1	1.8
Single parent families:**								
Veteran Israelis	19,238	100.0	11.4	10,7	15.5	59.8	0.6	2.0
Immigrants	19,233	100.0	9.7	6.1	37.4	45.4	0.1	1.3

* Target groups include IS recipients identified by bold numbers in Table 17.
** With women as heads of household.

Married persons constitute the largest group and the one with the most pressing needs (approximately 40,000 individuals). While almost 50% of the men in this group are unemployed, 23% are categorized as unplaceable, some after a period as unemployed (Table 18). Some of these individuals might have placement potential after obtaining the necessary training, services and support. Husbands work and receive income support benefits to supplement low wages in about 20% of these families.

The second-largest group comprises nearly 40,000 single-parent families

headed by women, with differences between veteran Israelis and immigrants: 60% of veteran Israelis are categorized as mothers of young children and only 16% as low wage earners, as compared with 37% low wage earners among immigrants.[8]

The third group consists of some 20,000 unmarried veteran Israeli men and women, with a significantly high percentage (men – 43% and women – 57%) classified as unemployed. Another 25% have been defined as unplaceable and their ability to enter the labor force needs to be reassessed. Over 20% of the men in this group receive income support benefits because of narcotics or alcohol addiction.

Whereas a large group of recipients, immigrants and residents alike, are in the system due to difficulties in obtaining work, younger women, both married and single mothers, are largely eligible by virtue of caring for young children. As indicated above, single mothers have an obvious incentive to remain in the system, since the benefits they receive (including housing, reductions in municipal taxes, etc.) are higher than those to which other groups are entitled. For some of these women, the combined income level derived from benefits and work is likely to be higher than the wages they would earn otherwise. For example, a mother with two children can attain a total income (IS and work) approaching the average wage. The incentive to remain in Income Support is powerful if we add to this income the value of these related benefits. Another significant group among resident Israeli women consists of unmarried women, most of them young, some unemployed and some unplaceable.

The figures indicate that we need to plan and focus job placement programs, treatment strategies, types of services and support required according to the characteristics and needs of these groups. Single mothers, for example, whether veteran Israelis or immigrants, constitute a special population group. A considerable percentage of them are already working, especially among immigrants. In contrast, as shown in Table 18, a rather large number of single women are virtually exempt from the employment criterion because they have children. Another large group consists of veteran Israeli married women, a decisive majority of whom, as anticipated, are mothers of small children, while a third comprises single unemployed veteran Israelis.

Analysis according to target group criteria reveals two principal target groups among men: Single veteran Israelis and family men, many of the former

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8. Percentages are higher among families of working single mothers (Table 13), although not all are classified as low wage earners

unemployed or unplaceable. The unemployed constitute about 47% of male recipients with families.

Major efforts may be required to achieve job placement, especially for married men and the veteran Israelis among them in particular. As numerous couples of relatively young and middle age will be included in job placement programs, such programs should be planned with families in mind to help reduce dependence on the support system, even by providing part-time work. Furthermore, the large group of single men and women will require further assessment for work potential to enable the planning of targeted training and assistance programs.

Summary and Discussion

This study sought to describe changes in the Income Support Law and in the size and characteristics of recipients during 1990-2000, against the background of unemployment rates and immigration. Similarly, it attempted to identify the principal target groups with potential for work.

The study did not relate to other significant factors related to the potential for job placement: educational levels of recipients, work history, etc. Moreover, we did not address the specifics of local job markets in places where recipients with work potential reside.

Income support recipients constitute a heterogeneous population with respect to gender, age, family structure, resident status and eligibility categories, all of which affect the likelihood of integration in the labor force. According to the findings, we need to differentiate among several principal target groups. For each group, it will be necessary to determine whether the objective is to place people in full or part-time work, while remaining in the Income Support program, even with low benefit levels. This question is especially relevant to mothers of young children, and especially single mothers many of whom are already working. Benefit structure, related benefits and the absence of an income ceiling constitute a powerful incentive to remain in the system and work at the same time. Unless programs provide work options with a relatively high income, continued benefits and subsidized child care, it will be virtually impossible to encourage this group to leave the Income Support program. For single-parent families especially it is also crucial that the support system remains as a safety net in time of crisis (e.g. job dismissal). Eligibility for related benefits such as tax credits, as well as reductions in medical costs and services should become available to low wage earners who leave the Income Support system.

Single Income Support recipients, men and women alike, constitute an

obvious target for immediate job placement programs. Many of these individuals are relatively young, and it is important to allocate resources in order to prevent dependence on Income Support as early in life as possible.

The largest target group consists of families: married men and women with children. Any job placement program will have to provide essential family services to make it easier for parents to work. It may be necessary to design several stages of job placement: gradual assumption of part-time work by women with children and placement of men in full-time jobs, with the option of remaining in the Income Support program in case of low wages. As with the other groups, vocational training, increased earning power and continued provision of related benefits and services (especially child care) will all be considered by families assessing the economic and practical viability of work as opposed to Income Support. No program will succeed unless the job market provides an alternative to benefits – i.e. wages higher than the inherent financial value of benefits – as well as the enhancement of human capital and options for advancement.

In planning job placement programs, the purpose is to guarantee an acceptable standard of living, maintaining the safety net, and recognizing that some people will be forced to continue to rely on the vital assistance they receive under the Income Support program.

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SELECTED ISSUES IN THE DELIVERY OF HOME CARE SERVICES TO THE ELDERLY AFTER A DECADE OF IMPLEMENTING ISRAEL'S LONG-TERM CARE INSURANCE LAW

By Hillel Schmid* and Allan Borowski**

The article presents several organizational and structural dilemmas after a decade of implementation of the Israeli Long-term Care Law. A description of the background, principles and goals of the law is followed by an analysis of the dilemmas that are associated with the policy of contracting out of services to nongovernmental organizations, the financing of the services and the relative merits of cash benefits vs. benefits in kind. Other issues discussed and evaluated are: home care workers, the strategic behavior of the service providers, the critical factor of monitoring and control in maintaining high standards of quality of services, the impact of the law on institutionalization of the elderly and the burden of care borne by primary informal caregivers.

Introduction

Israel's Long-Term Care Insurance Law (LTCI) began to be implemented just over a decade ago. The enabling legislation was passed following a prolonged struggle between proponents of different viewpoints concerning the need for a law that assured at least some assistance to the growing number of frail elderly. We now have sufficient experience of the law to make it possible to reasonably assess its major effects, to draw some select lessons, and to identify continuing dilemmas.

The framework chosen for the presentation of lessons learned from the law is based on three main components, which are addressed in the respective sections of the paper: Inputs, Process, and Effects. The *Inputs* section includes:

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Background, principles, and goals of the law; contracting out of service delivery; home care workers; financing long-term care services; and the relative merits of cash benefits versus benefits in kind, an issue that has been a focus of public debate. The *Process* section includes: The home care industry that developed as a result of implementation of the law; the strategic behavior of provider organizations that had to adapt themselves to the changing demands of their task environments; dilemmas related to monitoring and control, which derive from the unique situation of organizations providing services outside of the organizational boundaries, i.e., at the home of the elderly client. The *Effects* section focuses on three main effects: The impact of the law on institutionalization of the elderly, the burden of care borne by primary informal caregivers, and service quality. The article ends with a discussion and conclusions section.

Background to the Law, Its Principles and Goals

Israel's Long-Term Care Insurance Law was essentially enacted in response to the demographic changes that are typical of modern societies. Here we present some of the international and Israeli trends in these demographic changes. This is followed by an outline of the principles upon which the law was based and its goals.

1. International and Israeli Trends and Prospects in Population Aging

The Long-Term Care Insurance Law was enacted in response to population aging. The emergence of this phenomenon made it necessary to seriously explore alternative ways of providing needed services for the growing number of frail elderly.

Population aging, especially the growth in the proportion of the population aged 65 and over, is the dominant feature of the age structure of Israel and most of the Western industrialized nations. Thus, for the OECD countries, the proportion of the elderly population is expected to more than double from an average of 10% in 1950 to an average of more that 20% by 2050 (OECD, 1996). The considerable implications of this unprecedented shift in the balance between the young and the old for income security and health care policy have been broadly recognized for at least two decades.

The phenomenon of population aging has been accompanied by a secondary aging process, which refers to the rapid growth in the proportion of very elderly amongst the aged population – "the aging of the aged". For example, the

proportion of the elderly population aged 80 and over is projected to increase from 19.5%, 20.8%, 19.7% and 25.5% in 1990 in Australia, Canada, Japan and Switzerland, respectively, to 27.4%, 31%, 31.7% and 28.1% in 2040 (OECD, 1996). Given the correlation between age and functional disability, the sizable increases in the proportion and number of very elderly will place ever-growing demands on long-term care services. While projections of the scope of future demand for long-term care are sensitive to assumptions about likely rates of dependency among the elderly, even under optimistic scenarios long-term care will need to expand significantly. In England, for example, if no account is taken of other factors, long-term care will need to expand by 61% between 1995 and 2031 to keep pace with the rising number of elderly (PSSRU, 1999).

Moreover, the rapid aging process is occurring despite a comparatively high birth rate in Israel. This trend is mainly due to increased life expectancy (the life expectancy at age 65 is 8.15 years for men and 9.17 years for women, an increase of 19% over the life expectancy 20 years ago) and a major influx of immigrants (especially from the former Soviet Union and Ethiopia) comprised of a sizable proportion of older immigrants. The elderly population in Israel reached 568,000 at the end of 1996, or 9.9% of the total population (Kop, 1998). Of this number, 231,000 were over 75 years of age. In 1997, 492,000 elderly received an old-age pension and 40% of these pensioners also received an income supplement from the government (Kop, 1998).

Israel's elderly population has not only grown in size; its composition has also changed over time. Between 1955 and 1998, the population of Israel increased three-fold while the elderly population increased six-fold. The number of elderly above 75 years of age increased eight-fold. The number of elderly above 85, the most vulnerable age group in terms of disability, increased 100% during the 1980s alone and is expected to continue increasing rapidly. The proportion of women in the elderly population has also increased. It is expected to further increase by 37% by the year 2000 while the increase for men is projected to be 25%. In addition, the ethnic composition of the elderly population has been changing as the% age of elderly from the former Soviet Union and African and Asian countries has increased. Since the incidence of disability is greater among women than men and people of Asian-African origin (Kop,, 1998), the changes in the composition of the elderly population have contributed toward a steady increase in the number of disabled elderly. Thus, the proportion of disabled elderly entitled to home care due to limited functional ability reached 11% of the total elderly population by 1998 (Brookdale Institute and Eshel, 1998).

In addition, a large proportion of elderly individuals have health and

income needs and require a wide range of home care services. In recent years, expenditure on the elderly population has represented a major component of total government expenditures on welfare and social services. In the early 1990s, expenditure on the elderly represented 33% of total expenditures while in the 1998 budget, the expenditure level rose to 41%. From 1990 to 1998, expenditure rose by 120%. (Kop, 1998).

2. The Principles and Goals of the Law

The Long-Term Care Insurance Law is a social insurance law operating according to universal principles. Initially, the law provided for equal employer and employee insurance contributions of 0.1% of earnings (0.2% *in toto*). Thus, the receipt of home care services by the frail elderly, in contrast to other services (e.g., services to the developmentally disabled, the unemployed, and rehabilitation services) is no longer dependent upon the vagaries of the state budget and shifts in policy or priorities which may affect service eligibility.

Several principles guided the legislators involved in framing the legislation. The following are the most important (Ben-Zvi, 1989; Cohen, 1988):

(1) The Long-Term Care Insurance Law covers elderly people living in the community - either independently or with their families - and not residents of aged care institutions.

(2) The law accords priority to benefits in kind, i.e., direct services for the elderly such as personal care and help with home chores. Only in cases where such services are not available can the benefit be exchanged for a cash benefit. The stipulation that direct services be provided was based on the assumption that cash benefits may otherwise be consumed as part of the family budget without being used for the intended purpose.

(3) The benefit is targeted on frail elderly people who are completely or partially dependent on assistance from others to carry out activities of daily living. It is not intended for elderly people with mild functional disabilities and who are not highly dependent on help from others.

(4) Personal benefits are not intended to replace the assistance provided by family members. Since these benefits are relatively modest, it is assumed that supplementary aid will continue to be given by family members as a natural obligation, and that they are not paid or otherwise compensated for the services they render. Personal benefits are intended to alleviate the burden of care borne by the family in such caring activities as bathing, dressing, feeding, mobility in the home, and protection of the elderly person against potential risks. However,

such help in the home does not replace professional health and welfare services such as physiotherapy, occupational therapy, medical services, and psychosocial counseling.

The insurance law, by nature, guarantees home care services for all eligible applicants according to uniform, legally prescribed eligibility criteria. No eligible person can be denied services on the grounds that funds are lacking. Eligibility is a function of age, dependency and income. Thus, eligibility for benefits begins at age 60 for women and at age 65 for men and is primarily based on an Activity Daily Living (ADL) test. However, eligibility for personal care benefits is also subject to an income test. This stipulation is at odds with the principles of contributory social insurance and is an anomaly among the range of social insurance provisions (e.g., age pensions, unemployment insurance benefits, etc) administered by the National Insurance Institute (NII). The income test was introduced into the law due to "... the economic difficulties of the country and the desire to complete the legislation at a time of considerable cuts in welfare services." (Cohen, 1988, p. 9).

(6) The law provides for two levels of benefits, depending on the seriousness of the person's functional disability. For those who are highly dependent on help from others to carry out most daily activities benefits are equivalent to a full (100%) disability allowance. In the case of those who are completely dependent on others to carry out all daily activities, benefits are equivalent to 150% of a full disability allowance.

(7) A central aspect of the law is the need for cooperation between all of the relevant agencies that provide care for the elderly, i.e., government, voluntary non-profit and for-profit organizations.

Responsibility for implementing the law rests with the NII, which is assisted by local professional committees. The members of these committees include a social worker from the local social services department, a nurse from the local health services and a clerk from the NII. These committees are responsible for determining the care plan and monitoring implementation. The committees also direct the elderly to the various service providers in accordance with government policy to contract out to service providers within the nonprofit and for-profit sectors.

The Contracting Out of Service Delivery

The introduction of quasi-markets in the delivery of human services (contracting out of services to a "mixed economy" of the government, voluntary nonprofit organizations, or VNPOs, and for-profit organizations, or FPOs) has typically

been driven by considerations of economic efficiency, enhanced consumer sovereignty, improved service quality, greater flexibility and innovation in service delivery arrangements, and the desire to reduce the role of the state in the welfare domain (Glennerster and Le Grand, 1994; Glennerster, 1996; Knapp *et al.*, 1999). The role of governments in the mixed economy is, typically, to establish policies and standards and to monitor the delivery of the services for which they are the monopoly purchaser. The rationale for adopting the strategy of contracting out was based on the relative ease with which the government would be able to assure service delivery to a much larger beneficiary population as opposed to the difficulties involved in adding tens of thousands of home care workers to the civil service rolls. This strategy also allows for bypassing of rigid budgets and administrative rules and regulations, such as freezes on hiring of personnel or requirements for compliance with salary guidelines, and the avoidance of political constraints.

Studies of the implications of contracting out have revealed both benefits and problems associated with this strategy (e.g., Deakin, 1996). First of all, there is no doubt that the number of personnel directly employed by the government to implement the law is very small. Second, the relationship between the government and the service providers has stabilized over the years and management practices have been honed. Indeed, service providers even report increased access to policy makers and reduced bureaucratic and administrative difficulties. Third, the use of contractors allowed the government to save on the start-up costs involved in founding new services. Fourth, the government has also been able to successfully integrate FPOs and VNPOs into a single service delivery system. Finally, the government has been able to impose upon the provider organizations high professional standards by requiring them to employ professional personnel (social workers and nurses) and create preparatory and ongoing training programs for the home care workers.

The strategy of fostering the development of quasi-markets, however, poses several dangers - both actual and potential - arising from the relationship between the provider organizations and the government. One of these dangers is the creation of interdependency. Since the law took effect, the government has become increasingly more dependent upon the organizations as it has no alternative system for providing services to the eligible frail elderly living in the community. The government would be required to invest even larger sums of money in the provision of services in the absence of the providers. The result is that the government has found itself in a weakened position in relation to service delivery as the provider organizations have acquired great power

knowing that the government is obliged to provide for a very large beneficiary population.

On the other hand, the organizations are dependent upon the government for funding: They derive 75% of their income from government budgets earmarked for services to the frail elderly. This dependence engenders such close compliance with government policy that the provider organizations are unwilling or unable to provide needed services beyond those required of them by the government, such as day care centers and transportation (Gronbjerg, 1998; Schmid, 1998). The provider organizations have almost become extensions of the government, mimicking both its bureaucracy and politics rather than being efficient and flexibly responsive to addressing unmet needs.

Another danger stemming from the dependency of the provider organizations on government financing is their vulnerability to changes in government policy. A change in policy could have direct implications on resource allocation and upset the financial stability of the organizations. Indeed, recent discussions within government circles and the National Insurance Institute have canvassed the possibility of replacing the personal in-kind benefit with a cash benefit and placing a quota on the number of authorized provider organizations.

Yet another potential problem arising from contracting out is related to the degree of autonomy enjoyed by the organizations versus government control. The organizations have sought to strengthen themselves and, while government should be interested in fostering this, at the same time it has also sought to develop a strong degree of control over the organizations to assure the quality of their services. Thus, the organizations have found themselves subject to policy restrictions such as who shall be served (client eligibility): by whom (staff restrictions): and how (service delivery). They have also experienced unwanted interference with internal management and operating policies, such as standards of supervision and control or requirements for office equipment (such as voice mail or fax machines). Government control, to some extent, indicates suspicion of and a lack of trust in the provider organizations, especially the FPOs. The result is restrictions on the autonomy and development of the organization.

Whether quasi-markets are a better way of delivering services than the alternatives of public bureaucracies or pure markets is an issue that is much debated in social policy circles. The Israeli experience of delivering home care services to the frail elderly leaves open the answer to this question. Indeed, there appears to be little in the experience of many other countries to support the contention that quasi-markets necessarily yield more efficient and better human services (Hodge, 1996). Consequently, in some countries,

e.g., Australia (House of Representatives Standing Committee on Family and Community Affairs 1998), there are signs of a retreat from the formerly staunch support for quasi-markets in the delivery of human services.

The Israeli experience, at least so far, indicates that the adoption of contracting out as a service delivery strategy enables the government to deliver a substantially increased volume of services within a relatively short period of time without adding employees to the civil service payroll. Nevertheless, the relationships that have been created between the government and the provider organizations raise some questions regarding their mutual interdependence and the development of the provider organizations as independent entities responsible for the provision of high quality services.

Home Care Workers

The home care industry's single largest group of employees is, by far, its home care workers. Some 42,000 home care workers are directly responsible for providing services to the frail elderly. In addition, social workers employed by the provider organization are responsible for supervising and monitoring each client's care plan. Social workers employed by the social services departments and the regional committees are also part of the industry's labor force.

Most of the home care workers are unskilled women with a low level of formal education, and their average age is 43. The majority earn minimum wage and work part-time, so that their annual income is very low. As a class of workers, they are not unionized and have little job security, few fringe benefits and no opportunity for advancement. They are employed in positions with low prestige and their work is usually under-valued by their employers. Moreover, gender and racial stereotypes devalue salaries, especially when the jobs are not unionized, when they are traditionally associated with gender and race and when performance measurement is ambiguous - all traits of home care work (Schmid, 1993b).

The years immediately following passage of the law witnessed a rapid turnover of home care workers. Studies of the performance of home care workers (Schmid, 1998) have shown that, over time, the home care labor force has stabilized and that there has been a significant reduction in the turnover rate. In other countries, such as the United States, the labor force is quite unstable and turnover remains high (Neysmith and Aronson, 1996).

An important element of home care work is training. While the level of training was very low in the early years of the law, it has improved significantly

since then. Both FPOs and VNPOs recognize the importance of training home care workers and of engendering a greater sense of responsibility and commitment toward their work as a way of improving the quality of service (Rose-Ackerman, 1996). In the absence of proper training, there is a danger that service quality will decline as a result of the low level of expertise and management skills.

Research has also revealed that the home care workers' low remuneration is likely to affect their personal investment in their work (Schmid, 1998). There is extensive anecdotal evidence indicating that workers may try to compensate themselves by reducing the amount of attention they give to the elderly client, reducing the number of hours they actually work while falsely reporting a larger total, not coming to work, changing the schedule or care plan, and reducing their effort and commitment to the aged client.

Financing Long-Term Care

As noted above, the law initially provided for equal employer and employee insurance contributions of 0.1% each (0.2% *in toto*). When the collection of LTCI contributions began in 1982 following the passage of the framework legislation two years earlier, the employer's payroll tax for *all* of the various forms of Israeli social insurance was 10.25% of the employee's wages while the employee's contribution was 3.8% of wages. Beginning in 1986, the rates of social insurance contributions paid by employers and the self-employed were gradually reduced as part of a policy of reducing labor costs in order to foster competitiveness. Thus, in April 1990, the employer's LTCI contribution was reduced to 0.04% of wages and the government began to contribute 0.06% of employee's wages. In this way, the NII was compensated for the loss of revenue deriving from the reduction in the employer's contribution (this compensation is known in Israel as "treasury indemnification"), while the employee's contribution remained 0.1%. Excluding the national health insurance contributions introduced in January 1995, today the employer's social insurance contribution is 4.93% while the worker's share is 2.66% of earnings up to half of the average wage and 4.90% of earnings in excess of the average wage. Clearly, relative to the overall social insurance contribution burden, the LTCI levy has always been quite modest.

Although the LTCI basic legislation was passed in 1980, collection of contributions did not begin until 1982. However, the first expenditures were not incurred until 1986. Thus, the LTCI scheme was able to accumulate a "start up" reserve—not unlike some other new social insurance schemes elsewhere. For

example, in the US, the 1935 Social Security Act was scheduled to take effect on January 1, 1937 and payment of benefits was to begin five years later. As it turned out, payment of benefits began in 1940, two years earlier than planned.

Regarding the financial impact of the law, after a decade the LTCI scheme is in deficit. Indeed, this has been the case almost from the outset. As noted, the LTCI component of total social insurance contributions is very modest in and of itself and in comparison with similar schemes elsewhere. Thus, for example, the ambulatory or domiciliary care component of Germany's LTCI scheme introduced in 1995 was financed by an employer and employee contribution of 0.5% each of contributory income (Goerke, 1996). It was not surprising, therefore, that the LTCI's start-up reserves were soon dissipated in the face of a rapid growth in the number of beneficiaries once personal benefits became payable in 1988. As early as 1989 LTCI expenditures began to exceed the revenues generated by the insurance levy, a situation which not only persisted but also escalated over the ensuing years (National Insurance Institute, 1996). The total expenditure on LTCI benefits in 1998 was 1.29 billion NIS while the estimated deficit was 803 million NIS. Clearly, the LTCI scheme has not been self-funding. Shortfalls have been financed from the surpluses of other social insurance programs (most notably children's allowances), a practice permitted under Israel's social security laws, and through drawing on reserves and interest on investments. In addition, the government covers all payments made to new immigrants in receipt of LTCI benefits (Yaniv, 1998; National Insurance Institute, 1999).

