23

Health and Health Care in Israel

Ofra Anson

In many ways, Israeli society is no different from other western societies. Yet, beyond the social characteristics, structures, processes, and organizations shared with other developed countries, there are some unique features, which affect the well-being of Israelis and the organization of their health services. These unique features of Israel are the focus of this chapter.

The Social Origins of Illness and Health

Stress

Many of the stressors, which characterize daily life in the industrial and post-industrial arena, are present in Israel: poverty, unemployment, job insecurity, inequality, disability, and family violence. There are, however, stressors that are more salient in Israel than in other developed countries. Two such chronic stressors are the collective memory of the Holocaust and the implications of the geopolitical situation of Israel.

The memory of the Holocaust, the attempt to systematically eradicate the Jewish people during World War II, is continuously maintained by several institutionalized means. Just four years after independence (1953), the Israeli Parliament established a memorial institution in Jerusalem *Yad Vashem* to collect, preserve, and present all available names, knowledge, and materials related to the Holocaust and it victims. All foreign official guests to Israel are taken to this institution at least on their first visit to the country, and the ceremony held there is prominently reported in the media. The Holocaust is part of the regular curriculum of high schools, and in an increasing number of schools, eleventh-grade students make a journey to Warsaw and Auschwitz.

On the annual memorial day, one week before the Day of Independence, all entertainment facilities are closed by law, and memorial ceremonies take place in schools, local municipalities, and other public institutions, attended by survivors, political and religious leaders. The national ceremony, in which the President, the Prime Minister, and the two Chief Rabbis participate, is broadcast by all the media. On this day, written and electronic mass media are almost solely devoted to stories of the Holocaust. The main theme of all these different, institutionalized activities is "never forget" and "never again."

With this background, it is clear how the geopolitical situation of Israel has cultivated a sense of being a garrison state, constantly fighting for its survival. During the 50 years since the War of Independence, Israel has experienced five wars, countless military operations beyond its international boarders, and over 20 years of guerilla war in south Lebanon, the result of the Israeli Defense Force's effort to maintain a security belt (buffer zone) for northern Israel, a part of the country which has suffered frequent guerilla and artillery attacks in the past. Frequent casualties, public debate regarding the necessity of this security belt, and the inability or unwillingness of the political leadership to negotiate alternative arrangements further induce stress related to the insecurity of Israeli society as a collective.

Another source of stress is the threat of terror activities. Terrorism has become a global problem, but few developed countries experience terror attacks on the civilian population as frequently as does Israel. The very nature of terrorist activity is that both its timing and location are unpredictable. The sense of permanent danger is intensified in several ways: checking of personal belongings upon entering public places such as shopping malls and hospitals; guards in schools; advertisements encouraging the public to pay attention and report any suspected parcels; and a public announcement regarding an official blockade on the occupied territories on every holiday. All these maintain and increase a sense of insecurity.

The ups and the downs of the peace process in the Middle East are another source of stress. Since the late 1980s, the results of the general elections as well as public-opinion polls clearly show that Israeli society is split regarding a peace treaty based on territorial withdrawal and the establishment of an independent Palestinian state. The scenarios presented by each side are based on unprovable assumptions, in which the Jewish history, prejudices, national security and economy, and the collective memory of the Holocaust are intertwined. Thus, while half of the populations feels under threat with any advancement in the peace process, holding the process back is stressful for the other half.

Immigration

Immigration as a stressful life event has already been discussed in this volume. While the patterns of migration into and out of Israel resembles those of many postindustrial societies, it has some unique features (Shuval and Leshem 1998). First of these is the magnitude of immigration: in 1997, 38 percent of the Israeli Jews were immigrants, and 36 percent of those born in Israel were children of

immigrants. Immigration doubled the Israeli population during the first four years after independence (1948–53); immigration from former communist countries increased the population by 15 percent during the period 1989–95. Second is the open door policy, aimed at encouraging all Jews of the diaspora to immigrate to Israel (Anson et al. 1996; Bernstein 1997). This policy is grounded in the ideology that only Israel is the right and safe place for all Jewry, and that Israeli society is obliged to adapt itself to the immigrants' needs and to ease their absorption. Accordingly, major social resources are invested in both outreach efforts in the diaspora and in absorption programs.

Beyond the health risks associated with migration as a stressful life event for the individual migrant, an open door policy also entails public health risks. Israeli society must therefore handle a necessary tension between the values of free immigration on one hand, and the value of protecting and promoting its members' health, particularly at periods of mass immigration, on the other. The open door policy thus affects patterns of health, the burden on the health services, and on the quality of health care provided.

Migrants import patterns of illness, which reflect the health patterns and the available health services of their country of origin, presenting the health services with different challenges. The mass immigration during 1948–54 included refugees from post-World War II Europe, North Africa, and Asia. Many of these immigrants were in poor health, the result of malnutrition and high prevalence of infectious diseases, psychiatric conditions, chronic illnesses, and disability (Shuval 1992). Some of these conditions, such as trachoma, body lice, and trichophytosis seriously threatened public health. The physical and sanitary conditions in the temporary camps and settlements presented further health risks (Hacohen 1994). Frequent epidemics of dysentery and a polio epidemic increased infant mortality from 29 per 1,000 live births in 1947 to 52 per 1,000 in 1949.

