

# THE ISRAEL Equality Monitor

Adva Center Adva Center  
Adva Center Adva Center  
Adva Center Adva Center  
Adva Center Adva Center

Issue No.  
Aug. 1992

2

Published by Adva Center  
P.O. Box 36448, Tel Aviv 61363, Israel  
Tel 03-560-5470, Fax 03-560-3840

ISSN 0792-7010 © All rights reserved to Adva Center

## HEALTH CARE IN ISRAEL

Israel's national health statistics compare favorably with those of developed countries. In 1989-90, expenditures on health care were 7.8% of the GNP, a level recommended by the World Health Organization. The 1989 physician/population ratio — 1:340 — is one of the highest in the world, and teaching hospitals, research institutions and medical technology are internationally renowned.

About 90% of newborns receive services from a country-wide network of public mother and child clinics, including inoculation against polio, diphtheria, tetanus, whooping cough, and, since 1991, hepatitis. Immunizations against rubella, mumps and measles are administered at age 15 months, and boosters given in the schools.<sup>1</sup> The national infant mortality rate is relatively low: 9.9 for every 1,000 live births, and the average life expectancy at birth high: 78.1 for women and 74.6 for men.<sup>2</sup>

While Israel lacks a national health law, four government-subsidized health insurance schemes or sick funds, the largest of which belongs to the Histadrut, provide coverage for almost 95% of the population.

The Ministry of Health operates a nationwide network of community-based mother and child clinics, for which there is an annual fee, and the sick funds run community-based curative clinics and regional specialist centers for members. However, many services considered primary in some developed countries, like dental care, preventive care for adults, long-term nursing care, and contraceptives are not covered by the sick funds.

Israel has an extensive preventive system for pregnant women and infants, but no equivalent for others; public awareness of preventive health care is low, and existing facilities are often understaffed, poorly equipped, and underused.

Disparities in Health and Health Care Services 2 A Closer  
Look at the Health of Arabs in Israel 8 Major Issues in Women's  
Health 11 The Growth of Private Health Care 17 Past  
and Present: Are the Gaps Disappearing? 19 Israel in  
International Perspective 20 Prospects for the Future 22

### From the Editorial Board

- Over the last two decades, Israeli society has
- been undergoing a process marked by increas-
- ing inequality. The notions of equality of oppor-
- tunity and social justice, once cornerstones of
- social thought and policy in Israel, are being jet-
- tisoned. Wage scales now resemble those in
- many Third World societies.
- Contrary to expectation and popular myth,
- second and third generation Mizrahim — Jews
- of Middle Eastern origin — lag further behind
- their Ashkenazi — Jews of European or
- American origin — cohorts in educational
- achievements, employment opportunities and
- housing than the first generation.
- Women earn less, compared to men, than
- they did a decade ago, and their political rep-
- resentation is declining. Palestinian citizens of
- Israel are employed mainly in blue collar jobs,
- regardless of their educational achievements.
- Palestinians from the occupied territories
- receive the lowest remuneration, and they are
- not protected by Israeli labor unions.
- The editors of The Israel Equality Monitor
- aspire to put the idea of equality of oppor-
- tunity back on the national agenda. They will
- present an up-to-date picture of the state of
- equality in various areas of social life. The
- figures will be presented as clearly as possible,
- so as to make them accessible to lay readers.
- The Israel Equality Monitor will present com-
- parisons between various social groups in Is-
- raeli society, as well as between the past and
- the present situation and between Israel and
- other societies.
- The Israel Equality Monitor is designed for
- the use of concerned citizens, policy
- makers, and activists striving to promote the
- ideas of equality of opportunity and social
- justice in Israel.



# Disparities in Health and Health Care Services

Mother and child clinics are to be found in most Jewish communities but are absent in some 20 Arab communities. Primary curative care, present in nearly all Jewish communities, is lacking in about 1/3 of Arab communities.<sup>3</sup>

Secondary care is available at sick fund specialist clinics to their members and at regional hospitals to all residents of the region, including the uninsured, but treatment for the latter is conditioned on payment.

The majority of Arab communities still lack ambulance, mental health and geriatric services, dentistry, physiotherapy and occupational therapy services.<sup>4</sup>

Directed from the Ministry of Health in Jerusalem and the Histadrut headquarters in Tel Aviv, the Israeli public health system is highly centralized and lacking in local community involvement.