According to Morginstin et al. (1992): there has been ongoing concern about the deficit carried by the LTCI scheme. In recent years, however, the concern has become more serious as increased unemployment and a decline in the rate of economic growth have contributed to growing pressure to reduce public expenditure, including expenditure on the LTCI scheme (Stessman, 1998). The design features of several social insurance provisions have been the target of expenditure reduction proposals. Social insurance provisions are an issue on the agenda of those seeking to reduce public expenditure for at least two reasons. The first is that the government, under the National Insurance Law, participates substantially in the financing of some of these provisions, most notably old age and survivors' pensions and children's allowances. Second, because of the substantial growth in expenditures on these provisions and the expectation that this growth will continue unabated in the future, the government faces the prospect of ever-increasing levels of participation in their financing. Thus, in 1997 alone, government participation in the financing of social insurance

provisions increased by 11% (Yaniv, 1998, pp. E10-E11). Of particular importance in the context of this article is that, aside from unemployment benefits, the LTCI scheme has experienced the highest rates of growth in social insurance expenditures - a growth rate of approximately 20% in both 1997 and 1998 (National Insurance Institute, 1999).

In view of current and projected long-term care expenditure levels, 1998 witnessed efforts by the Treasury to reduce LTCI expenditure as part of its strategy to achieve cuts in Israel's 1999 national budget (Gilbert, 1998). In the same year, the NII began its own internal review process with a view to identifying means to curb the growth in LTCI expenditures (Stessman, 1998).

While successive Israeli governments appear to have been "resigned" to the sizable deficit carried by the LTC scheme, these recent initiatives suggest that this is no longer the case. The simplest solution would appear to be to increase the LTCI contribution levels imposed on employers and employees in order to bring income and expenditure into closer alignment with one another. Indeed, some of those involved in devising the LTCI scheme had recommended that 0.75% of the insured's income be contributed (divided equally between the employer, the employee and the government). However, it was not politically possible to set LTCI contribution levels at this higher level when the legislation was being prepared (Mann, 1988, p. 25). Thus, it was realized from the outset of the LTCI scheme that the "meagre" (Mann, 1988, p. 27) total contribution of 0.2% would not generate sufficient funds from contributions to cover expenditures (Mann, 1988; Morginstin, Baitch-Moray and Zipkin, 1992).

The prospects today for an increase in LTCI contribution levels are poor, just as they were during the scheme's formative days. This is because Israelis already pay high direct and indirect taxes as well as high social insurance (including national health insurance) premiums. The high levels of taxation are, in large measure, attributable to high levels of national expenditure on security. Governments remain averse to raising taxes in general and those that would add to labor costs in particular. In an environment of fiscal constraint, drawing even further on general revenues to subvent the LTCI scheme is also unlikely. In the absence of a willingness to generate more funds or draw further from existing sources, only two options appear to remain. The first is cost containment and the second is to pass on some of the cost.

The avenues for achieving cost containment include, for example, tightening eligibility criteria, reducing benefit levels, or reducing the number of items included in the basket of services. It should be evident that cost containment is tantamount to a rollback in the coverage and scope of the LTCI scheme. Yet,

as we have shown elsewhere (Borowski and Schmid, 1999), after a decade of implementation there is strong reason for seeking the exact opposite, i.e., broader coverage to include those elderly who are less severely disabled, higher benefit levels, and an expansion in the items comprising the service basket.

Another alternative is to encourage private long-term care insurance coverage. But the myopia of the young and the high premiums that would be necessary for those who purchase such insurance later in life when infirmity begins to loom suggest that, even with the tax incentives, coverage will remain very limited. Indeed, this is precisely one of the rationales for adopting a social insurance approach to the funding of long-term care.

Given that the state and the market do not seem to be viable avenues for dealing with the funding "crisis" faced by Israel's LTCI scheme, another option is to somehow pass on the costs to the remaining institutional pillar involved in aged care, viz., the informal caregivers. Indeed, in Israel and elsewhere (Rein, 1999) pressure appears to be growing to take this course. It can be achieved through various means, including co-payments for services or cashing out in-kind benefits at a discount. Both approaches would add to the financial burden borne by caregivers seeking to maintain the previous level of care, a burden that the LTCI seems to have effectively eased since its inception. If they could not sustain the additional financial burden, then the qualitative burden of care borne by the caregivers could be expected to grow as well. Here again, this would undo some of the good work done by the LTCI scheme.

It would seem, then, that Israel must face some hard choices regarding the future of its LTCI scheme. One choice is to take the difficult political decision of either raising contribution levels or increasing the level of subvention of the LTCI scheme at the expense of other areas of government expenditure. Alternatively, Israel can adopt some of the cost containment or cost-shifting strategies referred to above at the expense of some of the important achievements that the scheme has already realized. The size of Israel's frail aged population in need of community care will continue to grow – even without unanticipated events that would further increase the LTCI beneficiary population (e.g., the major influx of immigrants from the former Soviet Union, which began in 1989 and comprised a high proportion of older people). In the view of the authors, if the Israeli Government seriously wishes to protect elderly citizens against some of the costs associated with the normal life event of functional incapacity and to build on the successes of the LTCI scheme to date, it cannot escape the reality of the high cost involved, even in the case of a scheme which is as limited in scope as Israel's.

Benefits in Kind versus Cash Benefits

A number of countries have either proposed or actually provided clients with cash, which can be used to obtain services in kind at a reduced fee under their home care schemes. This proposal/option is fundamentally driven by cost considerations. However, debates on the issue of cash versus in-kind services are not triggered solely by such considerations.

The LTCI law provides mainly services in kind and not cash benefits. According to the law, elderly persons are eligible to receive a monetary allowance only when the services they require are not available. Advocates of services in kind emphasize the need to increase the scope and availability of the services, as well as the need to improve the quality of services in the community and even in institutions. The main argument in favor of services in kind is that the elderly population is not normally distributed in terms of its consumption of required services. Therefore, a large gap may emerge in the level of services provided among populations that invest the cash benefits in ensuring the elderly clients' quality of life, compared with populations that use the benefits to promote their own goals at the expense of the elderly client's well-being.

Indeed, when the law was first implemented, about 80% of the elderly population and their families were in favor of receiving benefits in kind (Schmid and Sabbagh, 1991). Now, a decade later, policy makers are reconsidering the issue of providing services in kind, and the issue of the "brokerage gap" deriving from payments to organizations providing the services. The "brokerage gap" refers to the difference between the amount paid by the NII to service providers, and the wages paid by the provider to the workers serving the clients. It is argued that this gap is wide, and that its main purpose is to increase the profits of provider organizations at the expense of the quality of services received by the frail elderly. This is one of the main arguments against benefits in kind. Specifically, many policy makers object to legitimizing profits at the expense of the quantity and quality of services for the elderly. Moreover, proponents of cash benefits argue that such payments increase the clients' choice of services and empower them by giving them autonomy to use their money as they wish. According to this view, cash benefits even give elderly clients an opportunity to control the quality of services themselves, since the government has difficulty monitoring the work of service providers. Furthermore, cash benefits free the government from responsibility for ensuring the elderly person's well-being, and give elderly clients and their families more power in their relationships with service providers. This generates competition between organizations, which ultimately contributes toward improved service quality.

Comparison of in-kind services with cash benefits reveals that provision of cash benefits generates inequality, owing to the above-mentioned differences between the elderly clients' consumer habits and culture. In this connection, elderly people are limited in terms of the information at their disposal and their ability to seek the services they need. Services in kind, by contrast, ensure equality between different socioeconomic populations. Nonetheless, given the current orientation toward empowering clients and broadening the range of options available to them, cash benefits may be still preferable. It should also be mentioned that these allowances may be preferable, owing to the large deficit in budgets available for funding of these services by law (see also the above section on financing long-term care).

The Home Care Industry

The home care industry evolved, both worldwide and in Israel, as a solution to the growing pressure on governments to provide an alternative to institutional care for the aged (Ruchlin et al., 1989). In addition to the fiscal constraints faced by governments, these efforts were motivated by the early discharge of elderly patients from hospitals as a result of problems and difficulties emanating from health budgets and the increasing awareness of the negative effects of institutional care on the elderly person's well-being. Although research on the effectiveness of home care service is limited and contradictory, there are a number of studies indicating that the elderly clearly prefer to stay at home and the quality of their life may be enhanced by doing so (Kaye, 1995).

In response to the rapidly increasing demand for home care, a burgeoning home care industry emerged in Israel. The industry is comprised of voluntary nonprofit and for-profit organizations whose services include personal care, companionship, shopping, house cleaning, provision of hot meals and household management. The cost of the services provided by these organizations to those receiving LTCI benefits are covered by the law.

The law created a new ecological niche which provided a total of 5 billion NIS (1.2 billion US$) between 1988 and 1998 to the providers of home care services to elderly clients. During the initial period after the law came into effect (1988-9), about 7,000 elderly clients were entitled to home care services. Today, 114,000 (32,000 men and 82,000 women. NII, 1998) are in receipt of services. In 1988, 70% of home care services were provided by VNPOs, 18% were provided by FPOs and the rest by kibbutzim.

During the course of the last decade, this niche has not only changed in size but also in composition. The proportion of home care services provided by

VNPOs has dropped to 41%, while the proportion for FPOs has increased to 57%, with the remainder of services provided by kibbutzim. There are now 150 organizations, with 420 branches, operating in the two sectors that provide home care services. This change can be attributed to the government's apprehension, when the enabling legislation was being formulated, about the ability of VNPOs to provide the required volume of services. Therefore, the government adopted a strategy of contracting out to service providers. In doing so it promoted the most significant process of privatization in Israel in the domain of personal service provision. Rather than depending upon one sector alone, the government also sought to encourage competition between nonprofit and for-profit organizations, i.e., to foster the development of a quasi-market. It did so with a view to trying to decrease the risk associated with an over-reliance for service delivery on one sector alone and also possibly in order to contribute to improved service quality. As a result, a mixed economy was created comprised of the government and nonprofit and for-profit organizations. The government is responsible for: (1) determining policies regarding the implementation of the law and standards, (2) funding the services, and (3) monitoring service delivery. The organizations are responsible for delivering the services.

The first years following implementation of the law were characterized by a high level of fluctuation in the entry of new organizations into the pool of service providers, by uncertainty regarding ways to deliver the services, and by a lack of stability in the relationship between the government and the service providers. All of these characteristics are unique features of industries operating in a turbulent environment (Schmid and Hasenfeld, 1993), and have been especially evident among the FPOs which entered the home care service industry with the encouragement of the government. In spite of this, and in contrast to the familiarity with the government enjoyed by the VNPOs, the FPOs needed to prove themselves as service providers. Although formally accredited by the government authorities, informally the FPOs had to fight to establish their legitimacy in the eyes of the government, elderly clients and their families. Further, neither the government nor the clients had reliable information available to them concerning the performance of the FPOs or the quality of their services even though the services were specified by the government. In contrast, the VNPOs were trusted by the government since their relationship with the government had been long-standing and stable and because they had been the almost exclusive provider of such services prior to the enactment of the law.

During the ten years of the law's operation, there have been major changes in the market, primarily in terms of the rapid growth in the size of the beneficiary

population and in the increasing share of services provided by FPOs compared to VNPOs. Uncertainty has been reduced and both the government and the service organizations have more information regarding client needs, solutions and the mutual expectations that they have of each other. The market has stabilized in terms of the number of service providers and the level of resources made available to them by the government (on average, 75% of the income of both FPOs and VNPOs is provided under the law). Contrary to trends in other parts of the world, especially in the United States, the mortality of the provider organizations is minuscule (from 1988 to 1998, less than 10 organizations have closed due to mismanagement or financial difficulties). The low mortality rate is primarily due to their substantial dependence on government funds provided under the law. This dependence guarantees a steady flow of resources to the provider agencies as long as they fulfill the requirements of the law and the government. In fact, most of the organizations in both the FPO and VNPO sectors primarily supply services specified by the law and have not developed new types of services or programs. Furthermore, over the years a mutual dependence has developed between the government and the service suppliers. The organizations are dependent on the government for resources (i.e., the elderly clients, much of their income) and the government is dependent on the organizations for delivering services to 114,000 frail elderly. This interdependence encourages the government to assure the survival of the organizations in order to be able to implement the law.

The ability of the government to apply sanctions against the provider organizations is constrained and complicated by legal considerations and the role played by interest groups. From a legal perspective, the government is faced with a number of constraints that prevent it from terminating the activities of provider organizations, even when the competence of the organizations is in doubt. In addition, the market is characterized by private and public interest groups that defend the providers and are interested in assuring their existence because of a formal or informal relationship between the groups. For example, the umbrella organization of associations for the elderly does all it can to protect the provider organizations, as funds from the law represent the main source of the latter's income. Thus, interest groups associated with the provider organizations protect their interests, applying both covert and overt pressures on the government to assure their continued survival.

In sum, Israel's home care industry operates in an ecological niche, has been provided enormous resources under the Long-Term Care Insurance Law, has grown substantially, and has experienced major changes in the market

share enjoyed by FPO's (an increase) compared with VNPO's (a decrease). The home care industry has stabilized after ten years and the level of certainty has increased as far as resources are concerned. The provider organizations have been legitimized by the government and the target population eligible for services has been clearly defined. At least in Israel, the home care industry now enjoys a relatively high degree of certainty in its task environment. Both strategically and structurally, this has allowed the provider organizations to stabilize themselves.

The next section deals with the strategic behavior of provider organizations attempting to adapt themselves to the changing demands of their task environment.

Strategic Behavior of Provider Organizations

In the process of adapting to their task environment, organizations usually employ various strategies to increase their effectiveness and respond to the changing demands of the environment. The particular strategy employed by an organization is a product of the unique characteristics of the environment in which it finds itself, such as the degree of its certainty and stability, the richness or paucity of resources, and so on.

Analysis of the strategic behavior of different service providers during the period immediately following the implementation of the LTCI law reveals that the FPOs adopted a strategy of generalism. They did so in recognition of the fact that they were operating in an uncertain environment and required legitimation of their programs and activities by the government. In these circumstances, the organizations preferred to spread the risk by offering a variety of services that would guarantee their survival in the event that their primary source of income (i.e., payment for services funded under the law) was discontinued. Initially, their organizational structures tended to be less formal and bureaucratic. This allowed for flexibility and effective adaptation to the changing demands of the environment.

In contrast, the VNPOs, which had developed a stable relationship with the government when they were major providers in the home care services market, adopted a strategy of specialization which focused on specific services. Their formal and bureaucratic structure may be attributed to the relatively stable, certain environment in which they operated as a result of this relationship. Over the years, however, and given the increasing competition between these organizations, both the structure of the VNPOs and the strategy which they employed changed. The VNPOs' market share decreased and they began to

recognize that they could no longer rely exclusively on the specialist strategy. As a result, they expanded their activities to new target populations, e.g., those frail elderly ineligible for services under the Long-Term Care Insurance Law and clients of the Rehabilitation Department of the Ministry of Defense. Nevertheless, most of their clients remain the frail elderly who have established eligibility for home care services under the law.

At the same time, due to the growing environmental stability enjoyed by the FPOs resulting from the legitimacy accorded them by the government as well as their organizational growth, the structure of the FPOs shifted from an informal, non-bureaucratic one to a more mechanistic structure. Indeed, the VNPOs and FPOs became increasingly similar as they began emulating one another and adopting similar service technologies. In this context, it is of interest to note Knapp et al's (1999) observation that "...there are actually lots of commonalities of perspectives and motivations which cut across the different sectors and provider types at any given time. ...all... organizations are sharing to some degree a common environment as contractors...they can face similar pressures and opportunities." (p. 15).

In addition, both types of organizations have understood for some time now that in order to attain a satisfactory level of efficiency, they must adopt advanced management technologies and base their activities to some extent on pricing, monitoring, financing and marketing.

The Dilemma of Monitoring and Control

One of the most complex challenges in the delivery of home care services to the frail elderly is that of adequate monitoring and control (see also discussion in Schmid and Hasenfeld, 1993). The source of the challenge is the fact that home care requires the home care worker to function under conditions that are not readily visible to the employing organization. Further, the organization cannot rely solely on its consumer to supplant or complement its monitoring function. This is because frail elderly clients become highly dependent upon home care workers and, consequently, can experience a considerable power imbalance that precludes effective control over the behavior and activities of the workers.

Although home care organizations have developed rules and procedures and have supervisory arrangements and reporting requirements in place, they nevertheless face the same dilemma experienced by "street-level bureaucracies" (Lipsky, 1980). That is, the home care workers are quite removed from the control center of the organization, and the organization is highly dependent on its substantially autonomous workers for the information needed for monitoring

purposes. The home care workers, despite rules and procedures, can exercise considerable discretion in their interaction with clients. Hence, the capacity of the organization to exercise supervisory control - to detect deviations from organizational rules and procedures - is greatly diminished, especially when either the client or the worker chooses to ignore them. The absence of institutionalized standards and measures of effectiveness or service quality reduce the monitoring function to such observable behaviors as attendance, reported hours of work, and client complaints.

Most street-level bureaucracies regard the implications of these elements of the work environment for client outcomes (possibly negative) and organizational control (problematic) with great concern (Borowski, 1980). However, for some provider organizations this situation provides them with the opportunity to reduce the quality and quantity of the service that their clients are entitled to under the law. Home care workers, sometimes with the tacit understanding of their agencies, may take advantage of their clients' dependence and fail to provide the required number of service hours and submit false reports on services rendered. This enables some providers to reap undeserved profits and some workers to supplement the minimal wages and benefits they receive. The absence of an effective control apparatus in an industry operating on a low profit margin invites unscrupulous practices (Fine, 1988).

One way to avoid this situation is to delegate more responsibility to workers, thus making them partners in addressing clients' needs. Research has shown this strategy to be positively and significantly associated with worker satisfaction, trust in management, belief in the equity of rewards allocation, positive attitudes toward the organization and low levels of turnover and absenteeism. All of these, in turn, influence the stability and quality of the worker-client relationship (Alexander and Ruderman, 1987; Folger and Konovsky, 1989).

However, workers' participation in service delivery decisions must also be coupled with frequent on-site inspections, close supervision and frequent communication with the elderly clients and their families. These are not common practices in the home care industry because of the costs involved and the lack of sufficient resources or incentives for providers to invest in such a control system (Harrington and Grant, 1990). Such incentives arise when there are outside demands for accountability, when the agency seeks a competitive advantage by emphasizing the quality of its services or when it has a strong client-oriented professional ideology. Similarly, an agency that provides a wide array of services to the elderly recognizes that the quality of home care can generate business for other services it provides. Professionally dominated home

care organizations also tend to invest more in monitoring and supervision, in keeping with their service ideology (Schmid and Hasenfeld, 1993).

The most common practice in systems providing personal services is to use clients and their families as monitoring agents to substitute for or complement the monitoring activities of the service-providing organization. Such a strategy has the obvious advantage of reducing administrative costs (Handler, 1990). This practice, however, places the agency in the position of having to rely upon a reactive monitoring system that, again, shifts to clients at least some of the responsibility for system failures. Undoubtedly, when an agency adopts a proactive monitoring strategy coupled with an active partnership with its clients and their families, both the clients and the agency benefit. Research has also shown that, to the extent that clients are involved in determining their care plan, they tend to cooperate with agency management and to be highly satisfied (Schmid, 1998).

Some Effects of the Law: Institutionalization, the Burden of Care, and Service Quality

There appears to be no universally subscribed framework for assessing the effects of the various arrangements that have been set in place around the world to fund and deliver home- and community-based long-term care services to the frail elderly. However, most of the various frameworks, at the very least, cast care outcomes in terms of the impact of these arrangements on admission to residential care, on the burden of care borne by primary informal caregivers, and on service quality.

1. Institutionalization of Elderly Persons with Disabilities

Research findings clearly indicate that receipt of services in accordance with the LTCI law delayed and sometimes even prevented elderly persons – particularly the frail elderly – from entering institutions. In this way, the law contributed directly toward economizing on resources for the elderly, their families, and the country (Naon and Strosberg, 1996). Comparative research on patterns of institutionalizing the frail elderly before and after enactment of the law has consistently revealed that the changes in patterns of institutionalization were greater among frail elderly patients with mild disabilities than among those with severe physical and mental disabilities. It was also found that expansion of the law for provision of community services primarily helped elderly clients without severe disabilities

and enabled them to avoid institutionalization. However, in the case of frail elderly persons with severe disabilities, the law did not significantly reduce the need for institutionalization. This may be attributed to the fact that these services involve high expenses and cannot be provided in the elderly person's home. It should also be mentioned that the frail elderly who applied to institutions after the law was enacted had more severe disabilities than those who did so prior to the enactment of the law.

The research findings also indicate that contrary to expectations, there was a substantial increase in applications to institutional facilities immediately after enactment of the LTCI law. Apparently, implementation of the law made it possible to identify a large population of frail elderly individuals who had not applied for services in the past. This evidence suggests that before the law was enacted many elderly individuals did not receive services at all. Thus, the law contributed toward identifying new populations whose needs were not addressed in the past.

2. The Burden of Care

The LTCI law was intended to ease the burden of care borne by primary informal caregivers, usually the family of the elderly person. The law has substantially reduced the financial burden of caring for a disabled elderly family member. It has not, however, resulted in a reduction in the hours of care provided by primary informal caregivers. This is rather surprising, at least on the face of it. While there was no expectation that formal service would displace any but the most marginal of informal caregivers, it was expected that the availability of formal services would decrease the load borne by informal caregivers. And this is especially so in Israel where women, the providers of much of the informal care received by their disabled elderly husbands and parents living in the community, enjoy comparatively high levels of labor force participation.

It has been suggested that the persistence of high levels of informal care despite the availability of formal services may be partially attributed to two factors: (1) The ethic of care in Israel (i.e., the strong tradition of duty and caring felt by children towards their parents); and (2) Israel's small size, which limits geographic mobility and facilitates access of adult children to their elderly parents (Cnaan, et al, 1990). However, what may appear to be a shortcoming on the part of the LTCI scheme raises a broader question, regarding the relevance of attempts to ease the temporal aspect of the caregiving burden for schemes that provide home- and community-based care for the disabled elderly. This

situation can be attributed to the fact that Israel's experience with the LTCI scheme in relation to easing the hours of informal caregiving is by no means unique. There is a growing body of research literature on home- and community care programs (including the prominent US National Long-Term Care (Channeling) Demonstration) which reports that the amount of formal care does not significantly reduce the amount of informal care received by the disabled elderly (see, for example, Chappell and Blandford, 1991; Hanley, Werner and Harris, 1991, and Shaver and Fine, 1995). There are a number of explanations offered for this phenomenon. These include, for example: (1) despite formal care many elderly have unmet needs which the availability of formal care now permit the informal caregivers to attend to; (2) while formal services may provide care with some of the same activities of daily living as those with which the informal caregiver provides assistance, the informal care is enhanced by the formal services (e.g., by sharing some of the physical tasks, by allowing more flexibility in the informal care's use of time, by sustaining affective bonds between family members through alleviating the stress associated with caregiving thereby facilitating the ongoing commitment to care, etc.), and (3) the caring task is so large that modest amounts of informal care do not change the perceived scope of the burden.

This suggests that attempts to ease the temporal burden of care borne by all primary informal caregivers may not be relevant as a goal for community long-term care insurance schemes. Rather, the focus should be on formal and informal caregivers working cooperatively to reduce the unmet needs of disabled elderly residents living in the community.