In recent years, two distinct immigration waves, one from Ethiopia, and the other from the former communist countries, posed new challenges. The Ethiopian immigrants arrived in Israel after a long period of social disorganization, the result of a transition from their home villages to Sudan or Addis-Ababa, where they stayed for up to two years in temporary camps. Those who survived the hardships of the exodus were, of course, younger and healthier. However, intestinal parasites were highly prevalent in this group, up to 80 percent according to some reports, and, compared to the Israeli population, so were infectious diseases, in particular tuberculosis and AIDS. Immigrants from Ethiopia comprised 36 percent of the new TB cases in 1993 and 40 percent of the known HIV positive cases in 1995, though they comprise only 1.3 percent of the Jewish population (Health Israel 1998). These figures should be cautiously interpreted, however, as only Ethiopian immigrants are routinely screened for theses conditions.

The patterns of disease brought in by immigrants from the former communist countries are completely different, reflecting the difference in age structure, sanitary conditions, and the health services in these countries. The age structure of these immigrants was older than that of the Israeli population as a whole, mainly as a result of lower fertility: 19 percent were children aged 0–15 and 15

Table 23.1 Health status of immigrants from the former Soviet Union and Israeli military veterans (in percentages)

	Total no.	*Age under 44*	*45–64*	*65–74*	*74+*
Subjective health evaluation:					
Good health					
Immigrants	39	58%	25%	14%	27%
Veterans	73	85%	70%	43%	38%
Poor health					
Immigrants	22	7%	22%	44%	53%
Veterans	6	3%	4%	14%	23%
Prevalence of disease, limitation, or disability:					
Immigrants	47	21%	55%	89%	77%
Veterans	30	21%	32%	61%	60%

Source: Nirel et al. 1996.

percent were aged 65+ years, compared with 24 percent and 12 percent in the veteran population in 1996 (Central Bureau of Statistics 1998). As shown in table 23.1, high prevalence of disability, functional limitation, and chronic conditions among the immigrants increased the prevalence of these conditions in Israel.

Another aspect of the open door policy is the emphasis on rapid integration of the immigrants into the Israeli labor force, and in an occupation as similar as possible to the one held in the country of origin. Health professionals were no exclusion. Under the assumption that health professions share a universal body of knowledge and code of ethics, all immigrant health professionals could obtain a license to practice their profession upon providing their graduation certificate, physicians were required to work for one year under the supervision of a veteran colleague (Shuval 1983, 1998). Indeed, 40 percent of the professionally active physicians in 1987 graduated from foreign medical schools, between 1989 and 1997 71 percent of all new licenses to practice medicine were issued to immigrants, mainly from the former communist countries (Ministry of Health, personal communication). Similar patterns were observed for dentists and to a somewhat lesser degree for pharmacists and nurses. Reevaluation and reconsideration of this approach started during the 1970s, when most incoming health professionals had been trained in eastern Europe.

Both the structure and the content of medical education in the former communist countries are very different from those prevailing in western countries. For nurses, prerequisites and length of training were similar to programs training practical, rather than registered, nurses. Health professionals were unfamiliar with modern diagnostic and treatment technologies, and restricted communication with the West curtailed access to recent scientific knowledge. These led to

questioning the quality of training and the competence of immigrants' health professionals.

The concerns regarding the quality of health care provided by immigrants coincided with an increase in the share of health expenditure in the GNP and in unemployment among physicians. In 1988, a new licensing policy was launched, first for physicians, and later applied to other health professions (Bernstein 1997). Yet, in congruence with the centrality of immigration in the Israeli value system, fully subsidized preparation courses, Hebrew and medical terminology classes were developed to assist the immigrants to qualify for the license to practice their profession in their new homeland. Table 23.2 shows that over 80 percent of the physicians, and even a higher proportion of dentists and pharmacists (who are required one year of supervised work, but no qualification examination) obtained a license three to five years after migration, dramatically increasing the supply of health care personnel. Moreover, 77 percent of the physicians, the profession most intensively studied, were employed in their profession within five years after migration (Bernstein and Shuval 1998), most of them in tenured or tenure-track, full-time, monthly salaried positions (Nirel and Nave 1996). It seems, then, that Israeli society consistently gives priority to pro-immigration values over the value of health and high quality health care.

Table 23.2 Immigration of health professionals, Israel 1989 and 1996

	Immigrated during (Absolute number)			*Rate per 1,000 population*	
	1989–95	*1988*	*1996*	*1988/9*	*1996*
Physicians	14,590	16,777	25,898	3.8	4.7
Dentists	1,574	4,607	7,256	1.1	1.3
Pharmacists	1,606	3,226	4,366	0.7	0.8
Nurses					
registered		15,900	23,853	3.6	3.8
practical		11,000	19,536	2.2	2.8
Total	14,341	26,900	43,389		

Sources: Ministry of Immigration 1996; Ministry of Health 1996, 1998.

Informal Coping Resources

Health is highly valued in the Israeli society. Traditionally, the maintenance of health and taking care of the ill are viewed as religious duties; saving life is a religious obligation, and treating and caring for an ill person is allowed even if it requires work on Sabbath. Physicians are highly esteemed, medicine is fully trusted, doctors enjoy high prestige and are perceived as omnipotent.

In some respects, it may be argued that Israeli society is a relatively traditional one. Only about one-fifth of the Israeli population defines itself as completely secular, another fifth as orthodox, and the rest as religious or traditional (Peres and Yuchtman-Yaar 1998). This could be one explanation for the high value of health in the Israeli value system. Symbolically, phrases such as "let us only be

healthy" or "health is most important" are common in every day language, especially when troublesome incidents, daily hassles, or economic hardships are discussed.