## Health Insurance

The high rate of insurance coverage in Israel is to a large degree due to the fact that union-negotiated contracts include insurance for the majority of full-time salaried workers and their dependents;<sup>5</sup> to government provision of medical insurance for pregnant women and for persons receiving welfare allowances, including the elderly and the disabled; and to temporary government agreements with sick funds which guarantee insurance to new immigrants. For the remainder of the population, health insurance is voluntary.

The uninsured, or partially insured, who constitute an estimated 25% of the Arab population (219,390 persons) and 2% of the Jewish population (78,980 persons), are likely to be unemployed or underemployed. This group also includes young adults no longer covered by their parents' insurance and not insured by virtue of either military service or student status.<sup>6</sup> Persons with no regular employment and their dependents are not accepted by the Histadrut Sick Fund, the main provider of medical services in Arab communities and Jewish development towns, where unemployment is the highest. Neither are drug addicts and their families.<sup>7</sup>

## Underlying Determinants of Health Status

Probably the most important determinants of health are socio-economic. The income of individuals and families and their social class, for which the figures on blue and white collar jobs are used as a proxy measure, have been shown to have a major influence on levels of health in every country in which they have been studied.<sup>8</sup> Likewise, educational level, particularly that of mothers, is directly related to the health of the community, and especially its children. Unemployment has detrimental effects beyond the obvious financial ones and leads to multiple psychosocial and psychosomatic ailments in the unemployed and his or her family.<sup>9</sup>

In Israel, the same ranking order appears whether one looks at education, income, or class: Ashkenazi Jews are on top, followed by Mizrahi Jews and Arabs. The 1983 Census found that for second-generation Ashkenazi women the median education was 12.9 years, for Mizrahi women 11.8 years,

## Infant Mortality Rates in Communities of 10,000 Residents or More, 1986-88.

Key: ◇ Mizrahi Majority ◆ Arab

◆ Tamra	25.5
◆ Sakhnin	24.2
◆ Rahat	22.4
◆ Maghar	22.3
◆ Kfar Kana	20.3
◆ Baka el Gharbiya	19.5
◆ Umm el Fahm	19.4
◆ Nazareth	17.7
◇ Migdal Haemek	17.1
◆ Shfaram	16.4
Kiryat Tivon	15.9
◆ Tira	15.4
◇ Beit Shean	15.0
◆ Arabe	14.6
◇ Kiryat Ata	14.3
Upper Nazareth	14.1
Arad	13.9
◆ Taibe	13.3
◇ Tiberias	13.2
◇ Neshet	12.4
◇ Acre	12.4
◇ Afula	12.3
Kfar Saba	12.1
◇ Tirat Hacarmel	11.6
◇ Rosh Haayin	11.6
◇ Eilat	11.2
◇ Ofakim	11.0
◇ Beer Sheba	10.9
Ma'aleh Adumim	10.7
Netanya	10.7
◇ Kiryat Gat	10.6
Kiryat Yam	10.5
Or Yehuda	10.5
◇ Ramle	10.5
Bat Yam	10.5
Jerusalem	10.4
◇ Kiryat Shmona	10.4
Hod Hasharon	10.0
Kiryat Motzkin	10.0
Raanana	10.0
Hadera	10.0
◇ Or Yehuda	8.9
◇ Lod	8.9
Haifa	8.7
Kiryat Bialik	8.6
Kiryat Ono	8.5
◇ Ashdod	8.4
◇ Ashkelon	8.4
Tel Aviv	7.9
Mevaseret Zion	7.9
Holon	7.8
◇ Yavneh	7.8
Carmiel	7.8
Rishon L'Zion	7.7
◇ Dimona	7.6
Rehovot	7.6
B'nai Brak	7.3
◇ Yahud	6.8
Nahariya	6.5
Herzliya	6.5
Petah Tikva	6.2
Ramat Gan	6.2
◇ Kiryat Malahi	5.5
◇ Safed	5.2
Ramat Hasharon	5.2
Nes Ziona	4.8

Source: CBS. 1991. Local Authorities in Israel 1988/89: Physical Data. Table 14, pp. 62-64.