3. Quality of Care

Quality of services may be measured in several ways. For example, it may be measured in terms of availability and coverage of the service, changes in the client's functioning and physical condition, the relationship that develops between the client and service provider, and client satisfaction. According to most of these measures, the Long-Term Care Insurance Law has led to improvement in service quality. A comparative study of the status of the frail elderly before and after implementation of the law found that, among elderly clients who received additional services as a result of the law, there was a decrease in the quantity of need that remained to be addressed. In the same study, elderly respondents reported an improvement in the response to their needs and in their general well-being as a result of the services they received. They also reported a feeling of heightened security as a result of receiving the

services (Brodsky and Naon, 1993). In addition, 76% of the clients reported that their personal care plans were fully implemented and 87% reported that their home care workers came to visit them according to the care plan. Coverage of service hours (the ratio of hours of service to which a client is eligible and the hours of service actually delivered) was very high (Schmid, 1998). Clients reported that placement of home care workers and responses to complaints were rapid and efficient. They also reported a high level of adaptation of the home care worker to their needs.

Client satisfaction with the services they received was also high. Clients were especially satisfied with their relationship with the home care worker (Schmid, 1993a). This supports the previous finding of Eustis and Fischer (1991) that the quality of service is shaped, in large part, by the quality of the relationship between the client and the home care worker. On the other hand, it could be that the high level of satisfaction reported by the clients is attributable to their dependency on the service provider, a dependency which prevents them from complaining about the quality of service, since alternative services are few and limited. In fact, the rate of complaints (another measure of service quality) by the elderly is very low (Schmid and Sabbagh, 1991; Schmid, 1998). The responsiveness of the home care workers and their attentiveness to the needs of the elderly client is also a source of client satisfaction (see also Challis and Davies, 1986; Weisseret et al., 1988; Hughes et al., 1988; Rabiner, 1992).

Based on the measures referred to above, it seems quite clear that over the last decade the quality of home care services, the status of the elderly clients, and their satisfaction with the services they have received have all improved.

Conclusions

The Long-Term Care Insurance Law represents a significant advance in Israeli social legislation. Israel's law, as well as related provisions in other countries, represents an explicit public acknowledgment of long-term care as a normal risk of growing old.

Israeli legislators sought to ensure that services provided to elderly clients by law are not dependent on state budgets. They also used legal means in an attempt to prevent political and interest groups from changing the goals and mission of the law. This independence is currently tenuous, since various government and nongovernment organizations have sought to introduce certain revisions in the law in light of processes that have occurred during the past decade, which the article describes in detail. The main change was the need to reconsider the type of benefits given to the frail elderly, i.e., cash benefits or services in kind.

Ideas for experiments related to this issue have been proposed by the National Insurance Institute, despite opposition by several organizations, including the service providers.

Considering the impact of the law, it is clear that during the ten years since the enactment of the law, the contracting out strategy adopted by the government has contributed to the sharp growth in the number of provider organizations. This, in turn, has led to rapid expansion in the coverage, volume, range and quality of services provided to the elderly who did not benefit from home care services before the law took effect. The services provided under the law are fulfilling their intended purpose, including alleviation of the burden of family care-giving.

Notwithstanding these important achievements of the law, a number of issues remain to be addressed by policy makers. Some of these issues concern the design of the Long-Term Care Insurance scheme and have been discussed in detail elsewhere (see Borowski and Schmid, 1999). They include, for example, the need to increase the number of service hours - despite the high cost involved - in order to further relieve the care-giving burden borne by families, and to provide for partially physically disabled elderly who, although ineligible for personal benefits, nevertheless need help in maintaining themselves at home.

The increase in hours of care for the elderly will clearly raise the expenses related to financing services that are already in a state of cumulative deficit. The government cannot avoid coping with this problem, and the article has dealt extensively with solutions for covering or reducing the deficit. As mentioned, however, there are still other issues that policy-makers will also have to address in the future, which derive from aspects of the home care industry that have emerged as a result of the law. One issue is the extent of government involvement in the internal processes of the provider organizations and their ability to respond to unmet needs - to move beyond merely providing those services prescribed by and funded under the law. Another issue is the inadequacy of supervision, monitoring and control, both by the government and the service organizations themselves, of the services provided by the home care workers. As Schmid and Sabbagh (1991) and Schmid (1998) have shown, no matter what techniques or methods of organizational control are used by the government or the provider organizations themselves, the frail elderly are still, ultimately, at the mercy of the individual worker who makes the home visits. Steps taken by provider organizations today (such as scheduled and surprise visits to the home of the elderly, telephone calls, etc.) are insufficient to remedy this weakness. More must be done to encourage the elderly and their families,

as well as formal and informal parties in the community (e.g., social workers and nurses), to assess the work of both the home care workers and the provider organizations, to listen to their complaints, and to reduce the vulnerability of the elderly to the service provider as much as possible. The provider organization must be made to feel that the continued demand for its services is dependent upon the desire of the elderly and the family to continue receiving them. Only when the balance of power and dependency changes will service providers do everything possible to improve their services and, thereby, assure their continued existence and inflow of resources. In addition, the service providers must invest more in professional development of the workers, for most of whom home care work is routine, stigmatized, and offers little opportunity for advancement. The lack of suitable working conditions,such as low wages, minimal benefits, and lack of opportunity for advancement, is likely to result in low motivation and commitment, which may affect the continuity and quality of care.

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A TOUGH LIFE FOR VICTIMS:
CRIME VICTIMS AND THE ISRAELI JUSTICE SYSTEM

By Uri Yanay*

Although much attention is given to criminal offenders in the Israeli legal system, paradoxically, no similar attention has been paid to their victims – those who suffered a criminal injury. Despite their hardships, crime victims have not been part of the public discourse in Israel, nor has their physical, mental, or financial well-being been secured. The state prosecutes criminal offenses, while the crime victim serves, at most, as a court witness. In many cases, the offender will not be apprehended; in others, he may be charged with a lesser crime, if a "plea bargain" is approved. When this happens, the victim may have no voice in court. Although a crime victim has the right to bring a civil, tort suit against the offender, he may not have the means or emotional stamina to do so.

Introduction

A society is measured by how it cares for its weakest members. These days, many people fall victim to crime – burglary, car theft, property damage. A property crime is not a pleasant experience, and its repercussions are painful. The experience is even more trying when bodily injury is inflicted during a violent crime: The routine of one's life can be disrupted and considerable time may elapse before one regains full use of one's faculties. For some, the trauma lasts a very long time, sometimes for the rest of their lives, either because of the consequences of the event or the scars on their body and emotional life, or because the injury affects their ability to conduct and enjoy a normal life and earn a living (Davis and Henley, 1990; Roberts, 1995).

This article focuses on adult victims and crimes committed outside the family, since crimes against minors and within the family require a special approach. We present here the trying events that a person may undergo after falling victim to a

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crime, and the status of the victim at each stage. Awareness of the problems and needs of crime victims has impelled international organizations and institutions to set standards that define the rights of these victims and the rules for dealing with them (United Nations, 1985; Council of Europe, 1988; Abell, 1989). Some western countries have developed a Victim Charter that defines the victim's rights (U.S. Department of Justice, 1998).

In most western countries, the state provides restitution to crime victims for their expenses, and even compensation if a complaint was filed with the police and the victim went through the questioning and investigation that are part of this process. The right of crime victims to restitution and financial compensation from the state is enshrined in law in some countries, such as the United States, Britain, and in the European Union. Victims of violent crime in these countries are also entitled to free medical and psychological treatment, since the assumption made is that the state failed to protect them from crime, and therefore is obligated to pay compensation (Parent et al., 1992; Greer, 1996; Miers, 1997; Tobolowsky, 2001).

For several hundred years now, the law has viewed commission of a crime against a person or property, regardless of how severe, as a crime against the public and the law, but not against the person injured. In principle, the crime is a breach of "Pax Regis" (the King's Peace), i.e. the social order. Hence, the crime is committed against the public weal and the law, while the victim is perceived to have been incidentally harmed – one of the many who might have been. Thus, the crime victim is accorded a status of less importance (Sebba, 1996): His[1] duty is to inform the police of the crime, file a formal complaint, and expose himself to detailed police questioning about the crime details, circumstances, and people involved. The victim is also expected to assist law enforcement agencies in their efforts to apprehend the perpetrator, prepare the indictment, present detailed evidence in court that may lead to a conviction, and ensure that justice is served.

However, this approach ultimately represents the ultimate interest of the public – catching the offender, bringing him to justice, preventing him from repeating the crime, and deterring others from committing similar acts. Focusing on the perpetrator diminishes the importance of the victim, who was directly harmed by the crime. This reactive approach makes the victim look and feel like a pawn in the struggle against the offender – merely a tool to prevent future crimes (Walklate, 1989).

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1. The masculine gender with reference to both the offender and the victim is used for convenience only, and should be construed as referring equally to men and women.

From this point on, the legal status of the victim is inferior. While the suspected offender and his rights are protected and guaranteed by law, and his right to legal counsel is ensured, the victim does not enjoy similar attention and protection. In fact, quite often the crime victim feels deserted, neglected, and forgotten by the system. He or she may not know what his rights are, receives no legal counseling during the legal process, and may not even be aware of the few rights he does have.

The Israeli Ministry of Justice is aware of the low status of the victim and the absence of legal rights (Israel, Ministry of Justice, 1987). Hence, policies are needed that will address the needs of crime victims and provide services in the spirit of the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (1985). These policies would address the status of the victim during the investigation, the court proceedings, and afterwards. One of the major issues concerns the victim's direct and indirect expenses incurred as a result of the crime, and compensation for the pain and suffering he experienced. These will be discussed in this article.

Part of this discussion will deal with the Victims of Crime Rights Law, enacted in Israel in 2001. This law gives crime victims some access to information about "their" case – the trial, conviction, incarceration, or release of the perpetrator, etc. This law, however, does not grant the victim any right to state restitution or compensation.

The article opens with a definition of violent crime and its incidence in Israel. This is followed by a brief description of the circumstances of filing a complaint and the subsequent police investigation, trial preparations, and considerations for keeping a victim informed of the proceedings. Although the law establishes the victim's right to compensation by the offender as part of the criminal process, the use of this option is examined in interviews with four district attorneys. This is followed by a discussion of the victim's right to information and involvement in the decision about the type and severity of the punishment, early release options, and parole. Thus, the article critically examines the status of the victim of violent crime in the justice system of Israel.

The Incidence of Violent Crime in Israel

A violent crime is defined as any offense listed in Chapter 10 ("Bodily Injury") of the Penal Code 1977, some of which will be cited below. The Israel Police records these as "reported" offenses, i.e., those made known to the police through a complaint filed by someone . As is known, many offenses are not reported because people – even those who suffer serious, violent bodily injury – do not

always file a complaint to the police. Some victims tell only their relatives or friends. Some share their terrible experience with no one.[2]

According to statistics from the Israel Police about crime in Israel (Data Division, Statistics Bureau, 2002, pp. 1, 24-27), the past decade saw an increase of more than 100% in new cases of violent crime. In 2001, 35,546 cases of violent crime were reported. Of these, one in six involved serious injury: 223 murders, 322 attempted murders, 658 rape cases, 1,834 indecent assault by force, 956 robberies in aggravated circumstances, 1,016 robberies, and 2,748 cases of grievous bodily harm.

In other words, a crime takes place in Israel every 1.4 minutes: robberies every 12.4 hours, rape every 17 hours, murder every 56 hours.

On the assumption that every crime has at least one victim, the data suggest that a broad range of people were injured in these offenses. It should again be emphasized that some victims, especially victims of sex crimes, fail to report them to the police. Therefore, one can assume that some crimes are not included in police statistics. Victims who do file a police complaint are embarking upon a long and difficult journey.

Filing the Complaint and the Subsequent Investigation

Those who file a complaint with the police and report having been injured in a crime begin a process that can be long and arduous. The goal is to find the offender and see that justice is served. The Israel Police is the body that investigates crimes based on complaints it receives. The police may (and often are required to) launch an investigation when they become aware of a crime committed (Criminal Procedures Law [Consolidated], 1982, Parag. 59). Complaints are followed by investigations. Police encourage the filing of complaints about offenses, and may also try to convince victims to cooperate with them, especially regarding crimes in which somebody was injured.

When a complaint is filed, the victim is asked to give details of the event, the circumstances that surrounded it, previous acquaintance with the suspect or with anyone the victim believes may have something to do with the crime, and any other relevant information. The professionalism of the investigator is reflected by his ability to elicit the main details from the victim's complaint, so that the offender can not only be identified, but be apprehended, brought to

2. The number of crime victims can be estimated based on household surveys, such as one conducted in Israel in 1992. This survey provides the demographic and socio-economic characteristics of households that suffered injury (Central Bureau of Statistics and Police Ministry, 1992). Since 1990, however, no survey of crime victims has been conducted.

trial, and convicted. The victim's complaint is the basis of the criminal case, and also provides testimony, which may become the main testimony in the file. Therefore, the police investigation is often long, detailed, personal, and may dip into intimate details that would never have been shared with another, had this not been an interrogation by law.

In recent years, the Israel Police has made an effort to improve the process of filing a complaint and make it as sensitive and caring as possible. Minors are interviewed and give evidence to professionally trained investigators. Female victims of sexual crimes submit testimony to women, and are often accompanied by a volunteer from one of Israel's Rape Crisis Centers. The intent is to provide the complainant with an environment that is professional, caring, and compassionate, so that the testimony will be comprehensive and complete, which is necessary for continuing the investigation.

The very need to share details with others about their ordeal, to respond to delicate, invasive questions, to have to persuade someone about the accuracy and completeness of one's testimony, to reconcile what the investigator may regard as apparent contradictions – all these can be very hard on the victim. Victimization can even be heightened if the victim is asked to testify in court. In light of the concern about secondary victimization, one can understand why victims frequently avoid turning to the police, and why some of those who do file a complaint stop cooperating at a later point (Williams, 1999).

Because the issue is one of public interest and focused on the perpetrator of the crime, and out of the desire of the police to prevent repeat offenses, the state has various means to pressure victims to complete their testimony and submit all the information relevant to the crime committed against him. But the state is not obliged to offer the victim anything in return.

For serious crimes, the complaint – including details of the event, the police findings, and sometimes even the police recommendation – are transferred to the District Attorney. This is where the indictment must be prepared so that it will be accurate, complete, and effective for convicting the suspect. Again the victims must repeat the details of their difficult experience, this time before another authority – the prosecutor.

It should be borne in mind that submitting information to the police and the prosecutor's office can put the victim at considerable personal risk, especially if the offender knows that the victim informed on him and might in the future testify against him in court. People who file police complaints are vulnerable to harassment and threats from those who perpetrated the crime and demand that the victim cancel the complaint and withdraw their incriminating testimony.

The victim is thereby injured again by the pressure and tension of the offender's demands and threats. Some victims withdraw their complaints, and the cases are subsequently closed, as it is unlikely that someone who cancelled a complaint would appear in court to testify.[3]

If the offender, his family or friends, constitutes a real threat to the crime victim, demanding that he withdraw or change the complaint, the prosecution can offer protective measures that are intended to minimize his risk. These are meant to prevent intimidation and harassment until the trial begins. Remanding the defendant until the completion of proceedings or distancing him from the victim are other ways to protect him, but these measures are generally terminated after the victim testifies in court. After his testimony is given, the incentive to harm the victim diminishes. Nevertheless, there is no guarantee that the defendant, whether found guilty or not, would not take revenge on the person who initiated the complaint and cooperated with the law enforcement authorities.[4]

The prosecuting attorneys who represent the state describe the personal connection they have with crime victims before they testify in court. This connection sometimes includes long conversations during and after work hours in which the victims share their concerns and fears about the process and the anticipated trial. These talks, in addition to helping allay the victims' fears, enable the prosecutor to probe further, gathering more information about the crime and the injury.

They also allow the prosecutor to assess the victim's ability to appear in court and recount the events in the presence of the accused, his or her family and friends, the curious, sometimes the media, and others. Thus, the prosecutor can assess the "quality" of the victim as witness in the impending trial: Can the

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3. Under some circumstances established by the Evidence Regulations (Revised Version) 1971, Parag. 10A (a), (b), (d), a written statement submitted outside the court by a witness can be admissible evidence in a criminal proceeding. Thus, a complaint filed by a victim can be used as evidence if the court is convinced that illegitimate means were used to prevent the witness from testifying. A statement of this nature would be admissible only with supporting evidence.
4. According to Parag. 72 of the Penal Code 1977, the court can order a convicted offender to promise not to commit a crime. This is one way to enforce behavior and may be viewed by the court as an alternative to punishment. Also, according to Paragraph 73, the court can order the parties, even if not convicted (including those who file the complaint) to refrain from any crime of violence for a period of up to one year. Violating this court order would result in punishment. These paragraphs can be seen as one way to protect the victim or force him to behave in a way that will prevent a crime (at least against him) in the future. Research should be done about whether this paragraph is implemented and effective in providing the victim with real protection.

victim be called to the witness stand to give evidence? Will his or her testimony be reliable – clear, smooth, and consistent? Will he or she bear up in complex situations, including the defense attorney's cross-examination? Or will he, or she, break down, retracting or changing details of their testimony?

It is not unusual to find that the crime victim is unable or unwilling to stand up to this task, or that his or her physical or mental health would suffer because of (or during) their testimony in court. When this is the case, the prosecution may decide not to call the victim to the stand, thereby losing a key witness who could help incriminate the defendant. This consideration is critical, as the interest of the victim may take precedence over the public interest in holding a trial and convicting the defendant. The responsibility for maintaining this balance belongs to the prosecutor or the district attorney.

Sometimes, after deliberations by the police or the district attorney, a decision is made to close the file, which effectively means canceling the complaint. Although the District Attorney provisions (Paragraph 8 in the Attorney General's Directives, Chapter 15.10, January 2, 1994) require that the complainant be informed about a decision not to press charges, there is no guarantee that this is done. It is doubtful, then, that the victim could prevent this decision or its consequences. By law (Criminal Procedures [Consolidated Version] 1982, Parags. 60-65), the victim has the right to appeal this decision of the prosecution or the district attorney to the Attorney General. If the victim does not file an appeal, or appeals after the deadline, the case will be closed.

Closing a file is not the only way a crime victim's involvement could come to an end. If the offender is not caught, the victim's complaint remains pending, conceivably for a very long time. Although the police are supposed to continue to investigate, the complaint will not necessarily be a priority for them, and may indeed be relegated to the sidelines. In such an event, the interests of the victim may not be safeguarded over time.

Similarly, a suspect may be apprehended, but – for various reasons – a plea bargain is struck between the prosecution and the defense attorney in which the suspect admits to some of the charges or agrees to conviction for a lesser offense in exchange for a lighter sentence. A plea bargain that includes a confession of guilt will shorten the legal process and prevent the need for the victim to testify (Cohn, 1996, p. 715).

Harnon (1997) notes the broad discretionary powers of the prosecution about whether to bring a suspect to trial, and for which offense. In this context, Harnon argues, "During negotiations about a plea bargain, the prosecution has a wide range of options for reducing the charges or making promises about the sentence

he will request from the court ...The victim may feel disappointed or frustrated as he belatedly discovers to his surprise that the prosecution and defense are negotiating a plea bargain in behind-the-scenes meetings, which the courts tend to ratify, and all this is happening without keeping the victim informed, and under no obligation to provide information about the bargaining or the deal." (Harnon, 1997, p. 598).

If a plea bargain is indeed signed with the defendant, the status of the victim has been harmed: It is not likely that he or she will be informed that the person suspected of the crime in which he or she was involved was caught, charged, and the proceedings concluded, whether by a confession or a plea bargain. The Attorney General's Directives (ibid., Parag. 7c) allow for summoning the victim of the crime "to address the court during the arguments for the sentencing", but it is unlikely that this actually takes place, which is a subject that should be researched, especially after enactment of the Victims of Crime Law (2001). Although this law made it clear that the victim has the right to information, it does not impose an explicit, parallel obligation on the prosecutor to keep the crime victim informed.

Indeed, the Attorney General's Directives (ibid.) are not obligatory, but worded as a recommendation. For example, Paragraph 8b notes, "...At the request of the victim of the crime, the prosecutor in charge of the file will explain to him the criminal proceedings and will also provide him, at his request, with information about it...". In other words, the victim has to initiate the request and monitor the proceedings. As noted, he will not always be told that the case was closed, that the subject confessed, or that a plea bargain was reached. These remain at the discretion of the prosecution. There is concern that because of work pressure and the heavy case load, as well as the lack of legal incentive (or sanction), the prosecution sometimes finds it hard to inform the victim about the decision to stop investigating his complaint, and thus the victim cannot exercise his right to appeal the decision.

Holding a Trial

As noted above, a complaint by a victim does not ensure that the matter will reach trial. Many considerations enter into the decision by the police and the prosecution about whether and how to continue dealing with a complaint. If a crime suspect is caught and indicted, the prosecution may need the victim's testimony to convince the court of the charges brought against him, and why it is asking for his conviction and sentencing.

For many victims, giving this testimony may be distressing, as they seek to

forget the painful incident. At the same time, they may feel that it is important to have their story told, especially that the judge hear their personal account of the consequences of the event, but they are not willing or able to deliver this account in public, before an entire courtroom.

The public act of testifying in front of an audience in a courtroom, sometimes in front of the media, describing the details of the crime to which the witness fell victim and the damages incurred as a result of the crime and its consequences, is not easy. Many victims find this hard even though it is important to them. Therefore, they require preparation before giving testimony, and should be given support before and during it (Davis and Henley, 1990). For some, on the other hand, telling their story publicly – convincing the court of the severity of the crime to which they fell victim – is one stage in their coping with the event, and perhaps even a kind of "just desserts" to the offender.

To help the crime victim, the court may sometimes deviate from the public nature of its deliberations and hear a case in camera, either to protect a minor, helpless person, or victim or defendant in a sex case, or because a public proceeding could deter a witness from testifying freely or at all (Law of the Judiciary [Consolidated Version] 1984, Parag. 68(b)(4), (5), (7)). The law also prohibits the publication of deliberations that are held in camera, unless approved by the court (ibid., Parag. 70a). The intent is to encourage the victim to give full and complete testimony in safe conditions.

In addition, the Procedure Law Amendment (Examination of Witnesses) 1957 (Parag. 2b(a)) notes: "In a criminal proceeding about a sexual offense, the court may instruct, whether at its own initiative or at the request of the prosecution, before or during the provision of testimony, that a complainant shall testify not in the presence of the accused, but in the presence of his or her defense attorney, if it becomes evident that testimony in the presence of the accused could harm the complainant or adversely affect the testimony; testimony not in the presence of the accused shall be given *outside the courtroom itself or otherwise as necessary to prevent the witness from seeing the accused.*" [emphasis added].

Recently, and in light of the Procedure Law Amendment (Examination of Witnesses) (Testimony from a complainant not in the presence of the accused regarding sex offenses) 1996 (Parag. 4(a)), a way was found to enable the victim of a sex crime to testify outside the courtroom. A closed circuit TV is used, so that a victim of a sex offense can testify and also be cross-examined in proximity to, rather than inside, the courtroom. This also prevents eye contact (and implied threat) between the victim and the accused, his friends, or family. It also protects the identity of the victim, especially if he is fearful of public

exposure and prefers to face the judge and lawyers from behind screens in the courtroom. As noted, this arrangement exists in Israel only for some types of crime, such as the rape of minors (*Ha'aretz*, May 28, 1997).