One other aspect of the relative traditionalism of the Israeli society is the centrality of the family. Although the social processes which brought about decline in fertility and increase in divorce and out of wedlock birth rates in many postindustrial societies are notable in Israel as well, these transitions were much slower, and the Israeli family has maintained its stability to a large extent (Peres and Katz 1990). Fertility rates are higher than in other industrial societies, marriage rates exceed those of most OECD countries, and divorce rates are lower than in most European and American countries, higher only when compared to Catholic societies (table 23.3).

The stability of the Israeli family may, at least partially, be attributed to the role of religion in Israeli society. Saturday and Jewish holy days take on a civil, as well as a religious, connotation, and are national days of rest by law. From early

Table 23.3 Marriage, divorce, and fertility rates in selected countries

	Fertility per 1,000 women age 15–49 1990–1993	*Marriages per 1,000 population 1993*	*Divorces per 1,000 population 1991–1992*
Europe			
Austria	48.3	5.6	2.1
Italy	38.7	4.8	0.5
England	53.6	5.9	3.0
Hungary	45.4	5.3	2.1
Greece	40.3	6.0	0.6
France	53.9	4.7	1.9
The Americas			
USA	62.0	9.0	4.8
Canada	56.6	5.5	2.7
Uruguay	75.8	6.2	3.1
Argentina	82.0	5.7	not available
Brazil	62.6	5.0	0.6
Africa			
Tunisia	105.3	6.4	1.5
Egypt	128.5	8.5	1.4
Asia			
Iran	147.8	7.9	0.6
Turkey	149.0	7.4	0.5
Jordan	219.7	8.0	1.2
Japan	38.1	6.7	1.4
Israel	*85.4*	*6.5*	*1.3*

Source: UN Demographic Yearbook 1988, 1996.

afternoon on Friday and on holiday eves, businesses, services, and public transportation close down, with very few exceptions. Emergency services and the defense forces operate with reduced staff, and even entertainment (e.g. restaurants, movie theaters) is available on a smaller scale. On these days, the nuclear and the extended family largely become the core of social life. In addition, life events such as marriages, births, rites of passage, and funerals are normatively celebrated with members of the extended family, enabling it to fulfill its integrative and regulative functions (for the role of the family in controlling health related behavior see Anson 1989; Umberson 1992).

As in other industrial societies, the Israeli family takes responsibility for the care needs of its sick members, the disabled, and the elderly (Avgar 1997). However, comparative data on long-term hospitalization and home care rates of the elderly suggest that the Israeli family is more inclined to care for its elderly than many postindustrial societies. In 1994, for example, 4.5 percent of the Israelis aged 65+ were institutionalized, compared with an average of 5.5 percent in 20 OECD countries in 1990–2; 10 percent of the elderly were provided with formal long-term home care in 1996, lower than that of most European countries (OECD 1996). Similar patterns can be found regarding institutional care for the mentally and physically disabled (Kop 1997). The Israeli family, then, is a major health resource.

Formal Support Systems

Like many other postmodern societies, Israeli society has undergone economic and social processes that have lead to the weakening of the welfare state (Quandagno 1999). At the same time, the underlying assumption that society is responsible for the education, health, and welfare of its members has persisted. The most recent manifestation of this perception is the National Health Insurance Law, which came into effect in 1995, by which every resident is entitled to a basic basket of services, regardless of his or her contribution (health tax). The law explicitly declares the social obligation to provide health care, based on the principles of justice, equity, and mutual help. Public education of nine years is mandatory, six-months unemployment benefits, old age and survivors' pensions, maternity, and children's allowances are universal, independent of other income. Disability pension and disabled child allowances are dependent on functional limitations only. Other welfare programs, such as single parent allowance, income supplement, and income support for the elderly serve as a safety net for lower income individuals and families. Only long-term home care is dependent on both income and functional ability. These programs, however, did not prevent individuals and families from falling into poverty: 16.5 percent of the population in 1996, 20.6 percent of the elderly and 21.4 percent of all children (Ministry of Health 1998).

Health, education, and welfare services are well distributed within the country, and most places are no further than 30–45 minutes drive from a hospital. At the same time, these services vary in quality and quantity, raising concern regarding the equity of the allocation of the available resources in different locations and social groups (Azaiza 1995; Swirsky et al. 1998; Shuval and Anson forthcoming).

Health Status, Health, and Illness behavior

The Population

By the end of 1997, Israel had 5,900,000 residents, 79.7 percent Jewish (of whom over one-third were born outside of Israel), 14.7 percent Moslem Arabs, 2.1 percent Christian, and 1.6 percent Druze (Statistical Abstract of Israel 1998). Due to high fertility, children age 0–14 comprise 29.0 percent of the population, and the elderly only 9.9 percent. The median years of schooling were 12.1 in 1997, with 61.6 percent of men and 45.8 percent of women over the age 15 participating in the civilian labor force.

Health Indicators

In order to present the health status in Israel, we choose to compare the 1980 and the 1994 health indicators of Israel with the average of the European Union (hence EU), whose members enjoy a similar level or better level of economic development and comparable health and welfare systems. As there is no consistent and continuous national data collection of the incidence and prevalence of most chronic and acute conditions, the discussion will focus on mortality-based health indicators as shown in figure 23.1a and 23.1b. These data demonstrate two long-term tendencies: first, on most indicators, Israeli men appear to be healthier than EU men while the health of Israeli women is poorer than that of their EU counter-

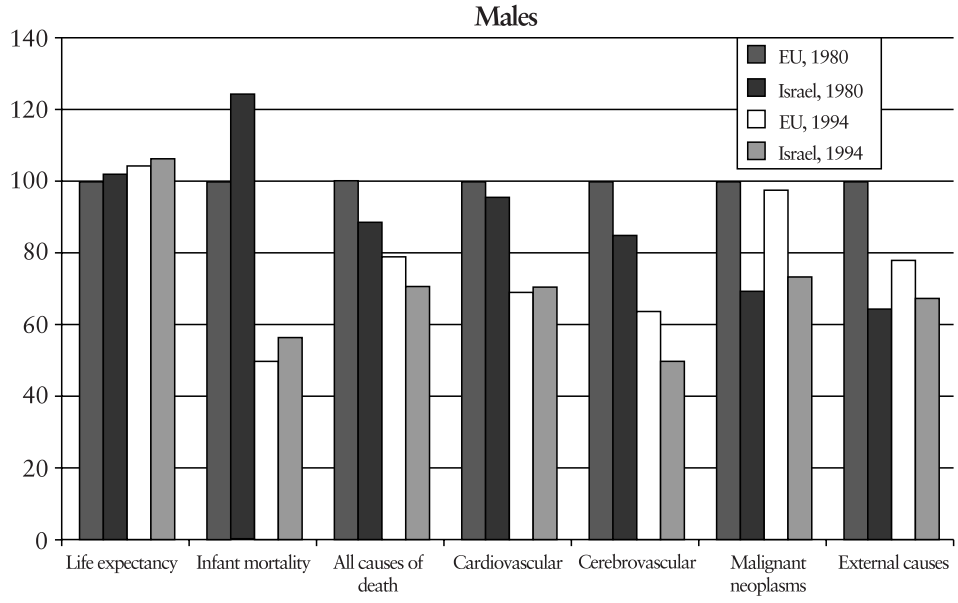

Figure 23.1a (males) Mortality-based health indicators: relative risk, Israel and the European Union, 1980–1994 (EU 1980 = 100)

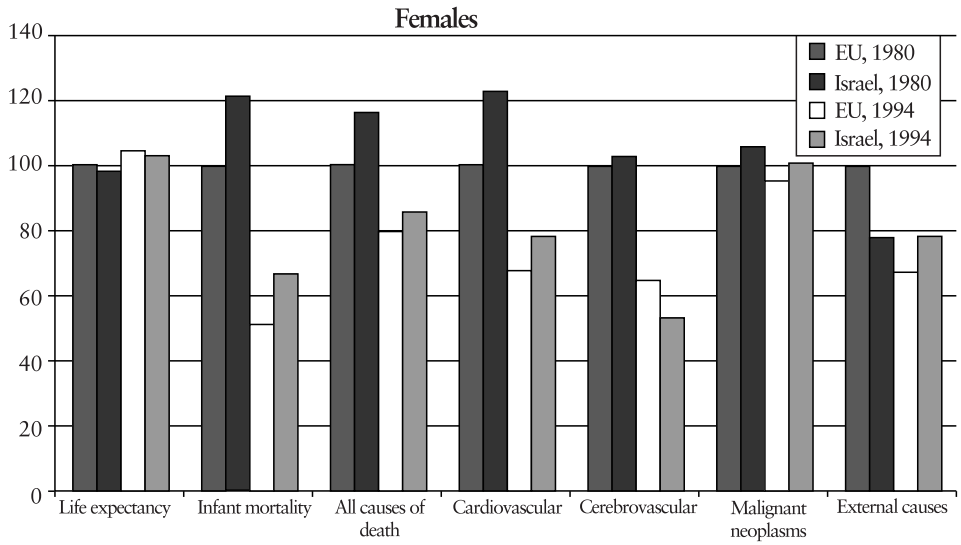

Figure 23.1b (females)

Note: Life expectancy is from birth infant mortality rate per 1,000 births, and death rates are per 100,000 in the population.

Source: Health for All European Region 1997.

parts; second, with few exceptions, age-adjusted mortality for the leading causes of death of Israeli men and women converges over time with the EU average.

Infant mortality rates in Israel are higher than the EU average throughout the 15 years examined, but Israeli male infant mortality declined faster than the rates for EU males and Israeli females. Death rates from external causes in Israel increased for both men and women compared with a decline in the EU average, but only the mortality of Israeli women from external causes exceeded that of EU women in 1994. Between 1980 and 1994, the average life expectancy at birth of EU and Israeli men increased by 3.3 years, Israeli men consistently live 1.5 years longer than EU men. The life expectancy at birth of Israeli women, however, is shorter than in the EU, and the gap declined by only six months during the 15 years studied.

These trends cannot be easily explained, especially the consistent smaller gender gap in life expectancy in Israel compared to the EU. One line of explanation is based on the hypothesis that the social origins of illness and healthdiscussed above affect men and women differently. It is thus possible that the stress imposed by Israel's geopolitical situation varies by gender, as women, on the average, have fewer coping resources than men (Anson et al. 1993).

Further, it is also possible that the Israeli traditionalism and familism, reflected in the gendered division of labor (Azmon and Izraeli 1993) and women's greater involvement in nurturing roles (Lieblich 1993), hamper their health. Over a quarter of a century ago, Gove (1973) showed that marriage "protects" men from mortality more than it protects women. The relatively high marriage and fertility rates and the lower rates of long-term institutionalization and long-term

home care services were discussed earlier in this chapter. Furthermore, compared to the EU average, Israel has fewer general hospital beds (4.1 and 2.4 per 1,000 population in 1993, respectively), compensated by shorter average lengths of stay (9.4 and 4.5 days in 1993, respectively). Much of the needs unmet by the formal health and welfare services are thus met by unpaid women family members, an overload with possibly negative affects on Israeli women's health (Avgar 1997).