In addition, according to Paragraph 187, Amendment to the Criminal Procedures Law (Consolidated Version) 1982, the court can allow submission of a Victim Impact Statement (Sebba, 1996, p. 16). Currently the Statement can be submitted in Israeli courtrooms only for sexual offenses. In Israel the Victim Impact Statement is written by a public official appointed by the Minister of Labor and Welfare. The responsibility for writing was given to the Probation Services for Adults. The purpose of the Victim Impact Statement is to present the experience of the crime victim from the moment the crime was committed and the impact of the crime on his life. This is intended to balance out the statements of the convicted offender during the sentencing proceedings as he requests clemency in light of his request for forgiveness and a promise to mend his ways. Against this, the Victim Impact Statement is meant to provide information and insight to the court about the consequences of the crime on the victim, thus serving as a counterweight to the appeal for clemency. The Statement is accepted only if the victim has agreed to its writing (ibid., Parag. 187(c)).

Presenting a Victim Impact Statement in court is innovative and should be assessed. If found effective, its admissibility should also be considered for other kinds of criminal offenses.

Whether because of the legal system's dependence upon cooperation from the victim – and therefore the desire to compensate him or her for it – or by virtue of the crime that he or she endured, the issue of the crime victim's rights to remuneration arises – if only as restitution of expenses incurred as a result of the criminal act or compensation for suffering and damage.

In Israel, victims of terrorism are clearly in a distinct category from victims of other crimes, and accorded special treatment. The legal status and rights of terrorism victims, as ensured by the Benefits for Victims of Hostile Acts Law 1970, are immeasurably better than those of crime victims, even victims of violent crime. This law created a parallel between the rights accorded to victims of hostile acts and their survivors, and those accorded to disabled soldiers and the families of fallen soldiers (Yanay, 1993). It is helpful to examine the rights of terrorism victims in Israel because the public attitude towards them – caring for their needs and ensuring their rehabilitation – can provide a model for supporting victims of violent crime, particularly when their needs are similar.

Restitution of Expenses and Compensation for Suffering and Damage

At the conclusion of the criminal trial, if the defendant is convicted, the victim may ask the court to rule that the defendant must restore that which was stolen, pay any expenses incurred as a result of the damage, and compensate the victim for suffering and damage – beyond the direct damage incurred. Deliberations about this claim are supposed to take place in a civil court proceeding. The petition filed by the victim against the offender is then based on the criminal decision ("A civil claim ancillary to a criminal case", Law of the Judiciary [Consolidated Version] 1984, Parag. 77; Cohn, 1996, p. 735).

However many, if not most, of those who fall victim to crime are not willing or able to go through with this civil proceeding – to cover its costs (legal fees, court fees, work time lost, etc.) involved or devote the time required. To remove these hurdles and costs, shorten proceedings, and ensure that justice is served, the Israeli legislature enacted Amendment 23 to the Penal Code 1977, passed in 1979-80.[5] This law authorizes the court, sitting in a criminal case, to deliberate compensation for pain, suffering, and damages to the victim as part of the criminal proceedings, thus removing the need for further, civil litigation and ancillary proceedings.

There were three underlying motives for allowing victim damages, restitution and compensation to be dealt with during the criminal proceedings (Greer, 1991; Zedner, 1995; Miers, 1997). First, this might encourage victims to come forward and file police complaints about the crimes, knowing that the prosecution will represent their interests during the criminal proceedings regarding the restitution of costs and compensation for suffering and damages. Having a vested interest in the outcome may enhance the victim's motivation to cooperate with the police and prosecution.

Second, awareness that the verdict of the criminal proceeding may lead to restitution and compensation of the victim may encourage the defendant to suggest this at his own initiative during the course of the criminal trial. The defendant might do this in an attempt to favorably impress the judge, who could conceivably view it as a mitigating factor during sentencing. The knowledge that the court might compel this as part of the criminal verdict would encourage the defendant to voluntarily offer to compensate the victim, which would also have educational value.

Third, the amendment could ease the burden in the civil courts, as civil suits that rest on a criminal offense could be handled during the criminal proceedings.

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5. Knesset Proceedings, volume 110, p. 2478.

Indeed, paragraph 77 (a, b) of the Penal Code 1977 notes: "If an individual was convicted, the court may obligate him, for each offense for which he was convicted, to pay the person who incurred damages as a result of the crime an amount no greater than NIS 84,400 in compensation for the damages or suffering incurred. The amount of compensation according to this paragraph will be based on the value of the damages or suffering on the day the crime was committed or the day the verdict was given about compensation, whichever amount is greater."

There are two ways for implementing this amendment. The first is that the indictment include as many details as possible of the damages and suffering incurred by the victim. Thus, before the start of the trial, the prosecution would elicit from the victim information about the expenses, damage, and suffering, all of which would be included in the indictment. A confession by the defendant would imply admission of the particulars about suffering and damages incurred by the victim, and the court could obligate him to pay compensation. If the defendant is convicted, the clauses regarding expenses, damages, and suffering would form part of the conviction.

The other possibility is that after the court verdict, during the sentencing deliberations – and only at this stage – the prosecution would submit a detailed account of the damages, pain, and suffering caused to the victim and ask the court to consider compensation as part of the sentence.[6]

It may be difficult for the court to translate pain, suffering, and damages into monetary terms, especially if they are vague or lack a price tag. It is a relatively simple matter if the court is presented with receipts for personal belongings, clothing, glasses, cell phone, or other material goods that were damaged during the crime and which have to be repaired or replaced. Other actual expenses that can be presented to the court are the loss of work time, medical expenses, travel required, therapy following the trauma, and the like. If the court is convinced of the genuineness of the need and the justice of these expenses, it can rule about reimbursement of expenses to the victim.

Reimbursement of expenses, however, does not include compensating the victims for pain and suffering. Indeed, it is not easy for a court during a criminal proceeding to deliberate the monetary value of the pain or suffering of the victim, or other damage that has no immediate monetary implications, or about which opinions are divided with regard to its monetary value. In such cases, the court could decide to bypass the issue of compensation during the criminal case, and

6. In his book *The Law*, Judge Haim Cohn wrote, "And if the victim submits his claim prior to the criminal procedure, the Criminal Court is authorized to deal with the civil suit too." (p. 693).

would propose that the victim submit an ancillary civil claim that would deal with the indemnification or compensation for damages and suffering incurred during and as a result of the criminal offense. Thus, if the court refrains from deliberating compensation to the victim during the criminal case, the litigation would eliminate the possibility of the victim receiving compensation from the offender.

The intent of the legislator in Paragraph 77 of the Penal Code 1977 is significant in administrative terms: It allows but does not obligate the court to deliberate compensation during the criminal proceedings.

Even if the court accepts the prosecution's claim and instructs the offender to restore to the victim what was stolen, his or her expenses, and perhaps even some compensation for suffering and damages, it is not clear that the offender would have the means to pay the amount set by the court. It is unlikely that all those sentenced to pay expenses and compensation to their victims are capable of doing so, despite the judgment that explicitly mandates it.[7]

In light of the difficulty of implementing such decisions through the "Execution of Judgment" and repossession authorities – a law was passed to consolidate the collection of fines, licenses, and expenses (1995). As a result, the Ministry of Justice established the Center for Fine and Tax Collection and Execution in 1996, which acts to ensure the collection of fines after judgments in favor of the state. The question is whether the Center will also seek to ensure the payment of restitution and compensation to crime victims in keeping with criminal court verdicts, and whether this will take precedence over the collection of fines for the state coffers.

Study Results

The Attorney General's Directives – Chapter 15.10 (dated January 2, 1994) – provide policy guidelines about "Aid to Crime Victims and Prosecution Witnesses in Criminal Proceedings". The goal of these directives, as noted in Paragraph 2b, is "to ensure that all members of the office of the prosecutor… help crime victims receive full compensation for damages they incurred to the extent possible by the existing law…".

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7. Paragraph 77(c) of the Penal Code 1977 addresses this issue: "Regarding collection, the law regarding compensation according to this paragraph is identical to the law regarding fines: An amount paid or collected against a fine that also carries a demand to pay compensation will first be credited to the compensation". Thus the state gives priority to compensation of the victim over payment of the fine to the state, thereby recognizing the obligation to first compensate the victim and only thereafter, the state.

According to Paragraph 11a of these directives, "In every instance he deems advisable, the prosecutor, when presenting the position of the prosecution about the sentence, shall request full compensation for the victim of the crime. Prior to this, he shall have instructed the injured party about preparing the necessary documentation and evidence for setting the amount of the damage, if in his opinion this evidence should be submitted during the sentencing hearing." A reservation is also raised here, however: "Prior to submission of the request to set compensation for the complainant, the prosecution should weigh the effect that the following factors might have upon the severity of the sentence: the nature of the crime (property crimes versus other crimes); the difficulty of proving injury; and the possible effect of obligating the defendant to pay compensation to the complainant. There may be reason not to request compensation for the complainant when there is concern about harming other public interests – the punishment or the efficiency of the deliberations. This is especially true in cases where there is no real chance of collecting the sum of compensation that would be set."

"In this context, it should be noted that for property damage, it is desirable to arrange for compensation of the injured party prior to the sentencing, because at this stage the defendant has an interest in proving that he compensated the person harmed. This is more likely during negotiations for a plea bargain. Nonetheless, in cases of violence, contact must not be permitted between the defendant and the victim – not even for matters of compensation – until after the trial and sentencing" (ibid.).

The Attorney General's Directives ostensibly encourage compensation of the victim, and even propose that this be accomplished before the trial is over. In reality, however, these directives are not unequivocal. Although they point to the importance of Paragraph 77 in the Penal Code, they also leave the prosecutor a wide margin of discretion based on "concern about harming other public interest – the punishment or the efficiency of the deliberations." Hence, these directives constitute a weak recommendation, with the interest of the crime victim not paramount. One study (Yanay, 2002) shows that police prosecutors do not always follow these recommendations. In fact, this study shows that not all police prosecutors even know about Paragraph 77 of the Penal Code 1977, and that it is infrequently applied. It is also doubtful that the district attorneys who deal with serious cases, such as felonies, use this paragraph.

To examine this, in-depth interviews were conducted with four (out of seven) district attorneys between November 1996 and February 1997. The district attorney has the formal and informal tools for supervising the prosecutors on

behalf of the state to ensure the rights of crime victims, including compensation according to Paragraph 77 of the Penal Code 1977. The four district attorneys were given the same question – each was asked "to clarify the status of victims of violent crime in the judicial system of Israel". Although these district attorneys do not represent all the opinions in the field, their replies are important, because they are senior officials who set the guidelines for less senior prosecutors in the district. Their responses can be summarized as follows:

District attorney #1 felt that it is not the duty of the prosecution to attend to the needs or take care of the victims. Since the district attorney is the prosecutor in criminal cases, his duty is to prosecute offenders of the law. Nevertheless, he added, the office of the district attorney does address the needs of crime victims, beyond just compassion. For example, it will raise the demand of compensation for the victim during the criminal proceedings, it will provide protection for the victim, and it will seek to restore stolen property. The very fact of compensation for the victim, he notes, serves an educational function – receipt of direct redress from the one who causes the harm. For serious cases, however, the prosecution will not ask for compensation for the victim, so that the court will not mitigate the punishment requested by the prosecution. This district attorney asserted that in "his" district, the demand to compensate the victim was made frequently during criminal proceedings – approximately one out of every ten files included a demand that the defendant compensate the victim, made at the discretion of the prosecutor. In the experience of this district attorney, the more random and coincidental the connection between the offender and the victim, the more willing the court will be to grant compensation for the victim during criminal proceedings. This is less likely if the offender and the victim were previously acquainted or had a history of complex relations or of causing damage to each other.

District attorney #2 believes that the language of the law should be studied, and the victim should be given what he deserves by right. Paragraph 77 is not often implemented because the criminal court prefers to transfer the victim's request for restitution and compensation to the civil court, where the victim can have a full hearing about his rights. In the opinion of this district attorney, this paragraph is rarely implemented. The prosecution will not initiate a demand for compensation. If, however, the victim or his lawyer insists on demanding compensation, and if damage is proven, the prosecution will probably include it. The more a victim knows his rights and is motivated to file a claim, the more likely that the prosecution will demand compensation for him through the court.

District attorney #3 asserts that the "rights pendulum" has now swung to the side of the offenders, ensuring that their rights are protected, rather than those of the victims. The accused generally have a lawyer to represent them, but victims rarely do. Indeed, the defense attorney will try to present the offender as a victim, and the victim as a dubious type who brought upon himself the crime of which his client stands accused. The prosecutor remains in touch with the victim until he testifies in court. Although one can ask the court to compensate the victim, this is not frequently done. In his district, he estimates that there are about five cases a year in which the prosecutor asks for and is granted compensation for the victim during the course of the criminal proceeding. According to this district attorney, the judges also do not encourage it. They want to bring the criminal proceedings to an end, and will not agree to deviating from deliberations exclusively about the offense. Imposing a fine also means increased income for society and the state, while compensation benefits only the victim. In this district attorney's opinion, the general weal is to be preferred over the good of the individual, even if he or she is a victim harmed in a crime. Practically speaking, it is also difficult to collect compensation and fines that are ruled upon. Few offenders are able to pay the amount of the fine or compensation. Foreclosure of an offender's property always meets with obstacles. For example, it is doubtful that drug offenders have property or means that could be repossessed. Therefore people should probably not be encouraged to feel and define themselves as victims, particularly because it places an extra burden on the state. In his opinion, compensation should be considered only in special cases, when the victim suffered a grievous injury.

District attorney #4 notes that the problem of compensating crime victims is complex, especially with regard to sex offenses. In his view, most crime victims are clients of or known to the welfare agencies, whose job it is to help them. For domestic crime, asserts this district attorney, there should be no compensation, as chronic offenders do not have the wherewithal to pay compensation anyway. The only cases in which compensation for the victim should be requested are those of fraud, since evidence of damage can be submitted and, if compensation is paid, the court will take that into consideration during the arguments for sentencing. Regarding other offenses, the damage cannot be estimated. Bringing in specialists to testify about the scope or severity of the damage will prolong the criminal trial, and no one has an interest in doing that. The directives from the Ministry of Justice are known, but they leave broad room for discretion and interpretation. Clearly, implementation of Paragraph 77 of the Penal Code 1977 is at the discretion of the prosecution. Very few victims of criminal offenses

know their legal rights as victims. They are not always informed of their legal options. He believes that crime victims should be encouraged to collect receipts for expenses incurred as a result of the crime, and keep documents related to their situation, health, ability to function. They should be encouraged to demand their rights at the stage of the criminal proceeding. From his experience, most crime victims are not aware of their legal rights. Women who fall victim to a crime, on the other hand, tend to get information and take an interest in how to obtain restitution and compensation, due, in part, to the work of the Rape Crisis Center volunteers, who inform those who contact them about their rights, including the right to ask for compensation during a criminal proceedings.

These were the responses of the district attorneys. The picture that emerges is of very little, if any, implementation of Paragraph 77 of the Penal Code 1977, which seeks to facilitate compensation to victims during the criminal proceeding. Three reasons may explain this:

First, due to the onerous burden of court cases, there is a strong desire to conclude criminal cases expeditiously, and not combine them with claims that belong in a civil proceeding. Combining them could not only complicate the criminal procedure, but even delay it: A compensation claim would necessitate deliberations, sometimes extensive, about the expenses incurred by the victim or the compensation he deserves. A decision to use this paragraph is more effectively made by the prosecutor when there are documents, receipts, or other evidence of expenses, and documentation to define the damage incurred by the victim. The difficulty is not in setting the amount of the expenses or damages, direct and indirect, incurred by the victim by the time of the hearings, but assessing future damages: Can one calculate the anticipated damage to the crime victim for the rest of his or her life?

Second, the prosecutors seem to be asking for complete freedom to get their job done vis-à-vis the criminal – addressing what they believe to be the overriding public interest: ensuring the conviction and appropriate sentencing of someone who committed a crime. Their responses to the interview question indicate that attending to the victim's needs is not only burdensome – dealing with something they deem irrelevant to the criminal case – but also introduces an element that could divert the court's attention from the appropriate punishment, and thereby mitigate the sentence, if indeed the court decides to award compensation to the victim. In the opinion of the prosecutors, the overriding public interest would be harmed.

Finally, despite the explicit reference to this in the law, there is a mistaken belief that if restitution and compensation are provided during the criminal

proceedings and the court rules on low compensation or restitution, this decision is final. However, Paragraph 88 of the Penal Code 1977 asserts that "acquittal of the criminal charge or imposition of a sentence or fine with regard to compensation in accordance with Paragraph 77 does not exempt from liability for damages according to any other law." In other words, the decision of the criminal court does not close the door on a civil suit by the victim.

On the other hand, fraud or property offenders, on the advice of their attorneys, often seem to have an incentive to offer the victim not just the restitution of stolen property, but also some compensation in the hope that the victim will be satisfied and the court will take this into consideration in the sentencing. Thus, the initiative for such compensation can come from the offender and not necessarily the prosecution or the victim (Van Dijk, 1985; Wright and Galaway, 1988).

Enabling the Victim to See that Justice was Done

In the cases described above, especially if the defendant confesses or strikes a plea bargain, there is no need for the victim to testify in court. The victim may sometimes not even know that a legal procedure was held, or he may learn about it – and how it ended – from the media. Despite the Attorney General's Directives (ibid., Parag. 7), a victim may not know if or when the trial was held, who presided, what the arguments were (had the victim testified, they may have been different), or the verdict and sentence. In the absence of the victim, it is unlikely that the prosecution would ask for restitution or compensation for the damages and suffering.

The district attorney and law enforcement agencies do not owe the crime victim anything: Despite the recommendations in the Attorney General's Directives (ibid.), the crime victim will probably not be informed about the sentence given to the offender – was he imprisoned, when will the punishment begin, and especially when will the prisoner be out on leave or released from prison.[8]

It could happen that the victim meets the offender during shopping, errands, or other routine activity, and it is reasonable to assume that this meeting, if random, would add to or perhaps even re-stimulate the trauma of the victim.

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8. Aviva Granot and Hava Ya'ari were sentenced to life imprisonment for the murder of Mala Malevski. Ms. Malevski's daughter complained (*Ha'aretz*, July 9, 1999) that no authorized party had ever asked her opinion about the sentence they received – shortening it, allowing prison leave, or their early release from prison. Although the daughter of the murder victim, she has no standing whatsoever in the process.

Representation of the Crime Victim by a Lawyer

Why, one may ask, would a crime victim need legal counsel when this would only add to the financial cost of his ordeal?

Crime victims do sometimes hire a lawyer to represent them. There seem to be three reasons for the victim to seek legal advice: First, apprehensions about filing a complaint and the accompanying police questioning may lead a victim to seek professional representation when the complaint is filed and the questions asked. Second, the victim may worry about incriminating himself when describing the event, and therefore may seek legal advice or the presence of a lawyer even at the stage of filing the complaint. Finally, some victims demand that "justice be done", and therefore hire a lawyer, despite the costs, to oversee the police investigation or the district attorney's actions, to ensure that his interest as victim of the crime will not be overlooked, and that the guilty party be caught and pay in full for the crime he committed.

Among his tasks, the victim's lawyer may clarify the stage in the investigation, whether the suspect was arrested, whether an indictment was issued, the nature of the evidence, and the like. If, for any reason, a decision is made to close the file, the lawyer will ensure that the victim receives appropriate notification, he may appeal the decision, and he may intervene if the option arises of a plea bargain in which the defendant admits to a lesser crime.

The victim's attorney can also make sure that the indictment prepared by the prosecution includes all the damage incurred by his client, and that the prosecution indeed demands that the defendant, if convicted, reimburse all expenses and pay compensation for pain, suffering, and damages, to which he is entitled according to Paragraph 77 of the Penal Code 1977.

One interesting issue is the attitude of the prosecution (the police, the district attorney's office) toward the crime victim who is represented by a lawyer. The willingness of these authorities to cooperate with a victim's lawyer should be explored. From the point of view of the prosecutor, the victim is just a witness, and a witness does not need legal representation. This issue deserves further examination.

In Conclusion

This article deals with the attitude of law enforcement and legal agencies in Israel toward individuals who are victims of violent crime. The State of Israel appears to fall short of fulfilling the tenets of the 1985 UN Declaration regarding the care, treatment, and compensation of crime victims. From the moment he files a complaint to the police, the crime victim has marginal status at best. A

victim who demands that justice be done is not likely to find it in this system. A felony by law is defined as an offense against public order and the state. The victim of this crime has lower status as a complainant.

Thus, in practice, the importance of the victim to society is his ability to help catch, indict, and punish the offender. The victim is therefore perceived by the state as a tool in coping with crime – a means of social control – and not someone injured whose well-being was disrupted.

Despite the key importance of the victim during the investigation, preparation of the prosecution, and trial, little interest is taken in him thereafter. It is not rare for victims of violent crime to feel that they have been "exploited", that there was no closure in their personal matter, and that justice was not served either.

The Attorney General's Directives – Chapter 15.10 (dated January 2, 1994) – reflect awareness of this (Parag. 2b), noting: "One hopes that adherence to these directives will lead to increased understanding and respect by the public of the legal system in general and the prosecution in particular, and *to an increased willingness of crime victims and prosecution witnesses to extend their vital help to the prosecution in the war against crime."* [emphasis added]. Hence, there is mutual dependence between the state, which needs the public support and trust for doing its job, and the crime victim with his needs.

From the moment someone falls prey to a violent crime, he or she needs and deserves comprehensive and sensitive attention: full medical care, treatment for the emotional trauma and its repercussions, coverage of the direct expenses and loss of income due to his or her reduced ability to work and earn a living. These services are not generally provided to the crime victim in Israel. Furthermore, a crime victim has the right to demand justice – that his voice be heard not only as witness, but also during the arguments about the punishment.

If the offender is not caught, however, or if he confessed or signed a plea bargain, the victim's testimony is usually not required, and the story of his anguish, intended to influence the court at various stages of the proceedings, will not be heard. Although some crime victims do not want to re-tell their story, and certainly not in public, they retain their *prima facie* right to do so, as well as the right to support and compensation for the expenses, pain, and suffering.

In Israel, the state does not compensate crime victims, other than victims of terrorism. Victims of other violent crimes can ask for reimbursement of their expenses as a result of the offense, and compensation for damages and suffering as part of the criminal proceeding, based on Paragraph 77 of the Penal Code 1977.

In the Directives of the Attorney General, the amount of discretion given to the prosecution about whether to make use of this option in the Penal Code is striking. As evident from interviews with four district attorneys, they are reluctant to implement this legal option more comprehensively. Some even view it as an obstacle. From the few testimonies collected for this article, the court – and the prosecution – apparently prefer to conclude the criminal case. Anything that delays that conclusion is viewed not only as a burden, but as a hindrance to the criminal, legal proceedings.

These delays and obstacles refer primarily to estimating the expenses, damage, and suffering experienced by the crime victim. Disagreement on even one element could not only delay the criminal proceedings, but also complicate them by focusing on the issue of damages – and why would the court, the prosecution, or the defense choose to prolong or complicate the deliberations?