Health Behavior

Another factor, which may explain men's longevity, is health behavior. Suicide rates are extremely low, alcoholism is relatively rare – Israelis consume less alcohol than Europeans (3.4 liters of wine and 9 liters of beer per person in Israel compared with 34.4 and 82.0 EU average in 1994 (Ministry of Health 1997)). Drug abuse is also relatively infrequent compared to EU members (Anderson 1995; Rahav et al. 1995), and Israeli children and youth are less likely to smoke cigarettes than their EU counterparts (WHO 1996). The proportion of adult smokers is similar to the EU average, but is gradually declining: from 37 percent in 1989 to 28 percent in 1996 (Ministry of Health 1996b). Only physical activity is relatively rare among Israelis (Heler 1994; WHO 1996).

How Israeli society has managed to prevent the dispersal of social diseases below the prevalence level of other industrial societies is not completely clear. It has been suggested that the perception of Israel as a society in continuous struggle for survival, the ongoing concern with national tasks such as security, immigration absorption, and economic strain inhibited the development of consumerism and indulgence (Shuval 1992). Others have focused on social control agencies, especially religion and the family (Shuval and Anson forthcoming). For instance, drug and alcohol consumption is less common among the married, children living with both parents, and religious youth (Rahav et al. 1995).

Illness Behavior

Israel has one of the highest average numbers of doctor visits in the western world, 9.4 visits per person per year in 1996. Of these, 4.9 visits to primary care physician, 1.8 visits to a specialist, and 2.6 dental visits (Health in Israel 1998). In 1992, the last comparative data available to us, only Germany and Switzerland reported a higher number of doctor visits than Israel (Bib-Nun and Ben-Ori 1996). As in other developed countries, utilization rates are higher among women, children under five years old, and the elderly. Judging by mortality-based health indicators, the high utilization rates cannot be explained by poor health status of the population. Shuval (1992) argued that this pattern can be explained by three factors.

1 First, the availability of readily accessible health services, with few barriers. There are 3.8 operating physicians per 1,000 population, primary care clinics are located in almost all rural settlements and urban neighborhoods, doctor visits are free of charge in three of the four sick funds (i.e. for 80% of the population), and medications are subsidized.

2 Second, a perceived need for medical care can develop against the background of chronic and acute stress, sense of failure, and the need for catharsis. The emphasis on the bio-psychosocial model and doctor–patient communication in the training program of family practitioners advances consumers' expectations for catharsis and approval.

3 Finally, medical authorization is required for various public benefits. Ground floor apartments, tax exemptions, long-term care, etc. are dependent on referrals from primary care physicals.

As in other western societies, the utilization of non-conventional medicine seems to be increasing. Many different healing systems are available; most healers are trained outside the country and practice in the private sector. As with the patterns of utilization in other developed countries, non-conventional medicine is complementary rather than alternative to conventional health care, used more often by persons whose needs were not satisfied by biomedical embedded care (table 23.4) (Bernstein and Shuval 1997).

THE HEALTH CARE SYSTEM

The Israeli health care system has some unique features, which have developed as a result of social and historical processes. Of particular note are the strong ties

Table 23.4 Satisfaction with family doctor: A comparison between users and non-users of alternative medicine practitioners (means[1] and standard deviations)

Satisfaction with	Users	Non-users
The relationships[2]	5.61 (1.65)	6.00 (1.33)
Amount of time he/she spends with you[3]	5.39 (5.87)	1.85 (1.46)
Convenience (consultation hours, distance, wait for appointment)[3]	5.02 (1.93)	5.57 (1.66)
Amount of information he/she provides[3]	5.54 (1.82)	6.00 (1.38)
Quality of care[2]	5.64 (1.71)	6.02 (1.31)
Overall[3]	5.59 (6.02)	1.69 (1.28)

Source: Bernstein and Shuval 1997.

Notes

1 On a seven-point scale from 1 = very dissatisfied to 7 = very satisfied.

2 $p < .05$.

3 $p < .01$.

between the health care and the political systems; the dual role Israeli Medical Association; the co-optation of non-conventional medicine; and the Patient's Rights Law. These will be shortly discussed.

Health Care and Politics

Long before independence, health services in Israel were established and developed not only in response to the health needs of the population, but also as a political asset in the struggle for power, while economic considerations and efficiency were largely disregarded. The first sick funds were established by regional workers' organizations in 1911. Seven years later, they merged to become one of the many services that the General Federation of Labor (*Histadruth*) provided for its members. Congruent with the Zionist and socialist ideology of the *Histadruth*, special attention was paid to rural communities. For over 60 years the medical insurance, to which all members of the *Histadruth* were entitled, was one of the main mechanisms for recruiting members, ensuring their commitment and conformity to the *Histadruth*, and through it to the Labor Movement and Parties. This triangular link proved beneficial to all parties involved and enabled the General Sick Fund to rely on the government to bail it out of frequent financial crises until the elections of 1977, when the Labor Party lost to the right-wing Likud Party (Chinitz 1996).

Similarly, *Hadassa*, the American Zionist Womens organization, established a sick fund for the self-employed farmers in 1931. The latter were not entitled to join the *Histadruth* because of their capitalist attitudes, but the rivalry between the medical delegation sent by *Hadassa* organization after WWI and the Labor Movement was no less important than the farmers' health needs. The revisionist movement, the political opposition of the socialist parties, established its own, albeit much smaller, National Labor Federation including a sick fund in 1933. Since the mid-1930s, several small sick funds were founded by physicians, refugees from Nazi Germany, to meet their employment needs and their preference to be self-employed.

The National Health Insurance Law implemented in January 1995, was also the result of political change in Israel, in the *Histadruth*, and in the Labor Party itself (Gross and Anson forthcoming). Over seven national committees recommended such legislation since Israel's independence in 1948, but the Labor Party, the *Histadruth* and its sick fund succeeded in preventing such an act which, they felt, was against their interests.[1] It was only after the Labor party lost its political hegemony both in the parliament and the *Histadruth*, the General Sick Fund's market share declined, and its deficit reached $1.5 billion, that the NHI Law was passed and implemented.

According to the Law, a legally defined service package is provided by four sick funds, financed through a progressive health-tax on incomes. Preventive care is mainly provided by Ministry of Health MCH clinics, and the Ministry also provides 55 percent of the psychiatric beds, 36 percent of acute hospitalization beds, and 12 percent of the long-term beds. Its involvement with direct care provision thus results in a conflict of interests and interferes with traditional ministerial roles (Gross and Anson forthcoming).

The Israeli Medical Association

The great majority of health professionals (except for dentists and pharmacists) are employees, organized in professional organizations. The most interesting of these is the Israeli Medical Association (IMA), which carries the dual role of professional association and trade union (Harrison 1993). As a professional association, the IMA strives to improve the quality of health care, either by advising the MOH on a variety of issues, or by organizing educational activities for its members. The IMA thus sets the qualifying exams for immigrant physicians and specialists, and is responsible for the content of specialization programs, continuing education activities, etc.

At the same time, the IMA is a trade union, which strives to improve the working conditions of its members. As such, it does not hesitate to employ proletarian strategies, that is, strikes, slowdowns, and working-to-rule every two or three years. In fact, physicians were the first to strike after independence, in the midst of the first immigration wave described above.

The tension between the physician's demand for recognition as a professional elite (Shuval 1992) and their proletarian behavior is reconciled in two main ways. First, health services are never shut down completely during industrial actions. Services are provided on a lower-scale, similar to those provided on Saturdays and holidays, along with treatments for conditions considered by the public as life threatening (e.g. cancer). Sometimes, industrial action is taken on a rotating basis, with physicians working in different hospitals, outpatient clinics, sick funds, or different parts of the country, striking on different days.

Second, legitimization for industrial struggles is sought by presenting the actions taken in terms of public interest. Overload, it is argued, whether caused by insufficient personnel or by too low wages, which force doctors to take on a second job, hinders the quality of patient care. Higher wages and additional positions in primary care and hospitals, on the other hand, will enable doctors to devote more time both to patients and to advancing their medical knowledge.

The advisory status of the IMA on licensing issues further enables it to protect the interests of its members. The patterns of absorbing immigrant physicians from the former Soviet Union demonstrate the exercise of such power. In line with the Israeli value system, the IMA supported local initiatives preparing immigrant physicians for local accreditation. However, while the structure of medical education in the former Soviet Union is highly specialized, the examination in Israel qualifies immigrants only for a general practitioner license. Physicians trained in a non English-speaking country are required to take the specialization examination together with graduates of the IMA specialization programs, regardless of their work experience and credentials from their country of origin. These procedures enhanced the elitist claims of Israeli and Anglophone trained physicians in two ways. First, many immigrant physicians were forced to enter primary care, which is perceived by both health professionals and consumers as less prestigious than hospital-based practice. Second, the intra-professional stratification criterion is based on formally recognized specialities.

Limiting immigrants access to specialist status thus promotes the interests of veteran, more established, physicians.

The Co-optation of Non-conventional Medicine

The reaction of conventional medicine to the growing utilization of non-conventional medicine described above was paradoxical. While physicians, as individuals, used some of these methods for specific conditions for themselves, members of their family, and even referred a few of their patients to practitioners they knew of (Borkan et al. 1994), the official stance of the IMA was one of total non-recognition.

A State Commission of Inquiry to examine the issue of non-conventional medicine in Israel was appointed by the Minister of Health in 1988. Its report, in 1991, included six recommendations, and sought to bridge the right of individual free choice with the State's obligation to protect its citizen's health. Only one recommendation, concerning the licensing of imported homeopathic medications, was partially implemented. In 1996 the State Comptroller heavily criticized the MOH for neglecting the commissions report. The IMA responded to that criticism with an official position paper (1997), declaring that "there is no alternative medicine . . . but one medicine, . . . and only certified physicians (M.D.) can practice it." According to the IMA, non-conventional medicine provides false hopes to patients *who think* that their needs were not met by the biomedical system and personal attention which biomedical physicians in the public sector are *unable* to provide due to *overload*.

At the same time, increasing utilization of non-conventional methods, public willingness to pay out-of-pocket for these services, and individual physician's confidence in the benefit of some complementary methods brought about a unique pattern of collaboration between non-conventional medicine and the biomedical establishment. During the period 1991–7, ten general hospitals and all four sick funds commenced outpatient clinics providing non-conventional services (Shuval 1999). The patterns that emerged, however, indicate that it is not collaboration among equals, but, rather, one that symbolically emphasizes the primacy of conventional medicine.

First, hiring policies overtly prefer biomedically-trained physicians who also practice complementary medicine. Second, a biomedically-trained physician is first to examine the patient, decides on the appropriate non-conventional method, and periodically assesses the outcome. Needless to say, no similar routine periodic supervision/assessment is practiced within biomedicine. Furthermore, in all formal publications, non-conventional practitioners are referred to as "healers" (*merapim*) rather than physicians (*rofim*), even when holding an MD. Finally, non-conventional facilities are geographically segregated from conventional medicine.