It is doubtful that Paragraph 77 of the Penal Code 1977 and the Attorney General's Directives are sufficient to motivate the system to adopt it. Clearly there is only partial awareness of this paragraph and its intent. Even the Attorney General's Directives, as noted, are only a recommendation and basis for discretion: These directives do not enforce the option of ensuring either restitution of expenses or compensation for suffering and damages to the crime victim. They leave the prosecution with a wide margin of discretion, and it is not likely that many prosecutors even consider using Paragraph 77 of the Penal Code.

Introducing the Victim Impact Statement into Israel's legal system may provide a breakthrough in the field. If the use of this Statement is extended beyond sex crimes and becomes more institutionalized, it may significantly improve the status of crime victims, on the assumption that submission of the statement in court would ensure attention to its content and perhaps also lead to addressing the needs of the victim.

Attitudes to the crime victim in Israel should be re-examined. The increased number of crimes and victims could lead to apathy in Israeli society, if not complete indifference to those injured. Every member of society is vulnerable to harm from a malevolent party. Israel has already ensured the rights of those harmed by terrorism, whose victims are entitled not just to substantial financial aid, but to medical treatment, rehabilitation, and ongoing financial support (Yanay, 1994). Why don't similar arrangements exist for everyone harmed by violent crimes that are not defined as terrorism?

A public defender exists in Israel to represent all those accused of having committed a crime. Thus, the state sees to it that the interests of suspects are

safeguarded. This is in striking contrast to the lack of representation of the interests of those who fall victim to crime. Victims lack representation and rights in the system. Thus, one might propose the provision of support and legal representation to the crime victim, to ensure that his rights be protected, whether during the criminal or civil proceedings.

Furthermore, the state is willing to invest considerable money in a suspect who agrees to cooperate with the prosecution as a state witness. The state may pay a considerable amount for his testimony or may invest in his defense, a change of identity, help with moving elsewhere, etc. The victim of a crime, on the other hand, even if he endured a difficult and painful personal experience, is not entitled to anything from the state.

Another significant question concerns which legal system is preferable for the crime victim to present his claims for restitution and compensation for damages and suffering. While the criminal court adjudicates according to the standard of "beyond reasonable doubt", the civil court adjudicates according to "the balance of probability". Even though in Israel a compensation claim could be ruled in a criminal court, perhaps the victim would be better off – stand a better chance of winning compensation – if his case were heard in a civil court. Recall that O.J. Simpson won acquittal in the criminal court, while the civil court that handled the case afterwards ordered him to pay millions of dollars of compensation to the survivors of the victims. Civil law might be more favorable to the crime victim than criminal law, although Israeli legislation ostensibly provides for compensating the victim in the criminal system.

As noted, society is said to be measured by how it serves its weakest members. The victims of violent crime appear to be the weakest and most worthy of attention, support, and aid. A suggestion for a program to compensate victims of crime in Israel was proposed several years ago (Miller, 1982; Miller and Sebba, 1987) and recently in a bill proposed by M.K. Yael Dayan and others, but this has not yet resonated in the powers that be or brought about the desired change.

Paragraph 77 of the Penal Code 1977 appears to be a fig leaf covering society's shortcomings in caring for its crime victims. The time has come to find a better way to compensate victims of crime for the damages and suffering they endured. As common in other western countries, the state should provide victims of violent crime with treatment, help, and compensation. The support and compensation should be forthcoming whether the offender is caught or not, since the state is responsible for the security of everyone, and the crime reflects its failure at fulfilling this duty.

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HEALTH INEQUALITY IN ISRAEL DURING THE 1990s

By Amir Shmueli* and Revital Gross**

Issues of equity and equality in health are drawing increasing attention from policy-makers and researchers, particularly in societies with social health insurance systems. This article presents findings on income-related health inequalities in Israel since implementation of major social health legislation in 1995. One of the primary goals of this legislation was to make the health system more equitable. Population surveys indicate that, indeed, equality in access, availability, utilization of services and satisfaction have increased since enactment of this legislation. However, although the mean health status of the population has improved slightly, inequality in adjusted income-related ill health has persisted. Therefore, in order to achieve greater equality in health, it may be necessary to directly address income-related inequality.

Introduction

Since the 1980s, issues of equity and equality in health have drawn increasing attention from policy-makers and researchers. Health care system reform in western Europe in the 1980s and early 1990s, and the protracted debate over the need for reform in the United States, have contributed to a significant increase in the research in this field. Many empirical studies have focused on one of two key issues: the extent to which the financing of national expenditure on health is *progressive*, and the extent to which the utilization of health care services is *equitable* (van Doorslaer, Wagstaff and Rutten, 1993; Achdut, 1999; Shmueli and Achdut, 1999). At the heart of both issues lies the principle of dual equity – that is, to finance health care according to an individual's ability to pay, while providing care according to his need.

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Israel has also been a party in the international debate over these issues. In Israel, equality is a desired value that guides health policy's attempts to ensure an appropriate level of and equal access to health care for all sectors of the population, regardless of social status, religion, ethnic background or financial ability (Ministry of Health, 1989; State Commission of Inquiry, 1990).

Dual equity also was a guiding principle behind Israel's 1995 National Health Insurance Law, which states that "national health insurance will be based on principles of justice, equality, and mutual aid." (*Book of Laws* 1469). Prior to enactment of the law, Israel's health plans were entitled to selectively enroll members and set the rate of membership dues. Since dues were income-linked, the health plans had an incentive to seek wealthier members by providing better services. Also prior to the law, the health plans defined their own benefits packages; this resulted in inconsistency and lack of clarity in coverage (Gross, Rosen and Chinitz, 1998). To redress this situation, the law stipulated the right of every citizen to health insurance coverage, regardless of his financial ability. It replaced income-linked membership dues with a progressive health tax premium, collected by the National Insurance Institute (Israel's social security administration) and distributed to Israel's four health plans according to an age-adjusted capitation formula (which serves as a proxy for health needs). The law also mandated a uniform, comprehensive benefits package, which all the health plans must supply to their members, and required the health plans to accept all applicants for membership. These stipulations ensure equal access to care, and freedom of choice among health plans.

Studies have shown that equality in utilization, access, availability and satisfaction have increased since enactment of the law, between the elderly and the young (Bentur and Gross, 2001), Arabs and Jews (Farfel and Yuval, 1999), low income and high income populations (Berg, Rosen and Morginstin, 2002), and peripheral and central regions (Nirel et al., 2000). These changes concord with changes in the incentive system and in health plan activities in the wake of the law (Gross, Rosen and Shirom, 2001 ; Gross and Harisson, 2001).

However, equitably financing and providing services is only part of the concept of equity as it applies to the structure of the health care system. In the final analysis, the critical issue is equality of *health*, which, after all, should be the system's end product. In many democratic societies, the persistent disparity in citizens' health – despite the implementation of a system based on dual equity – is troubling.

Socio-economic status is the empirical variable most often used to explain disparity in health status, with consistent results: High socio-economic status

is always associated with better health (Le Grand, 1987; Adler et al., 1993; Wilkinson, 1996; Macintyre, 1997).

The stability of the relationship between socio-economic status and health status, and the instability of the relationship between access to and utilization of health care and health status, has convinced many policy-makers that an improvement in the socio-economic status of the poor is more likely to improve that population's health than is better access to health care. Furthermore, equality in the health of different population groups has been found to be related to the equality of income distribution.

The fundamental link between unequal health status and the unequal distribution of income is a direct derivative of the health production function. Inputs into health production include the quantity and quality of medical care, an individual's level of education, and leading a healthy lifestyle – all of which usually increase with an increase in income. Using a "reduced form" of the health production function, we can use income as the key production factor. If income generates positive (or at least non-negative) marginal outputs in the production of health – which is a reasonable assumption – then the transfer of income from the rich to the poor (i.e. reduction of the inequality of income distribution) will lead to a decrease in the health of the wealthy and an increase in the health of the poor (i.e. reduction of the inequality in health status). In other words, if we compare two populations that have the same average income levels, but one of which has a more equitable *distribution* of income, we would expect to find less inequality in health status in that population. If we make the reasonable assumption that the marginal outputs of income in the production of health decrease with an increase in income (and health), we would also expect the overall level of health to be greater in a population with the same average income but with a more equitable distribution of that income (Wilkinson, 1996). The reason for this is that when income is transferred from the rich to the poor, the decline in the health of the rich is smaller than the improvement in the health of the poor.

One of the paramount, explicit goals of all social health insurance legislation (including Israel's National Health Insurance Law) is to sever the seemingly permanent link between access to and utilization of health care and income, with the aim of increasing the equality of the distribution of health care, and hence improving the general level of health.

The case of Israel is of special interest to researchers and policy-makers because the implementation of the National Health Insurance Law in 1995 has unequivocally improved equality in the access to and utilization of health

care. However, at the same time, there has been a slight increase in income inequality since implementation of the law, as measured by the Gini coefficient: 0.3366 in 1995; 0.3285 in 1996; 0.3332 in 1997; 0.3321 in 1998 and 0.3387 in 1999 (National Insurance Institute, 1998). Examination of the Israeli case therefore enables us to explore whether far-reaching social health legislation, which has managed to increase equality in access, availability, utilization of health services, has also increased equality in health status, despite persistent inequality in income.

The objective of this article is to describe income-related health inequalities in Israel over time, since implementation of the National Health Insurance Law. It also compares the situation in Israel to that in OECD countries, in an attempt to clarify whether social legislation directed at the health system can affect the link between income and health status.

Method

1. 1995-1999 Population Surveys

The JDC-Brookdale Institute conducts periodic population surveys as part of its evaluation of the 1995 National Health Insurance Law. We used these surveys to calculate measures of income-related inequalities in Israel following the enactment of the law. The survey method involved telephone interviews with a sample of respondents drawn from the computerized national telephone listing of Israel's sole domestic telephone company. A structured questionnaire was used, which covered satisfaction with level of service, access and availability, utilization, and self-reported health status. To date, three such surveys have been carried out – in 1995, 1997, and 1999 (see Gross, Rosen and Chinitz, 1998; Gross et al., 1998; Gross and Brammli-Greenberg, 2001). The telephone interviews were conducted by specially-trained interviewers between August and October of each year in Hebrew, Arabic and Russian, to ensure inclusion of all major segments of Israel's population.

The study population comprised all permanent residents of Israel age 22 and over. In each apartment or home sampled, one adult was randomly selected. In 1995, 1,089 questionnaires were completed, in 1997, 1,205 questionnaires were completed, and in the 1999 survey, 1,727 questionnaires were completed.

Sample weighting was carried out in two stages: First, each individual was allocated a weight according to the probability of his being sampled. The sampling fraction was determined according to the number of telephones in the dialing area sampled, the number of adults over age 22 in the household, and the

number of telephone lines in the household. Second, the population was divided into eight strata by ethnic group (Arab/Jew), gender (male/female), and age (under age 65/over age 65). Each stratum of the sample was assigned a weight that reflected its proportion in the total population.

We compared the three annual samples by health plan membership, gender, area of residence, chronic illness, main language spoken, years of schooling, and marital status. The only significant difference found between the 1995 and the 1997 samples was a higher proportion of Russian-speakers in the latter sample (16% versus 10%). No significant differences were found between the 1997 and 1999 samples.

2. Variables

The analysis presented here uses five variables, which were included in all three surveys: *health, income, family size, age, and gender.*

Health: This variable was measured by subjective self-report, based on a five-category scale. The five categories were "very good", "good", "not so good", "not good", and "poor". The rate of missing values with respect to health ranged from 2%-3%.

Like other studies, this study used a one-question subjective measure of health. Subjective evaluations are preferred to objective measures of morbidity and mortality, as they better represent health-related quality of life, which increasingly occupies a central role in the measurement of health sector production. Gerdtham et al. (1999) and Humphries and van Doorslaer (1994) found that inequality in health status that is calculated on the basis of a one-question evaluation does not differ from that calculated based on more complex measures, such as the Visual Analogue Rating Scale, the Health Utility Index or the Time Trade-off.

Family Income: Respondents to all of the surveys were asked to indicate into which of six (1995) or seven (1997) categories their family fell, based on their gross family income (including transfer payments). The non-response rate was 16%-17%. It should be noted that, in all of the surveys, the distribution of health status of those who provided a valid response about their income did not differ from that of non-respondents to this question (Kolmogorov-Smirnov test).

Income per Standard Adult: Family income is commonly regarded as a poor measure of a family's economic state, as it does not account for the number of people in the household. Income per standard adult is considered preferable. Therefore, we converted the number of persons in each household into the

number of standard adults, based on the equivalence scale used by Israel's National Insurance Institute. To calculate income per standard adult, all of the individuals in a particular income category were ascribed the mid-point income in that category. Individuals in the highest category were ascribed an income commensurate with the mean family income in that category, as indicated in the income surveys of the Central Bureau of Statistics for the appropriate years.

We conducted the analysis twice, using both measures of family income, since the calculation of income per standard adult suffers from measurement errors originating in the assignment of the category's mid-point to all members in a category. Comparison of the results from both analyses reinforced our conclusions.

3. Analytic Strategy

We used the concentration curve to describe income-related health inequality, and the concentration index to provide a summary measure of that inequality. Both measures are calculated using individual income data. Let us suppose that health status is measured as a continuous variable. If this is the case, we can calculate the cumulative percent of "total population health" for every cumulative percentage of individuals, arranged in ascending order by income level (or income per standard adult). For example, if 10% of those in the lowest income category enjoy 10% of total health, and 20% of those in the lowest income category enjoy 20% of total health (etc.), then health equality is fully income-related. Full equality may be signified by a diagonal bisecting a rectangle, where the horizontal axis represents a cumulative percentage (up to 100%) of individuals, arranged in ascending order by household income (or income per standard adult), and the vertical axis represents the cumulative percentage of "total population health" (up to 100%). The *concentration curve* describes the actual relationship between these two variables, which will usually diverge from full equality.

The *concentration index* uses a single number (including standard deviation) to summarize inequality, calculated as twice the area between the concentration curve and the diagonal. This number will therefore range from zero (full equality) to one (complete inequality). A negative value (-) of this measure would indicate that the concentration curve lies above the diagonal – that is, that inequality favors the rich.

When using the concentration index to compare levels of inequality across populations, it is only possible to rank these levels unequivocally when the concentration curves lie completely within one another. The concentration

curves that describe inequality in health status in 1995, 1997 and 1999 do not cross, and hence comparison of the concentration indices is meaningful.

The survey respondents' *self-reported health categories* were converted into a continuous variable by viewing the responses as indicators of a continuous log-normal latent variable, representing real health status (Wagstaff and van Doorslaer, 1994; Kakwani, Wagstaff and van Doorslaer, 1997). Each of the discrete categories of health was translated into the latent variable by dividing the area under the log-normal standard distribution curve by the category's relative frequency in the sample. Since it is common to indicate worse health by higher scores on self-reported health status, the higher the score on the continuous latent variable the worse the individual's health status, such that we are, in fact, measuring and discussing inequality in ill health.

Once we have a value for the health of each individual in the sample on a continuous variable, it is not difficult to calculate the concentration curve and concentration index, which describe income-related inequality in crude ill health. However, inequality also derives in part from health differentials, which in turn derive from uncontrollable factors not directly related to income disparity. The two most important of these uncontrollable factors are age and gender, and crude ill health needs to be adjusted for them. This we did by indirect adjustment, that is, by replacing individual health scores with the mean score of the individual's gender and age group, thus ensuring that the variation in health status in each income group was independent of demographic differences. The concentration curve and concentration index calculated in this manner represented inequality in ill health adjusted for age and gender, and enabled us to compare inequalities across populations, while accounting for the demographic structure of each income-health group. Evidently, inequality of adjusted ill health will be smaller than inequality of crude ill health.

Figure 1. The Distribution of Health Status

Results

1. Income-related Health Inequality, 1995-1999

Figure 1 shows the distribution of self-reported health as given by the 1995, 1997 and 1999 surveys. The Kolmogorov-Smirnov tests for the equality of pairs of surveys found no divergence in the distribution of health between 1995 and 1997, and between 1997 and 1999. Nevertheless, a certain improvement over time in the population's health status can be detected in the movement of cases from the "not so good" category to the "good" category. The key question, of course, is what has happened to inequality in health status during this time.

Table 1 displays the inequality in crude and adjusted ill health in 1995, 1997, and 1999, with the ranking variable being *gross family income.* The t-test values indicate that there were no statistically significant differences in the concentration indices for the inequality in *crude* ill health among these years.

The concentration indices for inequality in *age- and gender-adjusted* ill health show a statistically significant increase in inequality in ill health between 1995 and 1997 (from -0.0545 to -0.0763), with no change between 1997 and 1999 (0.0772).

Table 1. Concentration Indices for Ill Health
(Ranked by Gross Family Income)

	1995		1997		1999	
	Value	S.E	Value	S.E.	Value	S.E
Crude	-0.17	0.0215	-0.198	0.0198	-0.185	0.0165
Age-gender Adjusted	-0.055	0.0077	-0.076*	0.0085	-0.077**	0.0067

* t-test value for equality of difference in values between 1997 and 1995 (1.98) significant at $p<0.05$.

** t-test value for equality of difference in values between 1999 and 1995 (2.22) significant at $p<0.05$.

Table 2 presents the concentration indices for inequality of crude and adjusted ill health, when the ordering variable is *gross income per standard adult*. The age- and gender-adjusted concentration indices show an increase in inequality in ill health between 1995 and 1997 (from -0.0074 to -0.0029), with no change between 1997 and 1999 (-0.03). The two measures (based on gross family income and on gross income per standard adult) indicate the same trends, which reinforces the reliability of our conclusions.

Table 2. Concentration Indices for Ill Health
(Ranked by Gross Family Income per Standard Adult)

	1995		1997		1999	
	Value	S.E	Value	S.E	Value	S.E
Crude	-0.1296	0.0224	-0.112	0.0185	-0.125	0.017
Age-gender Adjusted	-0.0074	0.0081	-0.029**	0.0089	-0.03#	0.007

** t-test value for equality of difference in values between 1997 and 1995 (1.75) significant at $p<0.10$.
# t-test value for equality of difference in D values between 1999 and 1995 (2.09) significant at $p<0.05$.

2. Comparison of Health and Income Inequality Indices in Israel and OECD Countries

Inequality in age- and gender-adjusted ill health in the adult population that is related to income per standard adult is an internationally comparable variable. Using direct adjustment of health for age and gender,[1] van Doorslaer et al. (1997) and Humphries and van Doorslaer (2000) demonstrate that the countries they studied in the late 1980s and early 1990s could be divided into three groups based on inequality in adjusted ill health: egalitarian countries (Sweden, East Germany), where concentration indices were between -0.03 and -0.04; non-egalitarian countries (the United Kingdom, Canada, the United States), where concentration indices were less than -0.1; and intermediate countries (Switzerland, The Netherlands, West Germany, Spain and Finland), where concentration indices were between -0.05 and -0.07.

Calculating a comparable concentration index (based on gross income per standard adult) using data from the 1995 survey (chronologically the nearest of the three Israeli surveys to the time of the international study) produces a concentration index of -0.082 for the inequality of directly adjusted ill health. This score places Israel at the top of the intermediate group of OECD countries (for 1995).

If we adjust the Israeli data to account for the five years that had elapsed

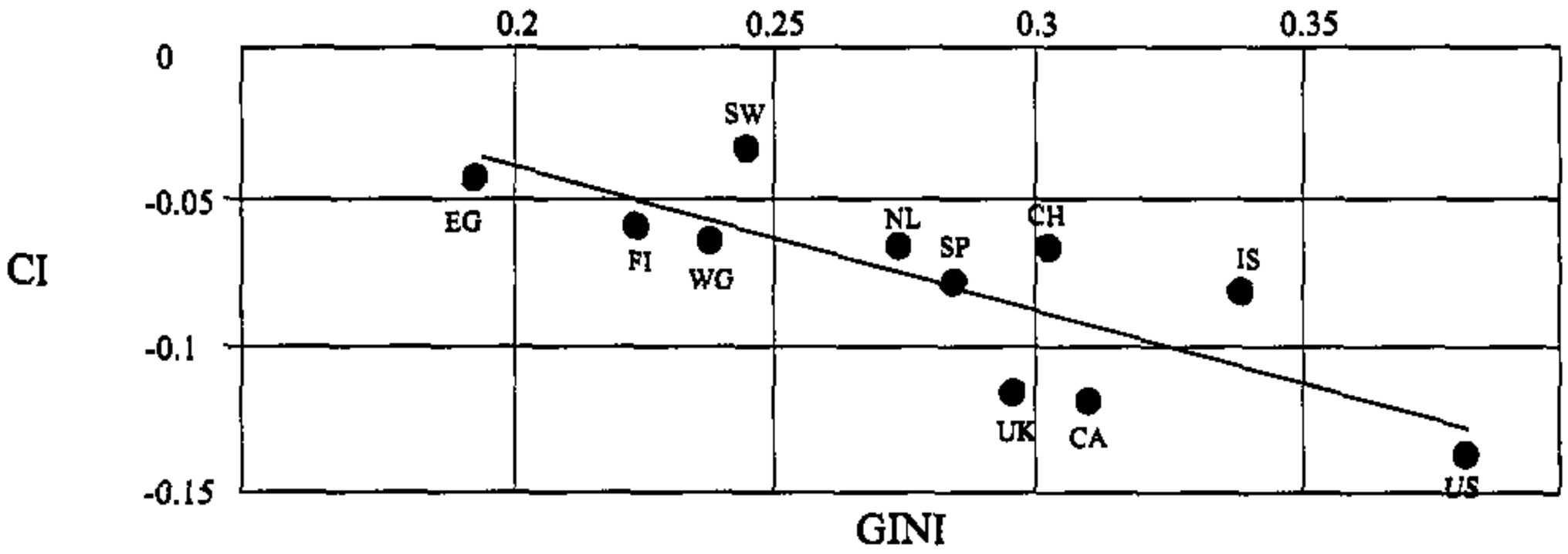
1. That is, each individual was assigned his own health score, but the mean health score for each income group was calculated while maintaining the age-gender structure of the national population.

since the gathering of the cross-national data, and for the income indicator (that is, gross rather than disposable income, on which there was no data in Israel), the level of inequality will be somewhat lower. This is because inequality in the distribution of income tends to increase with time: The Gini coefficient increased from 0.322 in 1988 to 0.3366 in 1995. Furthermore, the distribution of disposable income (see Kakwani, Wagstaff and van Doorslaer, 1997) is more equal than that of gross income. It is therefore reasonable to conclude that Israel ranks in the middle of the intermediate group, with greater health inequality than Sweden but less than the United States, Canada and the United Kingdom.

Comparison of the income distribution inequality index (the Gini coefficient) shows that Israel's is among the highest in the world (National Insurance Institute, 1998). The level of the Gini coefficient in Israel is closer to that of the U.S., the U.K. and Canada, all of which have non-egalitarian distribution of health care, than to that of the countries in the intermediate group. Figure 2 displays the Gini coefficients for the distribution of net income per standard adult and the concentration indices for inequality in health in nine OECD countries in the early 1990s (van Doorslaer et al., 1997), in Canada in 1994 (using gross income per standard adult, see Humphries and van Doorslaer, 2000), and in Israel in 1995 (using gross income per standard adult). Given its level of income inequality, Israel has lower health inequality than might be expected, compared to the other countries (the concentration index of Israeal is above the regression line).

It should be noted that the cross-national comparisons we have made here are not exact, due to the five-ten year difference in the dates of the respective surveys and the varying use of net versus gross income.

Figure 2. Inequality in Health and in Income – A Global Perspective



Discussion

Our findings show that between 1995 and 1999, the mean health status of Israel's general population improved slightly. However, inequality in adjusted income-related ill health increased somewhat between 1995 and 1997, and remained constant between 1997 and 1999. In other words, while the whole population's health improved, that of the wealthy improved more than that of the poor.

One possible explanation for the increase in adjusted health inequality may be the change in the composition of the sample. Between 1995 and 1997, the proportion of immigrants from the former Soviet Union in the sample rose from 10% to 16% (as noted, this was the only significant difference between the two samples). Since these immigrants tend to be less healthy and to have lower income than the veteran Israeli population (Nirel et al., 1998; Gross, Brammli-Greenberg and Remmenick, 2001), their greater representation in the sample could be expected to increase income-related health inequality. To test this hypothesis, we recalculated the indices of income-related crude and adjusted health inequality, excluding respondents who had immigrated to Israel from the former Soviet Union after 1989. There were no statistically significant differences in the value of the concentration index for adjusted ill health (ranked by gross family income) between 1995 and 1999.[2] This tends to support the explanation that the observed increase in the level of income-related inequality in health status in the total population was a consequence of the increased proportion of immigrants from the former Soviet Union in the sample. However, sample size limitations precluded us from calculating the indices for immigrants from the former Soviet Union and other sub-populations separately. We therefore cannot unequivocally conclude that the increase in inequality is due to the larger proportion of immigrants in the sample.

In any case, the data do indicate that following implementation of the National Health Insurance Law in 1995, not only was there no decrease in income-related health inequality, but there may even have been a slight increase. This finding shows that despite the equality-oriented articles of the law, and the increase in equality in access to and utilization of services (Farfel and Yuval, 1999; Nirel et al., 2000; Gross, Rosen and Shirom, 2001; Bentur and Gross, 2001; Gross and Harisson, 2001; Berg, Rosen and Morginstin, 2002) the law's ultimate goal of reducing disparities in health status has **not** been achieved during the first five years since its implementation.

The persistent inequality in health status may be attributed to the persistent inequality in income distribution, as measured by the Gini coefficient. The Gini

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2. The values were -0.0534 in 1995, -0.0562 in 1997, and -0.0601 in 1999.

values show that the rate of inequality in income distribution did not change considerably during the period under study (0.3366 in 1995, 0.3332 in 1997 and 0.3387 in 1999).

Our analysis leads to the conclusion that despite significant social legislation to promote equality in the provision of health care, and despite increased equality in the access to and utilization of services, the persistent inequality in the distribution of income has a stronger effect, and results in persistent inequality in health status. This finding corroborates evidence from other countries.

For example, van Doorslaer et al. (1997) also found health inequality to be correlated with income inequality. The more unequal the distribution of income, the greater the income-related inequality in health. Interestingly, this correlation was found to be more dominant than the correlation between inequality in health status and type of health care system. To illustrate, the U.S., the U.K. and Canada have thus far failed to achieve income-related health equality, despite having different types of health care system (the former two have "socialized medicine", while the latter has a private system that links premiums for and access to services to income) – possibly because in all three countries, income distribution is highly unequal.

When we compare Israel to these countries, we discover that Israel's income distribution is also relatively unequal (on a par with that in all three countries). In contrast, however, the equality of Israel's health distribution is moderate, and on a par with that in some European countries (with the exception of Sweden). This can be attributed to Israel's well-established socialized, egalitarian health care system.[3]

Conclusion

In conclusion, it appears that during the 1990s, the improvement in the standard of living in Israel, as in other countries, led to improved health for the whole population. However, it also led to greater socio-economic inequality, which even significant social health legislation and an increase in the proportion of GDP allocated to health care (from 7.2 in 1987/88 to 8.6 in 1995 and 8.3 in 1998) have not been able to redress.

The findings of this study have important implications for social policy. Policy-makers wishing to improve equality in health should consider investing social resources in the reduction of inequality in income among population

3. Even prior to implementation of the National Health Insurance Law, 96% of Israel's population was insured by one of Israel's health plans.

groups as a means of achieving greater equality in health. Despite the high probability of opposition from the very strong health system establishment, it may nevertheless be worth considering transferring resources from the health system to the welfare system, to accomplish this end. As our findings show, social health legislation is indeed effective in increasing equality in the system. However, it seems not to eradicate inequality in health – the ultimate goal of the health system. It therefore seems that efforts in other directions may be needed to facilitate the transition to a more equitable system.

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PSYCHOSOCIAL COUNSELING AND PREPARATION FOR IN VITRO FERTILIZATION IN SELECTED WESTERN COUNTRIES AND IN ISRAEL

By Ruth Landau*

The article describes the procedure of In-vitro fertilisation, the psychological and ethical issues it raises and the place of counseling in this area in some Western countries and in Israel. Despite the volume of infertility treatments in Israel, unlike in Western countries where psychological counseling is an inherent part of the IVF procedure, psychosocial counseling is not considered as vital in Israel. Moreover, in contrast to the direction emerging from the legislation, by-laws and recommendations of the public-professional committee on IVF, social workers and psychologists are usually not part of the IVF team. It is therefore suggested that the psychosocial needs of IVF patients in Israel be thoroughly examined and principles concerning the inclusion of psychosocial counseling in the health basket be determined.

Introduction

The significance of childbirth in the State of Israel is reflected to some extent in the inclusion of in vitro fertilization (IVF) among procedures covered by the 1995 National Health Insurance Law. While the Central Bureau of Statistics and Ministry of Health do not routinely publish data on the number, type and success rate of IVF treatments, partial information on the previous decade (updated to 1996) indicates that IVF births account for some 2% of all births in Israel each year (Ministry of Health, 1999), as compared with 0.2% in the United States, for example (McClure, 1996).

In vitro fertility treatments were first provided in Israel in 1982, under the supervision of the Israel Human Experimentation National Review Board, four years after the first test tube fertilization was accomplished successfully in the UK. In 1991, the Ministers of Justice and Health appointed a Public-Professional

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Commission in the Matter of In Vitro Fertilization (also known as the Aloni Commission after its Chair) to examine the social, ethical, religious and legal aspects of IVF treatment methods and the need for legislation to stipulate the rights and obligations of all involved parties (Ministry of Justice, 1994). The Commission's Report, published in 1994, revealed that the percentage of IVF treatments in Israel is among the highest in the world (*ibid.*, p. 7). One result of this situation is the growing number of twins and even triplets among Israeli babies, a phenomenon now known to be a side effect of IVF.

IVF treatments are known to demand powerful endurance in the face of long-term physical and emotional distress (see, for example, Birman et al., 1991; Gilai-Ginor, 1996; Levy-Shiff and Henman, 1996). Recognizing the intensity of this strain, especially for women, the Aloni Commission insisted that alternatives to IVF be examined, including the option of coping with the stigma of childlessness. It is no secret that many IVF patients never fulfill their dream of bringing a child into the world (Leitman, 1996), even though the media downplay failures in favor of the extraordinary breakthroughs achieved in this field. In 1996, Israel reported 12,345 cycles of embryo transfer treatment that yielded 1,950 births and 2,562 live newborns, constituting 15.8% of all transferred embryos (Ministry of Health, 1999a). Of these births, 31% were multiple. In 1996 (the last year for which figures are available), multiple births accounted for 3.9% of all live births, as compared with 3.3% in 1993 (Ministry of Health, 1999b). The relatively high percentage of IVF births indicates that many patients are receiving such treatment.

Numerous difficulties are entailed by IVF treatment, including a high probability of failure and the likelihood of multiple pregnancy following successful treatment (one out of three IVF pregnancies). Templeton (2000) and Olivannes (2000) discerned that medical intervention engenders complex implications among patients. This is apparently the reason that the Aloni Commission assumed that some couples would require supportive care during treatment and subsequently during pregnancy – should it prove successful – and following childbirth. Moreover, the Commission even considered ordering all IVF units to distribute detailed information on the likelihood of success and the attendant risks of the treatment proposed, although it later abandoned this proposal. However, it did recommend that the Ministry of Health publish annual information on IVF unit operation and that each such unit maintain an appropriately trained counselor – a social worker or psychologist – with whom patients may consult (Ministry of Justice, 1994, pp. 19-21). Neither of these two recommendations was carried out.

Fertility treatments entail numerous physical and emotional difficulties, limited likelihood of success and personal decisions by professionals and couples treated, including those of an ethical nature. This study focuses on the nature of IVF treatment, especially its psychological and ethical aspects, examining the issue of counseling and preparation for these treatments in selected Western countries and Israel.

Treatment

Only 25 years have gone by since the world's first in vitro fertilization was carried out in the United Kingdom in 1978, when a woman's ovum was fertilized by her husband's sperm in a test tube. The course of IVF treatment comprises numerous stages (Leitman, 1996), including stimulation of the woman's ovaries to produce numerous Graafian follicles containing ova, achieved by daily hormone injections. This stage, like the extraction of eggs from these ovarian follicles – a complex process conducted under general anesthesia – is known to bear numerous risks to the patient. Hormonal stimulation of the ovaries to intensify production beyond the natural rate of one at a time is liable to increase the risk of ovarian cancer (Thomas et al., 1997). The eggs are fertilized with the man's sperm in a test tube and transferred back into the uterus several hours thereafter. To increase the likelihood of fertilization, it is common to fertilize more than one ovum in vitro and transfer them all. When IVF treatments were first instituted, it was common practice to implant as many fertilized ova as possible. In those early days, some of the multiple pregnancies ended in loss of all fetuses and others in the birth of twins, triplets and quadruplets. Even as late as 1996, it was customary to assume that placement of four embryos in a woman's uterus was a precondition for achievement of pregnancy (see, for example, Leitman, 1996). Recently, doctors have begun to view multiple births as a source of concern to public health (Jones, 1995; Lieberman, 1998a; 1998b) because of premature birth, low birth weight and complications during and after childbirth. For this reason, they began experimentally reducing the number of fertilized ova implanted. In any event, hormonal treatment to accelerate and increase egg production, as well as surgical extraction and reimplantation following in vitro fertilization, demand numerous medical and laboratory examinations, entailing tight schedules and much physical suffering. At each stage, patients suffer considerable tension and anxiety because if anything goes wrong in their quest for pregnancy, the entire process will have to be started all over again. It is reasonable to assume that there are far more unknown or uncontrollable variables that may cause

treatment to fail. Obviously, the larger the number of failed treatments, the greater the fear of failure among patients.

Achievement of the desired pregnancy is no guarantee of the birth of a live and healthy child. Even if the fertilized egg begins to develop in the uterus, there are still numerous risks to both fetus and mother, especially in cases of multiple pregnancy (Olivannes, 2000). This may be the reason that IVF treatment data customarily indicates separate success rates for each of the following stages: Ovum extraction, discontinued cycle, in vitro fertilization and transfer to the uterus, pregnancy, births and live births (SART Registry, 1998). Moreover, the successful birth of a live offspring does not always mean the birth of a healthy child. The possibility of defects due to multiple or premature birth – both common outcomes of IVF treatment – raises an additional problem that may exacerbate the patient's already tense emotional state. The situation becomes even more complex when IVF treatments are applied in cases of male infertility or when the patients require donation of eggs, sperm or both or – if the woman lacks a uterus – a surrogate mother. Since 1978, when the necessary connection between sexuality and fertility was severed and it became possible to fertilize the ovum of any woman with the sperm of any man in vitro and transfer the fertilized egg to any woman's uterus, the number of people involved in the reproduction process increased as their range of options expanded. Various new combinations of genetic, biological and social parenthood are now a feature of contemporary family life.

The varied options, along with the possibility of freezing genetic material (sperm or fertilized eggs), enable birth to take place after the death of the donor (Landau, 1999) or after menopause. IVF is unique in that it requires the intervention of a third party, a professional, i.e. a trained physician, without whom the process could not take place. When genetic material donors are involved as well, they too constitute third parties in effecting parenthood. Unlike the physician, whose role is perceived as completed on conclusion of the medical treatment process, the other involved persons are parentally linked with the resulting children throughout their lives, if treatment is successful – and through those children also to the parents who raise them, even if such links are not always manifested overtly (Landau, 1998a).

Psychosocial and Ethical Aspects

People are strongly motivated to bring children into the world, especially in Israel. Difficulty in doing so is perceived as highly traumatic. Failure to meet one's own expectations in this respect, as well as those of one's spouse,

family and society as a whole, often constitutes a severe blow to quality of life. Diagnosis of fertility dysfunction itself may induce a personal crisis (Valentine, 1986), a decline in self-worth and sexual problems (Beck Black et al., 1992). Fertility treatment may intensify conflicts between partners and curtail sexual satisfaction and frequency of contact (Andrews et al., 1991), while differences between the respective partners' interpretation of infertility and style of coping with the problem may exacerbate pressure as well (Valentine, 1986). Gilai-Ginor (1996) details the psychological effects of infertility on individuals and couples and their implications regarding fertility treatment, including the adverse effect on sense of femininity among women and of masculinity among men under treatment, increased awareness of unsolved conflicts and ineffective patterns of interpersonal communication between partners.

In "family-oriented" Israeli society, pressure to have children is applied by the extended family and social network alike. However, even if a couple does succeed in having a child thanks to fertility treatment, such treatment does not necessarily render the infertile partner fertile and the implications of this situation for the couple and child should be borne in mind (Gilai-Ginor, 1996; Glazer, 1998).

Also patients whose reason for applying for fertility treatments is not infertility, generally have to cope with difficulties. The decision to become a single parent is a complex one and undoubtedly demands intense personal soul-searching, including self-acceptance and reconciliation and at times also revelation of secrets.

Considering this social pressure towards parenthood, it is hardly surprising that many Israeli couples view IVF treatment as virtually inevitable and that once such treatment has begun, it is rarely halted despite the rather poor chances of giving birth to a live, healthy child. This situation is problematic because it affects the patients' conscious freedom of choice insofar as decision-making is concerned (Hildt, 1998).

Making decisions based on the infertility of one or both partners or personal circumstances preventing normal conception is no simple matter. Both such instances involve complex psychological processes affecting partners individually or as a couple, including a sense of loss and guilt. Treatment itself, as described above, includes many critical points that justify counseling, supervision and support by the relevant professionals. Nevertheless, mere awareness of the difficulties entailed by IVF treatment cannot put doubts and misgivings to rest.

One problem that patients encounter is the matter of multiple embryos. The

literature reports cases of intentional cessation of multiple pregnancy resulting from extended IVF treatment, including acceptance of donor sperm and ovum. Requests to halt such "precious" pregnancies originate in the couple's difficulty accepting multiple pregnancy, as well as inability to make decisions concerning Multiple Pregnancy Reduction (MPR) (Edozien, 1998; Marcus and Brinsden, 2000).

The need for donor sperm, egg or both means inability to produce genetic and biological offspring. Patients have to relate not only to the loss of biological continuity and all it implies but also cope with the involvement of a third party in the production of a child. Use of donor sperm, eggs or embryos raises questions concerning the function of genetic material donors, the missing or unequal genetic bonds between couple and child, confidentiality/disclosure to the child and others and so on (Landau, 1998a; 1998b; Blyth and Hunt, 1999). There is special significance to the issue of candor vs. secrecy concerning both IVF and genetic material donors. For example, in the case of a sperm and egg donor, is the genetic mother (who provided the genetic material), biological mother (who bore the child) or social mother (who raises the child) the "real mother", while the father is a social father alone, with the genetic father in the background? Such questions acquire prominence when severe conflicts arise between partners.

The issue of children's welfare vs. parents' wishes is also relevant in cases of surrogate motherhood, wherein one distinguishes between the commissioning parents and the woman who bears the child. As child-rearing is a challenge in any family, it is patently unrealistic to ignore the difficulties engendered by the involvement of numerous parents in the process. Furthermore, the raising of children by single mothers as a result of anonymous sperm or fertilized egg donation (with no genetic link to the future offspring) at an age beyond the natural range of fertility or with the sperm of a deceased man are extraordinary situations indeed, placing the involved parties in unfamiliar situations, even if the desire for a child leads them to deny that any problems could arise in the future.

In Israel, there is a tendency to disregard the full import of genetic material donation. The only opinions voiced on this issue are those of women interested in obtaining such material, calling for an increase in the number of donated eggs from women undergoing IVF treatment and for legislative initiatives enabling egg harvesting from others, despite the physical risks involved and irrespective of future physical and emotional implications. However, a realistic analysis shows that this situation cannot continue. Only recently, a ruling was handed

down in the United States declaring that sperm donors do not have unlimited rights to confidentiality and privacy and that they may be required to testify in court concerning their state of health. In a case described in the ruling, donor sperm was sold to a couple by a (private) sperm bank despite the donor's having indicated on the application form that his aunt suffers from kidney disease. His testimony is now required for a lawsuit against the sperm bank for selling that sperm as if the donor were in normal health (Marquis, 2000). The issue arose when it emerged that the girl born thanks to the sperm donation, then 11, had contracted a hereditary kidney disease. The donor involved sold 320 portions of his sperm over a five-year period. If he is indeed a carrier of the kidney disease gene, there is a 50% likelihood that other children born as a result of his donations will contract the disease as well. This case underscores the complexity of genetic material donation and the need for all parties to understand the significance of their actions, including acceptance of present and future responsibility for them.

It is precisely because IVF involves so many people and issues and concerns a key foundation of human life and society that we seek to identify the mechanisms that society must provide to reduce apprehension and uncertainty among patients and ensure that their decision is the result of conscious consent to all that is entailed by these treatments and their possible implications.

Psychosocial Counseling and Preparation for Treatment

Every physical dysfunction has an emotional aspect as well. Consequently, we should not consider medical treatment and psychosocial counseling as two separate entities. Both types of intervention are interconnected and of equal importance (Kemeter and Fiegl, 1998). Patients' lack of information on future difficulties, complications and implications and failure to discern the psychological and social coercion inherent in IVF treatment render prior clarification, counseling and preparation essential to treatment (Hildt, 1998). Once treatment has begun, uncertainty over the success of each stage is extremely difficult for patients to bear (Boivin et al., 1999). Such anxiety and uncertainty may be alleviated somewhat by appropriate preparation for treatment. Similarly, IVF patients should not commence the relevant treatment (e.g. egg donation) before obtaining current information about the nature of the treatments themselves and are given the opportunity to examine how they might feel if, say, the recipient conceives while the donor does not (Tizzard, 1998).

In the United Kingdom, the first country to enact a legislation governing in vitro fertilization (the 1990 Human Fertilisation and Embryology Act), a

special Human Fertilisation and Embryology Authority was set up to supervise and monitor treatment. According to British law, each treatment cycle must be registered with the Authority, as well as the details of the sperm and egg donors, if applicable. The law recognizes the need for an impartial counselor to assist couples in examining all options available to them, not only those concerned with the desire to bear a child, even those with little to no chance of success, such as treatment at an advanced age. In such circumstances, couples should be presented with alternative sources of satisfaction and happiness besides bringing a child into the world.

British law declares counseling to be a significant part of IVF treatment. Three types of counseling are now recognized in the UK:

(1) The effects and implications of IVF treatment, i.e. provision of precise, comprehensible information to patients so that they can make decisions regarding subsequent measures to be adopted;

(2) Support, concerning emotional coping with the processes and severe pressure entailed by treatment;

(3) Therapeutic, neither informative nor emotionally supportive, but rather an opportunity for clarification and discussion of emotions that concern life in general, the meaning of parenthood and the price it exacts.

Therapeutic counseling provides patients with an opportunity to speak to an impartial person about disturbing issues concerning IVF treatment and their present and future implications, including those concerning their own lives. In practice, although the law explicitly mentions counseling, its application is only partial. A survey assessing the efficacy of diagnosis of candidates for IVF treatment from the point of view of children's well-being found that only about 44% of clinics reviewed provided access to counseling as part of their standard procedure (Patel and Johnson, 1998). On the positive side, a fertility counselors' organization, comprising social workers, psychologists and health care personnel, has been active in the UK for several years, offering seminars, workshops and training courses, publishing a quarterly journal and maintaining a representative in the British Fertility Society. These two bodies recently won a joint British Health Ministry grant for development and planning of an official training program awarding accreditation to fertility counselors (Pike, 1999).

The State of Victoria in Australia recognized the importance of IVF counseling as early as 1984 and enacted consequent legislation in 1995 declaring psychosocial counseling to be an integral part of IVF treatment (Waller, 1999). According to this law, all physicians are obliged to provide IVF candidates with a list of certified counselors in this field before commencing treatment. Moreover,

couples are obligated to participate in preliminary counseling, including review of a predetermined list of topics, to ensure that they are provided with adequate information on what awaits them. According to that same law, IVF counselors must be trained and accredited in counseling or another relevant profession. Victoria imposes special regulations concerning donor involvement in IVF treatment, stipulating that both recipients and donors must be aware of their rights and obligations as participants in the process. Furthermore, the law recognizes the role of the donors' spouses and their right to participate in the relevant decision making. The law seeks to guarantee that the child's best interests are upheld at all stages of the process. Meetings with potential sperm or egg donors emphasize examination of donor motivation, legal aspects of donor confidentiality, possible effects on donor's children and/or spouse and any other issues donors may raise. There is also an association of IVF patients in Australia that has noted the need for counseling and for clarifying the significance of genetic material donation from the donor's point of view.

In New Zealand, as in Victoria State, counseling services are part and parcel of IVF treatment (Daniels, 1999). These services are available to patients, but there are differences within and among IVF clinics regarding treatment duration, financing and service provision. The nature of service is also affected by the counselor's profession: Some counselors have had training in psychology, others in social work and still others in both professions. Daniels (*ibid.*) claims that demands for inclusion of counselors in IVF treatment programs largely originated with consumers, who considered counseling a necessary prerequisite to treatment. Most counselors in New Zealand belong to a local IVF counselors' association or to the Australian organization. In both countries, all involved parties will soon be granted access to information about donors and recipients, a measure expected to intensify demand for psychosocial counseling (*ibid.*).

In Canada, access to IVF treatment and counseling largely depends on geographic location and financial situation (Haase, 1999). The Royal Commission on New Reproductive Technologies (1993) declared that a counselor is to be an integral part of IVF services provided at clinics or by referral to appropriate external professionals. However, no law has been passed to date to regulate the procedure. According to Haase (1999), the present level of IVF counseling services is woefully inadequate. As most physicians involved in IVF treatment do not refer patients to counselors, few people practice in this field.

In the United States, IVF treatment issues, like most others, are decided by market economics. There is no health insurance law in the United States nor any

legislation regulating IVF treatment. As the interested parties bear the costs of medical treatment themselves, only rarely does the number of treatment cycles reach a magnitude considered normal in Israel. U.S. physicians involved in IVF treatment generally follow the guidelines set down by the American Society for Reproductive Medicine (ASRM), that do not require patients to undergo any preparation or preliminary counseling (Licker Feingold, 1999), although they do recommend that psychological counseling services be made available to all candidates for IVF treatment of a difficult nature or entailing psychological implications, such as egg and embryo donation. In practice, many of the couples who opt for non-donor IVF treatment are not referred for counseling even if such treatment is difficult and fraught with pressure. According to Licker Feingold (*ibid.*), counseling services in this sphere are highly varied and differ from one medical center to another, as well as from state to state. The ASRM includes members who define themselves as mental health professionals and it has determined minimum demands for IVF counselors, namely a degree in one of the treatment professions, certification as a counselor, one year of experience in IVF counseling, appropriate training in the physical and psychological aspects of IVF treatment and post-graduate study in this field. Besides assuming the traditional counselor's role, the IVF counselor also serves as an educator, advocate, evaluator and gatekeeper and is considered an important member of the multidisciplinary team providing assistance to IVF patients (*ibid.*).