These patterns of collaboration/co-optation serve the interests of both systems. Non-conventional practitioners gain a legitimate practice setting under the prestigious biomedical umbrella, which, in the long run, may develop to full recognition. The biomedical system gains symbolic primacy and some actual control over the non-conventional medicine (Shuval 1999).

The Patient's Rights Law

As in many western countries, increased bureaucratization of health care organizations has brought about a growing alienation between consumers and providers. At the same time, processes of globalization and the spread of knowledge through written and electronic media have increased demand for the most recent technological developments, and for greater equality in decision-making between patients and physicians. It also increased awareness of the uncertainty aspect of the biomedical body of knowledge and the unavoidable limitations of the individual health practitioner. These same processes advanced the diffusion of ideas, and familiarity with the consumerist trends in the field of health around the postindustrial world. These processes were exacerbated by the elitist attitudes of medical professionals, mentioned above, and the development of black medicine, out-of-pocket payment to elite members of the profession for services ostensibly covered by one's insurance and provided in public facilities. All these processes were associated with a growing sense of dissatisfaction with the health care system, and the portrayal of physicians as arrogant and greedy. One result of these processes was the legislation of the Patient's Rights Law in 1996.

The stated purpose of the law is to guarantee patients' privacy and respect. Nevertheless, some paragraphs of the law can be interpreted in terms of deprofessionalization (Haug 1973, 1988). The law largely limits professional control over knowledge and self-regulation, two of the core sources of professional power (Anson forthcoming). Health professionals are obliged to share their knowledge with their patients, and to explain in great detail the arguments for and against all possible treatment alternatives in order to obtain informed consent.

The profession of medicine obtained social legitimization for self-regulation under the claim that professionals alone can evaluate their colleagues competence and performance, and the fundamental need to learn from mistakes and unpredicted intervention outcomes for maintaining and improving the quality of care. The Israeli Patient's Rights Law created two separate mechanisms to fulfill the dual function of self-regulation: one for promoting the quality of care, the other for social control over professional performance. The function of improving the quality of care by exploring undesired episodes, such as infections, mistakes, a patient's disappearance, or falling off the bed was assigned to an obligatory quality-control committee. The results of this committee's investigations and all the information gathered is confidential to the public and may not be presented as evidence in court. The function of social control over the performance of members of the medical team has been placed in the hands of an "inquiry committee," which is established at the request of a patient or anybody he/she authorizes. Its report goes to the person(s) who initiated the inquiry; the provider who is the subject of the complaint; the Ministry of Health; and the general administrator of the health care institution, which treated the patient. All the information collected by the inquiry committee, including the chronology taken during the discussions held, may be presented as evidence in court.

Summary

Some of the unique features of health and health care in Israel were presented in this chapter. We made an effort to present the social origins of illness and health, namely the unique stressors threatening the health of Israelis and the informal and formal social support available to them. The unique patterns of health and illness behavior were shortly described. Some outstanding characteristics of the Israeli health services and policy, particularly the strong link between politics and health provision, the dual role of the Israeli Medical Association, patterns of collaboration between conventional and non-conventional medicine, and the social processes that lead to the nonpareil Patient's Rights Law, were portrayed. Other important characteristics, such as patterns of health inequalities and inequity in the allocation of the available health services, by age, gender, ethnicity, and geographical periphery have been left untouched, despite their importance.

Note

1 It should be noted that over 95 percent of the population had medical insurance before the NHI Law.

References

Anderson, Katherine. 1995. *Young People and Alcohol, Drugs and Tobacco*. WHO.

Anson, Ofra. 1989. "Marital Status and Women's Health Revisited: The Importance of a Proximate Adult." *Journal of Marriage and the Family* 51: 185–94.

——. Forthcoming. "Professionalism and the Israeli Patient's Rights Law." *Medical Law International*.

Anson, Ofra, Esther Paran, Lily Neumann, and Dov Chernichovsky. 1993. "Gender Differences in Health Perceptions and their Predictors." *Social Science and Medicine* 36: 419–27.

Anson, Ofra, Dina Pilpel, and Valentina Rolnik. 1996. "Physical and Psychological Well-Being among Immigrants Referrals to Colonoscopy." *Social Science and Medicine* 43: 1309–16.

Avgar, Amy. 1997. "Womens Health in Israel: A Feminist Perspective." *Social Work in Health Care* 25: 45–62.

Azaiza, Fu'ad. 1995. "Welfare Services in the Israeli-Arab Sector." Pp. 207–23 in *The Israeli Arabs toward the Twenty-first Century*. Jerusalem: Magnes Hebrew University Press (Hebrew).

Azmon, Yael and Dafna Izraeli. 1993. "Introduction: Women in Israel – A Sociological Overview." Pp. 1–21 in Y. Azmon and D. N. Izraeli (eds.), *Women in Israel*. London: Transaction.

Bernstein, Judith H. 1997. "Israel's Open Door Policy: Implications for Immigrant Physicians." Pp. 67–86 in J. T. Shuval and J. H. Bernstein (eds.), *Immigrant Physicians: Former Soviet Doctors in Israel, Canada and The United States*. Westport, CT: Praeger–Greenwood.

Bernstein, Judith H. and Judith T. Shuval. 1997. "Non-conventional Medicine in Israel: Consultation Patterns of the Israeli Population and Attitudes of Primary Care Physicians. *Social Science and Medicine* 44: 1341–8.

——. 1998. "The Occupational Integration of Former Soviet Physicians in Israel: Findings From A Five-Year Follow-Up Study." *Social Science and Medicine* 47: 809–19.