In some Western countries, such as those mentioned above, counseling for persons in IVF treatment is – or will become – an integral part of treatment, as stipulated by law or in medical association guidelines. Despite some differences in practical application, there is a general trend towards recognition of the importance of psychosocial counseling for IVF patients. In other Western countries, such as those of Scandinavia, counseling is not legally mandatory, but counselors are responsible for determining whether a given treatment is suitable for the applicant. Note that evaluation of IVF candidates by a social service professional or psychologist is obligatory, even though egg donation and surrogacy – the two IVF treatments that involve a third party and are likely to arouse psychological problems – are prohibited in Scandinavia (Landau, 1998a).

Discussion of counseling would not be complete without noting that when faced with distress, many patients prefer relying on informal support sources such as their spouses and families rather than involving an additional professional factor in treatment. In a survey of couples undergoing non-donor IVF treatment that does not require donation of genetic material, most reported that they do not

need counseling and that they rely on their natural support networks (Connolly et al., 1993; Boivin et al., 1999). It is estimated that only about 15% of patients required intensive and extended treatment. In contrast, no study has assessed the effects of having to pay for treatment – including counseling – from one's own pocket, as is the case in most Western countries.

In any event, the challenge facing professionals is prompt identification of patients in distress who require counseling, so that those who really need such resources may benefit from them at the right time (Connolly et al., 1993). Awareness that such services are available may accord patients a sense of confidence even if the options are not exercised. In parallel, many IVF patients may derive maximal benefit from written informative material concerning treatment (Boivin et al., 1999). The situation is different in cases in which a genetic material donor or surrogate mother is involved; experts believe that such patients always require comprehensive counseling on the psychological implications of treatment (Breaways et al., 1997).

The Situation in Israel

1. In Theory

As early as 1985, three years after the first test tube baby experiment in Israel, in a study examining the mental and social situation of Israeli women undergoing IVF treatment, patients voiced complaints about the lack of information and guidance on treatment and expressed their expectations regarding greater emotional support from the treatment staff (Birman et al., 1991). The findings emphasized the need for multidisciplinary IVF treatment staffs, including a social worker and psychologist or psychiatrist. Also stressed was the need for preparation and counseling before, during and after treatment (Gilai-Ginor, 1996).

The 1996 Patients' Rights Law is supposed to address these issues, but apparently falls short of doing so in practice. According to a 1990 Ministry of Health Circular on acceptance criteria for couples seeking IVF treatment, a physician asked to provide IVF treatment services may request an expert opinion of the candidates' suitability for such treatment from one or more of the following professionals: A clinical psychologist, social worker with at least three years' experience and a psychiatrist. The decision is to be submitted to a multidisciplinary team; in case of rejection, the team's reasons for doing so should be stipulated in writing. Regulations of a similar nature, based on expert opinions of a social worker and psychiatrist, were drawn up to determine whether unmarried women are suited to be mothers, but were revoked in 1997.

Since then, there have been virtually no restrictions imposed on IVF treatment; single and married women alike are eligible for treatment, including sperm or egg donation, with no prior consultation whatsoever.

These first initiatives at relating to the psychological-mental aspects of IVF treatment sought to assist physicians rather than offer counseling services to candidates for treatment. The Aloni Commission, as indicated above, assumed that some couples would require support during treatment, pregnancy (should it occur) and following childbirth, maintaining that "patients should have the option to obtain professional counseling and support that complement and accompany medical services and assist them in their decision making at all stages of treatment." (Ministry of Justice, 1994, p. 21). The Commission recommended that each IVF unit staff include a suitably trained counselor – a social worker or psychologist – available at patients' discretion to provide further explanations of information obtained from the attending physician or to support patients who encounter various difficulties during treatment. It was important for the Commission to emphasize that while patients have the right to counseling, there is no intention whatsoever to force counseling on them, render treatment contingent on counseling or create a covert system of supervision or control.

To date, no aspects of IVF have been regulated by legislation in Israel, with the exception of surrogacy, for which a special law was enacted, the 1996 Surrogate Motherhood Agreements (approval of agreement and status of newborn) Law. According to this law, IVF treatment involving a surrogate mother requires the approval of an interdisciplinary committee that is to review psychological assessments of the suitability of each of the involved parties to the agreement and confirmation by a psychologist or social worker that the intended parents participated in appropriate professional counseling, including receipt of information on other options for parenthood. Approval of the agreement is contingent on all sides having entered it of their own free will and having demonstrated that they understand its significance and consequences.

The above observations clearly reflect recognition of the need for counseling, clarification and preparation for parenthood, including intervention by external factors, at least in extraordinary cases. Moreover, the counselor's function is to be assumed by emotional/mental treatment personnel, i.e. social workers, psychologists and psychiatrists.

2. In Practice

There are more than 20 IVF units at hospitals in Israel, but psychosocial counseling is only offered at two of them as an integral part of the treatment

program (Bar Hava et al., 1999; Reicher-Atir, 2000; Bar Hava, 2000). According to information received from social and nursing care services at hospitals, other units only provide on call counseling by a social worker or psychologist in highly extraordinary cases. Note that Women's Health Units operating at health fund clinics employ social workers who are often consulted by both patients and medical staff when facing special issues.

At present, one of the two hospitals offering psychosocial counseling has a half-time position for a psychologist and the other a three-quarter position for a social worker. Although one should not ignore differences in personality and professional background among professionals in counseling positions in the two IVF units, there are more similarities than differences in the nature of their work.

In the two units, applicants are referred for psychosocial and ethical counseling in one of the following ways:

(1) Self-referral (notices about the service posted in prominent locations at the units);

(2) Referral by other staff members (physicians, nurses, administrative staff) when patients are perceived as mentally distressed or express doubts regarding ethical issues;

(3) Following lectures on relevant topics that the two counselors organize;

(4) Group referral of patients with similar characteristics.

In each case, meetings with the physician and nurse generally precede counseling. The physician is the first to see the candidates for IVF treatment, obtaining initial information on their general state of health, fertility problems and previous attempts to have children, if any.

After obtaining a general explanation of the proposed treatment program from the physician, all patients receive personal medical guidance (from the nurse) about the projected course of treatment (physiological aspects, medication, nature of laboratory examinations and clarification of cases in which medication is to be stopped or the unit contacted).

As indicated, some applicants for counseling had attended open public lectures, offered in the evening or on Fridays and organized and recommended by the counselors (psychologist or social worker) themselves, who consider dissemination of information to be part of supportive care. The lectures, delivered by members of the unit staff (physicians and laboratory technicians) and guest speakers (jurists, clergy and others) concern issues such as the nature of IVF treatment, the function of the laboratory, male fertility, sexuality and marital relations, legal and religious aspects, etc.

At both units, the counselors, in cooperation with another staff member, usually a nurse, offer group work for patients with similar needs: Women, couples, prospective single mothers, women who have miscarried repeatedly, etc. Groups are small (about ten participants) and meet eight to ten times. Topics for discussion vary from group to group, but most concern coping with the treatment itself; loneliness engendered by physical dysfunction; bonds with one's partner, family and workplace; contact with the social network and so on. Sessions provide counseling, guidance and support, harnessing the positive forces inherent in group activity.

The following is a clinical example of group and couple counseling: Tali and Ido got married in their late twenties after dating for five years. Two years ago, after they completed their advanced studies and furnished their home, they decided the time had come to raise a family. Following several months of relations without contraceptives that did not result in pregnancy, Tali, 30, consulted with a gynecologist. After waiting another half year and undergoing comprehensive and invasive medical examinations, Tali began fertility treatments. Tali, who had previously believed she was in control of her life, began to sense a confrontation with loss: A lack of privacy, no control over her own fertility, inability to determine her daily schedule and the shattering of her dreams. Conception, that she assumed to be the most natural aspect of her life, turned into a technical medical procedure in which all details about her sex life and intimate organs were the subject of examination. She felt anger at her body for betraying her and at the doctors who hurt her during treatment, anger over her fate and the four attempts at IVF that failed to fulfill her dream of motherhood. She was also angry at her family and friends who pressured her to become a parent or who were themselves pregnant. At the same time, she also felt anxious over adverse effects that fertility treatments might have on her relationship with her husband. It was not easy for Ido either: Even if he did not suffer intrusive treatments and a disrupted schedule as his wife did, he still felt hurt by the lack of control over his life, Tali's moods and pressure from the surrounding environment.

The couple's referral to a group of IVF patients turned out to be the right step at the right time. Tali and Ido found out that their feelings were shared by most patients. At group meetings, they learned more about the implications of the treatments themselves and the various methods that other couples adopted to cope with unexpected aspects of treatment. Using input from the group and the counselor, they discussed the matter and decided which of their relatives and friends could be taken into their confidence and informed about their treatment.

The opportunity to share a secret with someone dear alleviated pressure for the couple. Furthermore, Tali and Ido's exposure to the ethical dilemmas they are likely to encounter as treatment continues led them to consider applying for marital counseling. Their participation in several such discussions enabled them to talk about the role treatment plays in their lives, their relations with one another and ethical aspects of fertility treatments that concerned them at the time. Clarification of their personal expectations regarding treatment and their attempt to determine a treatment time frame through counseling rendered their approach to treatment more flexible. Counseling provided them with additional information, reduced tension, relieved anger and anxiety, reinforced marital bonds and improved communication with the medical staff. By internalizing recognition that they alone are responsible for deciding whether to continue treatment, Tali and Ido regained some sense of control over their lives.

Both units emphasize short-term intervention and rarely work with individuals and couples unless IVF treatment itself is involved. When long-term professional intervention of any other kind is required, the two counselors refer patients to other local therapy services.

Lecture series and support groups constitute a platform for forming support groups facilitated and guided by counselors at the two units. At one of them, a group of veteran patients, guided by the counselor, assists new patients by offering support through telephone calls and face to face conversations. One of the two counselors considers it obligatory to be available to patients by telephone at all times. Both believe that IVF patients require counseling of various intensities and types. Consequently, there is considerable freedom for creativity and integration of various complementary intervention techniques.

A description of the two unit counselors' work indicates the following:

(1) The counselors serve medical personnel and patients alike when psychosocial issues are involved;

(2) They combine various intervention techniques to reach as many target groups as possible;

(3) Counseling for individuals and couples focuses on the most pressing issues and the most stressed patients; as such, it may not serve patients who do not apply on their own initiative;

(4) Intervention is of brief duration, concentrating primarily on IVF treatment itself;

(5) Counseling work is structured gradually according to personal conception, with no predetermined procedures applying.

Summary and Conclusions

IVF treatment, whether provided due to infertility or for personal or social reasons, is still perceived as an unconventional way to bring children into the world. Because of the physical and mental difficulties typifying such treatment and the risks entailed therein, some patients will require counseling, preparation, supervision and support before, during and after treatment, particularly individuals and couples relying on sperm and/or egg donors and/or surrogate mothers.

In Western countries, referral for psychosocial counseling has gradually become part of the IVF treatment process. The significance ascribed to such counseling is reflected either in legislation or guidelines published by professional organizations. The professional literature indicates that both types of counseling connected directly with treatment – decision making regarding choice of treatment and support during treatment – can be provided by professionals in the medical and nursing professions, on condition that they have been trained for it. In contrast, there is no doubt that psychosocial counseling that focuses on the special personal significance of the concepts of parenthood and childbearing is the province of social workers and psychologists – and in rare instances, psychiatrists.

Israel's national health service finances fertility treatments until the birth of two live children. As of 1999, treatments were limited to six per year for women up to age 45 who use their own ova and up to age 51 inclusive for treatments involving egg donors. In other words, treatment for women over 51 is possible only if privately financed and only with a donated egg, as the body is then too advanced in years to produce viable ova. In Israel, IVF treatment is available to all who fit the above criteria, with no screening and virtually no restrictions, but the absence of attention to counseling as part of IVF unit treatment programs and the lack of counselors addressing psychosocial issues on the staffs of these units indicate that there is little awareness of the issue's significance. It is interesting that Israel, that provides so many treatment cycles at government expense, does not allocate the resources necessary for psychosocial counseling at all IVF units. Moreover, failure to recognize the place of psychosocial counseling in IVF treatment and the lack of qualified counselors implies that no attempts have been made to advance the development and training of such professionals.

Nevertheless, the well-being of patients, their families and future children demands establishment of a forum that will define the functions of counseling at IVF units, determine criteria for counseling content, training, professional background and special certification as practiced in the United Kingdom, for

example (Cooke et al., 1999) and propose alternative and complementary methods of implementing the various types of counseling.

In conclusion, considering the number of IVF patients in Israel, most of them at public hospitals and financed by public funds, as well as the 1994 *recommendations of the Aloni Commission* and the 1996 Surrogate Motherhood Agreements Law and experience gained throughout the world, it would be appropriate to accomplish the following:

(1) Thorough and intensive assessment of the Israeli IVF patients' need for psychosocial counseling;

(2) Determination of counseling principles according to counselors' respective professions, including training requirements and certification procedures;

(3) Development of various complementary intervention programs for different population groups;

(4) According all prospective IVF patients the opportunity to seek psychosocial and ethical counseling before deciding whether or not to begin treatment; ensuring that they are aware of what awaits them during and after treatment;

(5) Guaranteed inclusion of social workers and psychologists in IVF treatment staffs.

Provision of a professional psychosocial counseling system for IVF patients is essential for increasing patients' awareness of the types of treatment and their implications and for intensifying their control of their own lives. At the same time, studies should be conducted to determine the long-term consequences of IVF treatment and the effects of counseling on the mental and emotional state of IVF patients.

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ORGANIZATIONAL ASPECTS OF COALITION ACTIVITY IN A SOCIAL CHANGE CAMPAIGN

By Roni Kaufman*

The article presents and analyzes findings of a multiple-case study that described and compared the participation of 23 voluntary organizations in a coalition for social change. The organizations in the coalition represented diverse *populations – disabled, women, low-income neighborhoods and development* towns, widows, children, and the elderly. The coalition successfully influenced the recommendations of a committee appointed by the Israeli *government to* propose a major tax reform, including changes in social security benefits. The article presents an analytical framework to describe the coalition structure and the participation of voluntary organizations in the campaign.

Introduction

Voluntary organizations for social change are established by citizens to advance their solutions to social problems. One of the forms of influence employed by the organizations is participation in *ad hoc* coalitions established to conduct campaigns against undesired policies. The establishment and operation of these coalitions is especially important to organizations that represent populations with few resources (Fisher and Kling, 1993; Snow, 1996).

The growing interest in social change coalitions is the result of the increased use that voluntary organizations are making of these structures (Mizrachi and Rosenthal, 1992; Roberts-DeGennaro, 1997; Mizrahi and Rosenthal, 2001). Despite this interest, little is known about the activity of voluntary organizations in coalitions and specifically in campaign coalitions (CCs) (Caplow, 1992; Fisher and Kling, 1993). New knowledge regarding the forms and modes of activity of organizations in CCs is important both to coalition builders and to leaders of organizations invited or considering joining action coalitions.

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The study reported here focused on identifying, describing, and examining the various forms and expressions of coalition participation among 23 voluntary organizations that took part in a CC in Israel in 1987-88. The coalition goal was to influence the recommendations made by a policy-setting commission of experts that was appointed to propose major tax reform and changes in social security benefits in Israel. The coalition disbanded after 6 months of campaigning, when the government announced that it was rejecting the commission's recommendations. During this period of coalition activity, Israeli society at large was marked by ideological struggles to change the character of Israel as a welfare state (Doron, 1995).

Research about coalition activity for social change in Israel is important, because recent years have seen a dramatic rise in the number and variety of non-establishment, voluntary organizations that address social problems (Yishai, 1987; Gidron, Katz, and Bar, 2000). The increased activity of Israeli social change organizations is connected to processes of democratization and liberalization that Israeli society has undergone, reflected in decentralization of some government activity and increased political, cultural, and social pluralism during the last two decades (Ben Simon, 1997). In parallel, nonprofit organizations have made greater use of public campaigns and coalition activity (Wolfsfeld, 1988; Silver and Rosenhek, 1999). One reason for this is that public campaigns are considered by Israelis to be an acceptable way to penetrate the media and impact the authorities (Dery, 1992; Lehman-Wilzig, 1992).

Why and When Do Voluntary Organizations Establish Coalitions for Social Change

Joint activity makes it possible to pool resources that enhance political participation and power. Coalitions – unlike more established cooperative frameworks such as federations or umbrella organizations – are limited in time and focus on specific objectives. A coalition also enables the participating organizations to maintain their autonomy and ideological individuality, which are vital for their existence (Gerlach and Hine, 1970). Dluhy (1990) points out several advantages to work in a coalition: Cooperation enables organizations to affect policy in a way that one organization acting alone cannot; to act on a range of issues without a major investment in infrastructure; and to take advantage of the variety of tactics in which the participating organizations specialize. Mizrahi and Rosenthal (1994) emphasize the great potential of social change coalitions for creating the infrastructure to support broad social change movements.

Participation in a coalition may be perceived by organizations as threatening

to their autonomy. After all, every organization has its own agenda and therefore also a stake in preserving its resources and developing its own distinctive objectives and activities (Wilson, 1973). Working alone also means that, upon success, one does not have to share credit with others (Olson, 1965). Working within a coalition, on the other hand, requires that organizations invest some of their ongoing resources in the joint effort. Furthermore, coalition activity is based on consensus, meaning that organizations are forced to compromise on ideological issues and strategies (Black, 1983). The accepted assumption in research about various types of coalition structures (Riker, 1962; Schlanger, 1995) is that a coalition is formed only when the participants view it as a preferred alternative to independent action or no action at all.

Main Aspects of Campaign Coalitions

Campaigns are organized by coalitions established for the purpose of mobilizing, coordinating and managing resources of organizations and individuals. These campaigns are unique in that they are public, planned, and based on a series of activities aimed at achieving defined goals (Marwell and Oliver, 1984). The success of the campaigns depends on their ability to mobilize public support. To conduct a successful campaign, it is necessary to pool resources that provide the power base for political influence and enable effective media exposure.

A review of the literature of case studies that describe campaigns and coalitions for social change, identified five main aspects: goals and modes of activity; membership and size; coalition process; organizational structure and decision-making mechanisms; and the meaning of coalition activity.

1. Goals and Modes of Activity

Campaign Coalitions (CCs) usually have a final goal, an intermediary goal, and instrumental goals. The final goal relates to achieving a change in policy. To achieve that goal, it is necessary to assert public pressure on decision-makers. The definition of the goal itself and the tactics used to achieve it are important because they influence and may even define the potential members of the coalition (Zald and McCarthy, 1987). A change of tactics can occur at different stages of the campaign. At the beginning, it is important that the issue of the campaign and the coalition become part of the public agenda. Therefore, more militant actions can be expected at the early stage, compared to later on when it is important to garner broad public support (Rubin and Rubin, 1992). In turn, the instrumental goals of a CC usually focus on establishing and managing a broad

organizational infrastructure, capable of pooling needed resources for political activities and the operation of the coalition.

2. Membership and Size

It is difficult to define the minimal amount of resources required to achieve "victory" in a voluntary public campaign or to establish a winning coalition for social change (Dluhy, 1990). Because of the need to run a long-term campaign and accumulate the political clout necessary to achieve the goals, initial efforts will focus on mobilizing and marshaling the maximum resources from the maximum number of different organizations. Resources can be mobilized from two kinds of sources: organizations for social change that are interested in advancing a solution for the issues addressed by the coalition; and external allies, institutional patrons (Jenkins, 1987), intellectuals, and politicians (Rubin and Rubin, 1992). The interest of the external allies in cooperating with the CCs is a result of the fact that public campaigns are usually a manifestation of deep social conflicts (Coser, 1956; Brams, 1975).

3. Coalition Processes

During the first, *establishment* phase of the coalition, organizing efforts center on building and operating an initial power base. This is usually when the goals, tactics, and division of roles are set. The emphasis is on mobilizing and utilizing the resources necessary to become a legitimate actor in the public arena, capable of influencing the issue at hand. During the second, *extension* phase of the coalition process, efforts are applied in two directions: toward extending the power base and keeping up the pressure until the goal is achieved (Rubin and Rubin, 1992). Because the coalition is established on an *ad hoc* basis, its dissolution can be expected under two circumstances: when the goal is achieved, or if it becomes clear that the goal cannot be achieved. However, some coalitions unexpectedly break up because of difficulties in mobilizing and managing needed resources.

4. Organization Structure and Decision-making

Defining the organizational structure of a CC is problematic because these often operate on an informal basis with no clear rules regulating relationships among the participants. The division of labor and exercise of authority are informal. Planning and coordinating meetings can be incidental and irregular. A similar

difficulty can be observed in defining informal coalitions in other contexts: coalitions in formal organizations (Stevenson et al,, 1985) and public policy advocacy coalitions (Schlanger, 1995).

Decisions are often made by reliance on gaining consensus among those attending the meetings. The majority of the decisions are made in what is termed the *core* coalition, which is composed of the leadership. The *core* coalition is the body of people who coordinate and manage the campaign. In addition to the *core* coalition, there is a *broad* coalition, consisting of all those who participate in the campaign. Most organizations participating in the *broad* coalition usually do not participate in decision-making, but do participate in some or most of the activities held by the coalition, or they initiate their own activities in conjunction with the coalition.

5. Meaning of Coalition Activity

Participation in a CC offers the opportunity for the organizational leadership and membership to be involved in two kinds of unique and meaningful experiences:

(a) A moral experience: Involvement in a CC enables an organization and its members to operate on the moral level of promoting social change. This means that they are able to promote the values and ideology that led to the establishment of their organization. Moral and value-based activities are crucial for the existence of voluntary organizations (Zald and McCarthy, 1987) and active participation in a CC can provide opportunities for such activity.

(b) An empowering experience: Joint activity exposes each of the participants to meaningful and unique interactions, on ostensibly equal terms, with various other organizations, policymakers, the media, experts from academia, and representatives of established institutions and organizations (Mizrachi and Rosenthal, 1994). The knowledge, understanding and experiences that are acquired in the process, are invaluable to the organizational representatives and members, and can motivate and enable them to act more effectively in the future.

Research Methods

This study was based on a multiple-case design, which enables researchers to make systematic comparisons between subjects. In recent years, this design has become popular as a means of increasing the understanding of organizational behavior (Miles and Huberman, 1994).

1. Research Population

The 23 organizations studied differed from one another in the populations they represented, their size, the year they were established, their geographical spread, and the strategies used to advance social change.

The organizations studied were categorized according to the population they sought to represent. Ten of the organizations were active on behalf of widows and the disabled (WIDOWS; AYALA-Dis; ANI-Dis; WORK-Dis; MENTAL-Dis; DEAF-Dis; BLIND-Dis; IDF-Dis; IDF-Wid; UMBRELLA-Dis); five represented low-income neighborhoods and development towns (TENTS-Neighbor; DAI-Neighbor; SHAHAK-Neighbor; BESHAR-Neighbor; MNR-Neighbor); two promoted child welfare (CHILDREN; FAMILY), and three dealt with women's issues (WIZO-Wom; NA'AMAT-Wom; IWN-Wom). Other organizations studied were the national social workers association (ISWA), a senior citizens' organization (ELDERLY) and a peace advocacy organization (PEACE).

2. Data Collection and Analysis

To enhance the reliability of the research (Yin, 1984), the following tactics were used:

A standard protocol was developed to collect data about the participation of each organization. An identical database was created to describe the coalition participation and organizational profile of each organization in the study. A chronology of activity of the coalition and each of its organizations was carefully reconstructed and documented.

Qualitative and quantitative data were collected from several sources:

- In-depth, semi-structured interviews were conducted with 46 participants who were directly involved in the joint campaign.
- Archive material, including press reports, were reviewed and analyzed.
- A closed, structured questionnaire provided data regarding the participation of each organization in major collective activities (N=18).

Prominent participants in the coalition (N=18) with a comprehensive overview of the campaign (who participated in at least 30% of the core coalition meetings) were chosen to be raters and evaluate the participation of each of the 23 organizations on two criteria: the level of commitment of the organization and its members to the campaign, and the level of investment of the organization in the campaign relative to other organizations (see Table 2). To test the reliability of the rating, the W-Kendel Coefficient of Concordance test was used (Siegel, 1956) and its result indicates a high level of reliability (w=0.86-0.97).

Table 1. Characteristics of the Organizations
(listed alphabetically by sector)

Name	Sector	Size	Year stablished	Strategy
ANI-Dis	Disabled people	Small	1976	Lobby, service
AYALA-Dis	Disabled people	Medium	1984	Services
BLIND-Dis	Disabled people (blind)	Small	1982	Service
DEAF-Dis	Disabled people (deaf)	Small	1953	Service
IDF-Dis	Disabled people (army)	Medium	1949	Lobby, service
MENTAL-Dis	Disabled people (mental health)	Medium	1978	Service
UMBRELLA-Dis	Disabled people (umbrella organization)	Large	1980	Education, service
WORK-Dis	Disabled people (work accidents)	Medium	1954	Lobby, service
IDF-Wid	Widows (army)	Small	1986	Lobby
WIDOWS-Wid	Widows (general)	Small	1976	Education
IWN-Wom	Women's organization	Medium	1984	Lobby, Education
NA'AMAT-Wom	Women's organization	Large	1921	Lobby, service, education
WIZO-Wom	Women's organization	Large	1920	Service
BESHAR-Neighbor	Neighborhoods and development towns	Small	1987	Lobby
DAI-Neighbor	Neighborhoods	Small	1982	Protest
MNR-Neighbor	Neighborhoods	Medium	1982	Services
SHAHAK-Neighbor	Neighborhoods	Small	1982	Protest
TENTS-Neighbor	Neighborhoods	Medium	1973	Lobby, protest, service
PEACE	Peace and social justice	Medium	1984	Education
ELDERLY	Senior citizens	Small	1987	Lobby
ISWA	Professional association (social workers)	Medium	1962	Lobby, education
CHILDREN	Children's rights	Medium	1979	Lobby
FAMILY	Large families' rights	Large	1972	Lobby, service

Table 2 presents the findings about organizational participation (scored 0-3, with 3 being the highest).

Data processing had three main stages: reconstruction of the coalition history and operation, preparation of an organizational profile for each of the 23 participating organizations, and preparation of case studies describing the unique participation of each organization.

Data analysis consisted of two major stages (Miles and Huberman 1994): The first was a *within case analysis*, aimed at arriving at an intimate understanding of the unique ways each organization operated, and how various factors and experiences were demonstrated. The second stage was a *comparative case analysis* aimed at systematically identifying and describing the influence of various factors, which seemed to lead to different patterns of participation.

Field of Research: The Victims of Tax Reform Coalition

The coalition was established in response to the establishment of a state commission of experts to make recommendations on tax reform. The coalition founders explained in a letter they sent to potential members that "The composition of the commission – mostly right-wing economists and lawyers, with no social justice experts – tells us that it is nothing but a "rubber stamp" to promote the government's anti-social reform by way of the back door." The coalition discontinued its activity after the commission of experts submitted its recommendations to the Minister of Finance. Formally, the coalition disbanded when the government announced its decision to reject the commission's recommendations.

To influence the recommendations of the commission, the coalition organized a number of activities, most of which received wide media coverage. Media interest in the coalition's activities was aroused because the campaign reflected rare opposition to the massive anti-welfare state policies, including privatization of social services (Doron and Karger, 1993), which were introduced by the Israeli government in the 1980s. It is important to note that during this period, the government had successfully controlled run-away inflation and was banking on its popularity to carry out major structural reforms that would change the nature of the Israeli welfare state.

During the *establishment phase* of the coalition, the main goal was to gain public recognition as a legitimate representative of the potential victims of the commission's recommendations. During this stage, the coalition launched two particularly militant actions. The first was a demonstration outside the home of the chairman of the commission. The second was a vocal demonstration during

a major economics conference at Tel-Aviv University, at which the Finance Minister was the key speaker.

Media coverage of these two events contributed to public recognition of and interest in the activity of the coalition. As pressure mounted on the commission, the chairman made a number of attempts to split up the coalition by dealing separately with different members. For example, he invited militant neighborhood leaders to a special meeting with the commission, where he tried to convince the leaders that taxation would not harm residents of low-income neighborhoods. Another attempt was a letter sent to the charismatic director of the children's rights organization promising not to tax child benefits. These attempts failed because members of the coalition regarded the campaign as larger than the struggle against taxation of benefits. The major issue was defense of the values and principles of the welfare state. Later, when the coalition was joined by several other organizations, its main activity became public lobbying and the organization of media events in order to exert pressure on the commission. In December 1987, on the day that the commission of experts held an important meeting, the coalition held a big public rally against taxation of benefits. At this rally, many new and important organizations and public leaders expressed their support for the campaign, including leaders of the powerful women's organizations, six members of the Knesset (parliament) from various parties, the Minister of Health, the Executive Director of the National Insurance Institute, and the Managing Director of the powerful Israeli trade union federation (the Histadrut).

The vigorous coalition activity received wide public attention, and it had a major impact on both the duration of the commission and its recommendations. Public pressure on the commission led to a substantial delay in submission of its recommendations: The report was submitted four months late. It is likely that this delay contributed substantially to the government's decision to reject the recommendations made by the commission. The decision-makers were busy campaigning for the national elections. The timing made it impossible for any politician to be identified with tax reform that had such widespread opposition.

Table No. 2 summarizes the chronology of the campaign.

Expressions of Coalition Activity

Figure 1 offers a spatial and conceptual map describing the makeup of the coalition and the activities conducted by each participating organization.

Table No. 3 presents a comparison among organizations regarding participation.

Table 2. Chronology of the Victims of Tax Reform Coalition Campaign

Month	Activities in the Coalition's Public Campaign (date of the event in parentheses)
June 1987	- Appointment of a commission of experts, headed by Professor Sheshinski. Target date for submission of recommendations to the government: October 1987.
September 1987	- Establishment of a task force to organize a campaign against the commission. Informational materials and proposed activities were sent to 60 organizations, which were invited to join the planned coalition and lobby the commission.
October 1987	- Founding meeting of the "Organization of Victims of the Sheshinski Commission" (October 18). - Demonstration outside the home of the commission chair in Jerusalem (October 23)
November 1987	- Demonstration at the Conference of Finance Ministers at Tel-Aviv University (November 1). - Meeting of a coalition delegation with Israel Kessar, General Secretary of the Histadrut Labor Federation (November 11). - Meeting of a coalition delegation with the commission (Nov. 13). - Demonstration of organizations of the disabled outside the Prime Minister's office in Jerusalem (Nov. 17) - Meeting of a coalition delegation with Moshe Katzav, Minister of Labor and Welfare (November 23). - Meeting of a coalition delegation with the Director of the National Insurance Institute (November 27).
December 1987	- Major conference in Jerusalem of Organizational Leaders Against the Taxation of Social Exemptions, with the participation of 30 organization heads, 6 Knesset members, the Minister of Health, and Secretary General of the Histadrut Labor Federation (Dec. 14).
January 1988	- Demonstration against cancellation of the surtax (on high wages) outside the Prime Minister's office (January 3).
February 1988	- Demonstration at the Hyatt Hotel in Jerusalem upon submission of the commission's final recommendations (February 15). - Press conference of the coalition's reaction to the report (Feb. 28).
May 1988	- Disbanding of the coalition upon the government's decision to freeze the recommendations of the commission.

Figure 11 Mapping of Organizations that Participated in the Coalition and the Number of Activities in which they Participated

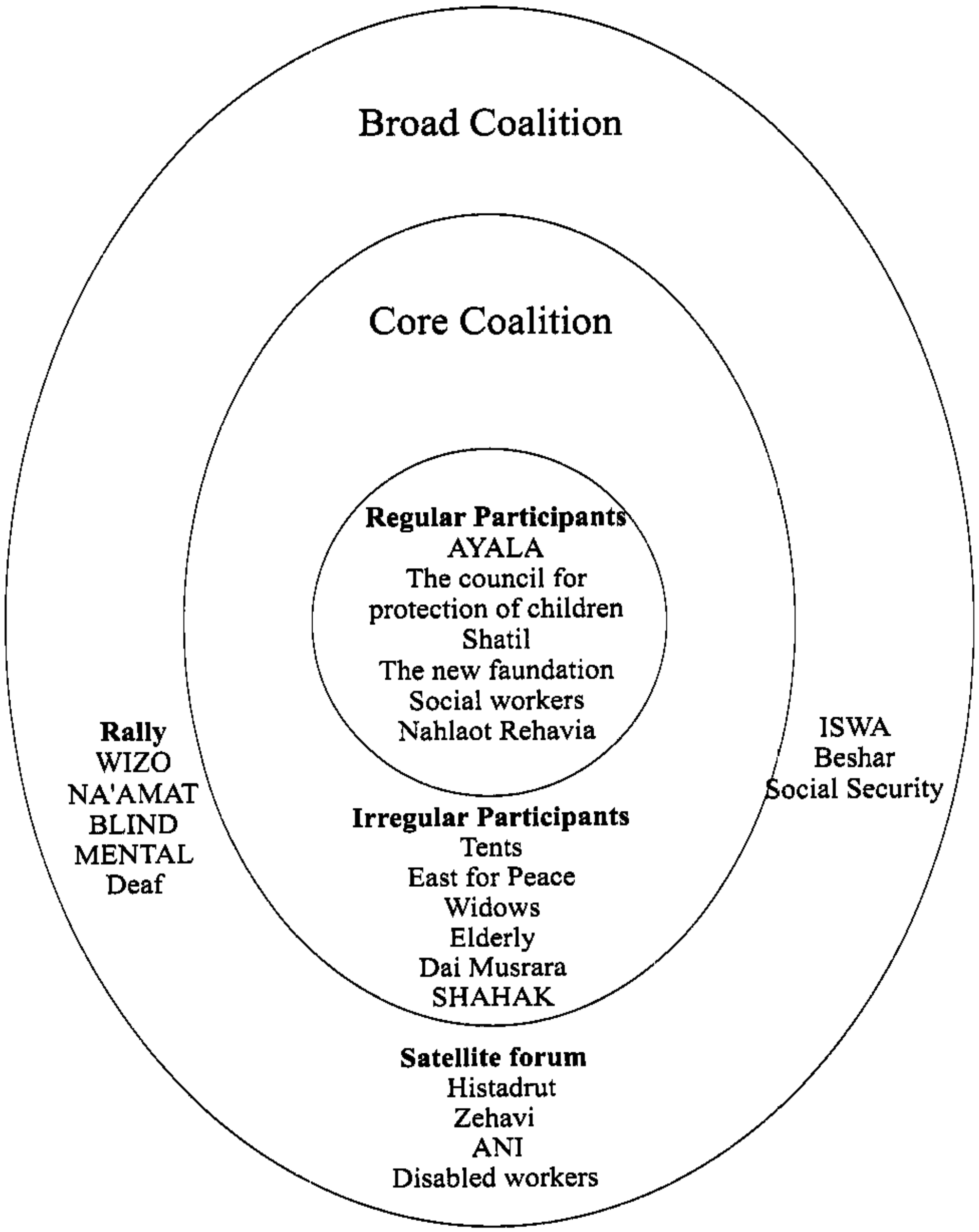

Table 3. A Comparison of Organizations: Participation in Activities, Duration of Participation and Degree of Investment:

Organization	Number of activities	Number of months	Degree of Investment
TENTS-Neighbor	18	6	2.3
AYALA-Dis	15	5	2.3
CHILDREN	14	6	3.0
PEACE	13	4	1.3
MNR-Neighbor	13	5	1.4
WIDOWS	10	5	1.7
ELDERLY	8	4	1.8
DAI-Neighbor	7	4	1.3
SHAHAK-Neighbor	6	3	1.1
FAMILY	3	2	1.0
BESHAAR	2	3	0.8
ISWA	2	2	1.4
ANI-Dis	2	2	0.8
WORK-Dis	2	2	1.1
MENTAL-Dis	1	1	0.6
WIZO-Wom	1	1	0.4
NA'AMAT-Wom	1	1	0.1
DEAF-Dis	1	1	0.1
BLIND-Dis	1	1	0.1

Description of Mobilization Process

The coalition organizers invited sixty organizations, verbally and in writing, to form a coalition. Initially nine organizations decided to join and establish the coalition. All did so on a formal basis. Most had prior working relationships with the coalition organizers and, for several, the decision to join was swift. The chairman of *PEACE* joined after a single phone call from one of the coalition initiators: *"How did we decide to join? A phone call and mutual trust, that did it"*. Among other organizations, the decision-making process was longer and more complicated. For example, the board of *WIDOWS* spent several meetings considering whether to join or not.

Some of the organizational leaders decided not to join the public campaign

during the *establishment phase*, but did begin to influence the commission's decisions by quiet lobbying. For example, *WORK-Dis's* legal experts prepared a position paper for the commission. Some organizations publicly joined the campaign during the *extension phase* of the coalition. For example, three organizations (*FAMILY, WORK-Dis, ANI-Dis)* created a forum that acted as a satellite to the core coalition. This forum was established for the purpose of enlarging the circle of members in the campaign. Later their leaders participated in a big protest rally organized by the coalition. The rally included politicians and was a show of strength and legitimacy that led five new organizations to join, among them two powerful women's organizations (*NA'AMAT-Wom, WIZO-Wom)* which had not yet been publicly involved.

Some organizations decided not to join at all: Several turned down the invitation because of lack of interest in the issue, such as a neighborhood organization that did not believe it was their mission to influence tax policy. Four organizations (IDF-Dis, IWN-Wom,, *UMBRELLA-Dis and IDF-Wid)* refused to join despite the immediate relevance of the campaign to their members and the active, ongoing effort to mobilize them due to their strategic value and public importance.

Mode of Coalition Activity

The findings indicate that organizations that joined the coalition during the *establishment phase* and were part of the *core coalition* differed significantly from those that joined during the *extension phase.* The *core coalition* organizations invested more and were more active in joint activities than in self-representing initiatives. In contrast, the *broad* coalition organizations were more involved in self-representing initiatives and less in joint coalition activities.

The *core coalition* organizations also differed among themselves in the manner of their participation in joint activities. Most of the *core* organizations participated on a regular basis in the joint activities of the coalition, but others participated less consistently. Their representatives did not view the coalition's meetings as significant and they often attended the important meetings only after receiving an individual invitation and reminders.

Another component identified by the data analysis was the role that representatives from different organizations played in the coalition. Even though no formal positions existed, there seems to have been an informal division of labor. The representative of *CHILDREN* served as the spokesperson for the coalition at large, and the representative of *AYALA-Dis* served as the lobbyist in the Knesset. Several organizational leaders regularly met with the media or

engaged in lobbying efforts. For example, the chairman of *TENTS-Neighbor* served as the representative of the low income neighborhoods and development town sector, and the representative of *ELDERLY* represented the elderly sector in addition to his own organization.

Types of Resources and Level of Investment

Each of the organizations that joined the coalition contributed its name and public legitimacy to the campaign. The major investment in the campaign was the time and energy invested by the organizations' representatives while participating in shared activities of the coalition. Another type of investment was mobilization of various organizational resources, such as activists, for campaign activity. A comparison of the participation of organizations in the *core coalition* and the *broad coalition* (see Fig.1) reveals that the former participated in considerably more joint activities than the latter (an average of 11 versus 1.2 activities).

Another indicator of resource investment was the extent to which the organizational leadership allocated all or only part of the organization's resources to support of the joint campaign. One organization that stood out in terms of high resource allocation was *CHILDREN,* which allocated the majority of its director's time (its main resource) for the campaign. Other organizations, even those very active in the coalition, invested most of their resources in their own ongoing organizational activities, either because they had other agendas or because their leaders failed to mobilize additional resources. For example, the leaders of *FAMILY* were not able to recruit even a few of their thousands of members to participate in campaign activities.

The Meaning of Participation

The organizations and their representatives can be divided into two main groups based on the weight they gave to coalition activity, in comparison with other organizational activity. Notable among the organizations was the general widows' organization *WIDOWS*, which put coalition activity very high on its agenda. The organization's leadership adopted participation in the coalition as the central activity of the organization during that period and allocated many of its resources to support the coalition. Their organizational representatives were highly committed to the joint campaign (rated 2.8 – Table 1) and their representative described the period as "*...very intensive, like when our organization was established. We were very devoted...*".

The leaders of four other organizations (*CHILDREN, AYALA-Dis, TENTS-*

Neighbor and *MNR-Neighbor*) were also very invested in the activities of the coalition. They reported that their participation in the campaign was a gratifying and enriching experience, which contributed to their ability to take action in subsequent social change efforts. However, the coalition did not become the forefront of their organizations' activities, and the experience involved the leadership rather than the members. For example, the chair of the *TENTS-Neighbor* neighborhood movement emphasized the extent to which his participation in the coalition enhanced his understanding of the important role of National Insurance: "*I'll tell you what came out of the campaign: people like me started to value National Insurance. They started to learn things they didn't know*".

Representatives of a second group, consisting of both *core coalition* organizations (*SHAHAK-Neighbor, DAI-Neighbor, PEACE*) and organizations in the *broad coalition* (*FAMILY, ANI-Dis, WORK-Dis*), reported that they did not develop a commitment to the joint campaign and that the coalition was relatively low on their organization's agenda. In the interviews, however, they reported that they remember participation in the campaign as an especially meaningful and enriching experience that influenced later activities. The chairman of *ANI-Dis* reported that the presence of other organizations in the campaign had an energizing effect. He was accustomed to campaigning alone or in partnership with other organizations for the disabled, but that campaigning with organizations from many different sectors taught him a great deal and he felt re-energized by the experience.

Levels of Coalition Participation

The different forms of activity can be plotted on a continuum. At one end are organizations that did not join. In the center are organizations that were partially active in the campaign – they joined the coalition, but did not persevere and were invested less, by comparison with other organizations (*SHAHAK-Neighbor* in the *core coalition* and *FAMILY* in the *broad coalition*). The leaders of these organizations reported that they felt their involvement in the campaign was low-key, routine, and not very meaningful. At the other end of the continuum are organizations whose representatives were more intensively active in the *core* coalition during the full period of the campaign. They viewed coalition activities as extremely important and believed that their participation was a valuable contribution toward advancing an important social mission. The representatives of these organizations played a key leadership role in the campaign, participation was ranked quite high on their personal and

organizational agendas, they successfully mobilized needed resources, and they invested comparatively more time and effort in the coalition than did others. The leaders of these organizations (*CHILDREN* and *TENTS-Neighbor)* were highly committed to the coalition and the goals of the campaign.

Summary and Conclusion

Several important findings regarding the participation of organizations in a Campaign Coalition emerge from this study. The organizations differed regarding the phase of the coalition during which they joined, their modes of operation, the duration of their activity, the resources they invested to promote the collective goal, and the level of activity.

The phase the coalition was in at the time an organization joined seems to have been a major factor affecting the quantity and quality of participation. The findings (Table 2) highlight the fact that organizations that joined during the *establishment phase* were active for a longer period (4.7 months on average) and involved in more joint activities (an average of 11 activities), compared with organizations that joined during the *extension phase* (an average of one month of activity and 1.2 joint activities). The coalition's leadership was drawn from the initial group of participants who joined at the early *establishment phase.* The differences are dramatic, even when one takes into account that seven of the coalition activities took place during the initial phase.

It also appears that meaningful and morally gratifying participation is positively associated with higher levels of coalition participation. Higher levels of coalition participation were found among organizations whose representatives functioned as members of the *core coalition*, and also played leading roles in the campaign. However, it is important to note that these empowering experiences were limited to organizational representatives who personally participated. Most organizations did not succeed in involving substantial numbers of their members in the coalition's collective activities.

This article presented a framework to describe and analyze the coalition participation of voluntary organizations in a public campaign. Such information is important to coalition builders and the leadership of participating organizations, as well as for organizational theory development.

This research provides only initial findings about the coalition activity of social change organizations, and should be used as a foundation for further research and discussion. The data and analysis were based on the participation of organizations in one specific CC with special characteristics. Among the participating organizations in this study, only several patterns of activity could

be documented. For example, no organization was identified that joined during the *extension phase*, persisted in activity, and then became part of the leading *core coalition*. Dluhy (1990) suggests that the study of this pattern is important. He maintained that due to the high rate of attrition among organizations in social change coalitions, new organizations must enter and become integrated in the coalition to ensure its long-term success. Further research in this area needs to focus more on identifying the different patterns of participation in coalition activity, and must systematically identify and assess the factors and processes that contribute to meaningful and empowering participation in social change coalitions.

An important question not examined in this study is the effectiveness of a campaign carried out by a coalition, rather than an individual social change organization. The findings suggest that the coalition increased the capacity to affect policy by the founders of the coalition, which were small organizations. The intense activity of some of these organizations was sufficient to turn the coalition into a catalyst that mobilized large voluntary organizations and outside partners (the Histadrut, Knesset members, professionals) – parties that have the necessary influence and resources to impact public policy. One can assume that the large organizations and some of the external partners would not have joined a campaign about National Insurance allocations and tax reform had the Victims of Tax Reform Coalition not existed.

Another aspect is how Israeli policymakers react to public campaigns designed to influence their decisions. Investigation of this subject could make an important contribution to those who seek social change at the grassroots level. During the course of the campaign described above, the commission met with representatives, and sought to persuade them, especially the leaders of the protest movements, that the commission would not harm social rights, and therefore the campaign was superfluous. There are also reports of informal attempts to influence some coalition leaders to terminate their campaign (Kaufman, 1998).

The significant involvement of outside partners in the coalition and the joint campaign raises questions about the role that professional and institutional parties – governmental and public – should play in coalitions for social change in Israel. Should they prefer support for coalitions rather than individual organizations? Does consistent institutional support for grassroots coalitions of social change increase the effectiveness of these organizations, or does it have the effect of co-opting grassroots efforts for change?

Grassroots coalitions for social change have become an important component

of participatory democracy in Israel. Enhancing our knowledge about the participation of social change organizations in general, and organizations that represent recipients of National Insurance allocations, in particular, would contribute to the ability of citizens to have a say in the processes of shaping public policy that affects their lives.

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