Bib-Nun, Gavriel and Dan Ben-Ori. 1996. *International Comparisons – OECD and Israel*. Jerusalem: Ministry of Health (Hebrew).

Borkan Jeffrey, Jon O. Neher, Ofra Anson, and Bret Smoker. 1994. "Referrals to Alternative Therapies: A Three-Site Study." *The Journal of Family Practice* 39: 545–50.

Chinitz, David. 1996. "Israel's Health Policy Breakthrough: The Politics of Reform and the Reform of Politics." *Journal of Politics, Policy and Law* 20: 909–32.

Gove, Walter R. 1973. "Sex, Marital Status, and Mortality." *American Journal of Sociology* 79: 45–67.

Gross, Revital and Ofra Anson. Forthcoming. "The Reforms in the Israeli Health Care System." In A. Twaddle (ed.), *Comparative Medical Care Reform*.

Hacohen, Debora. 1994. *Immigrants in Storm* (Olim Beseara). Jerusalem: Izhak Ben-Zvi Memorial. (Hebrew).

Harrison, Michael. 1993. "Medical Dominance or Proletarianization: Evidence from Israel." *Research in the Sociology of Health Care* 10: 73–81.

Haug, M. 1973. "Deprofessionalization: An Alternative Hypothesis for the Future." *Sociological Review Monograph* 2: 195–211.

——. 1988. "A Re-examination of the Hypothesis of Physician Deprofessionalization." *Milbank Memorial Fund Quarterly* 66: 48–56.

Heler, Arie. 1994. *Attitudes and Behavior Regarding Physical Excercise*. Tel Aviv: Modi'in Ezrahi (Hebrew).

Kop, Jacob. 1997. *Resources Allocation to Social Services, 1997*. Jerusalem: Social Policy Research Center (Hebrew).

Lieblich, Amia. 1993. "Preliminary Comparison of Israeli and American Successful Women." Pp. 195–208 in Y. Azmon and D. Izraeli (eds.), *Women in Israel*. London: Transaction.

Ministry of Health. 1996a. *Knowledge, Attitudes and Health Behavior.* Jerusalem: State of Israel (Hebrew).

——. 1996b. *Health in Israel, 1996*. Jerusalem: State of Israel (Hebrew).

——. 1997. *Health in Israel, 1996*. Jerusalem: State of Israel (Hebrew).

——. 1998. *Health in Israel, 1998*. Jerusalem: State of Israel (Hebrew).

Ministry of Immigration. 1996. *Immigration and Absorption: Data, Challenge, and Goals*. Jerusalem: State of Israel (Hebrew).

Nirel, Nurit, Bruce Rosen, Revital Gross, Aieleth Berg, and D. Yuval. 1996. *Immigrants from the Former Soviet Union in the Health System: Selected Findings from National Surveys*. Jerusalem: JDC–Brookdale Institute.

Nirel, Nurit and Giora Nave. 1996. *The Employment of Immigrant Physicians in Israel: Is it Stable?* Jerusalem: JDC-Brookdale Institute.

OECD. 1996. *Caring for Frail Elderly People: Policies in Evolution*. Paris.

Peres, Yochanan and Ruth Katz. 1990. "The Family in Israel: Change and Continuity." Pp. 9–32 in L. Shamgar and R. Bar-Yosef (eds.), *Families in Israel*. Jerusalem: Akademon (Hebrew).

Peres, Yochanan and Ephraim Yuchtman-Yaar. 1998. *Between Consent and Dissent: Democracy and Peace in the Israeli Mind*. Tel Aviv: The Israel Democracy Institute (Hebrew).

Quandagno, Jill. 1999. "Creating Capital Investment Welfare State." *American Sociological Review* 64: 1–11.

Rahav, Giora, Meir Teichman, Refael Gil et al. 1995. *The Use of Psychoactive Materials in Israel 1995: Epidemiological Survey III*. Jerusalem: Pory Institute (Hebrew).

Statistical Abstract of Israel 1998. Jerusalem: Central Bureau of Statistics.

Shuval, Judith T. 1983. *Newcomers and Colleagues: Soviet Immigrant Physicians in Israel*. Houston: Cap and Gown Press.

——. 1992. *Social Dimensions of Health: The Case of Israel*. Westpoint, CN: Praeger.

——. 1998. "Credentialling Immigrant Physicians to Israel." *Health and Place* (in press).

——. 1999. "The Bear's Hug: Patterns of Pragmatic Collaboration and Coexistence of Complementary Medicine and Biomedicine in Israel." In S. Saks and C. Benoit (eds.), *Professional Identities in Transition*. Monograph no. 71. Stockholm: Gotenberg University, Almqvist & Weksell International.

Shuval, Judith T. and Ofra Anson. Forthcoming. *Health Is the Essence – Social Structure and Health in Israel*. Jerusalem: Magnes, Hebrew University Press (Hebrew).

Shuval, Judith T. and Eli Leshem. 1998. "The Sociology of Migration in Israel: A Critical View." Pp. 3–50 in E. Leshem and J. T. Shuval (eds.), *Immigration to Israel: Sociological Perspectives*. New Brunswick: Transaction.

Swirsky, Barbara, Hatim Kanaaneh, and Amy Avgar. 1998. *Health Care in Israel*. Tel Aviv: Adva.

Umberson, Debra. 1992. "Gender, Marital Status and Social Control of Health Behavior." *Social Science and Medicine* 34: 907–17.

UN Demographic Yearbook. 1996. New York: United Nations.