and for Arab women, 7.9. Nearly 50% of second-generation Ashkenazim, but only 17.6% of second-generation Mizrahim and 9.1% of Arabs presently have 13 or more years of schooling. The average income for urban households in which the head of the household is a wage-earner is 4,475 NIS for second-generation Ashkenazim, 3,046 NIS for second-generation Mizrahim, and 2,546 NIS for Arabs; the official unemployment rate is 5.9% for second-generation Ashkenazim, but 10.6% for Arabs, and 15.8% for second-generation Mizrahim. And about 1/4 of Ashkenazim, compared with nearly 1/2 of Mizrahim and over 70% of Arabs are blue-collar workers.<sup>10</sup> As the following pages will show, the figures on health match the socio-economic level of the three groups.

## Health Status Indicators

### Infant Mortality Rate

The most sensitive measure of the overall social and physical well-being of a population is the infant mortality rate, the number of deaths during the first year of life per 1,000 live births. In 1977-80, the average infant mortality rate for Jews was 12.7, and for Arabs, 24.6 deaths per 1,000 live births.<sup>11</sup>

A study conducted by the Health Services Research Unit at Sheba Medical Center found wide variations among both Arab and Jewish communities, and, on the basis of deviations from a regional norm, designated 36 locations for intervention on the part of The National Program for Reduction of Infant Mortality. (The use of two separate standards for determining excessive mortality, one based on the mortality rate in Jewish communities and the other on that in Arab ones meant that numerous Arab communities with high infant mortality were not slated for intervention.)

The pilot program was instituted in Or Yehuda, a Mizrahi town whose infant mortality rate (19.1) was nearly twice that of the surrounding area (10.3), and whose socio-economic level was the lowest in the district. Research revealed that the group at risk was characterized by a combination of 4 or more risk factors usually associated with high mortality, including low maternal education (0-8 years), teenage pregnancy, high birth order (4+), and birth weight under 2,500 grams. By 1986-1988, infant mortality in Or Yehuda, as well as in a number of other communities targeted for intervention, like Dimona and Ashkelon, had been considerably reduced, demonstrating the possible benefits of improved health care services for high-risk groups.<sup>12</sup>

The graph of infant mortality rates for urban communities on page 2 shows clear disparities between Arabs and Jews. It also demonstrates the fact that infant mortality in a number of Jewish development towns is much higher — 50% — than the national average. Although there are exceptions, most affluent communities are at the bottom, most development towns cluster around the middle and all Arab communities are near the top of the infant mortality graph. Infant mortality is relatively low in Jewish rural communities: in 1987, the rate was 4.8 in kibbutzim and 7.5 in moshavim.<sup>13</sup>

### Standardized Mortality Ratios

Geographical variations have also been found in the standardized mortality ratios (a measure based on the actual number of deaths, standardized to account for differences in the age and gender composition of populations). A comparison between mortality ratios for Jews during 1968-78 and those during 1983-86 found significant increases in the Ramla, Tel Aviv, Ashkelon and Beer Sheba districts, and significant decreases in the Jerusalem and Rehovot districts.

Among the suggested, but untested hypotheses concerning the factors contributing to higher rates of mortality are the presence of cement and building construction industries (connected with stomach and lung cancer and leukemia) in the Ramla district and the low standards of care and surgery (associated with septicemia) in the Beer Sheba district.<sup>14</sup>

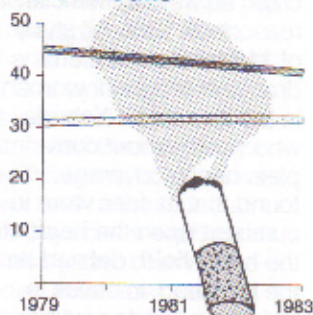
## Health-Promoting Behaviors

Research indicates that socio-economic status is associated with factors like diet, smoking and alcohol consumption.<sup>15</sup> While about 1/3 of the Israeli population smokes,<sup>16</sup> smoking is more prevalent among Arabs than among Jews, and more common among Mizrahim than among Ashkenazim (see table at top right).

A 1985 survey of smokers aged 60 and over found that the percentage of heavy smokers (20 cigarettes or more per day) was highest among Arabs and lowest among Ashkenazim (see table at bottom right).

Moreover, more Ashkenazim (28.2%) than Mizrahim (20.1%) had quit smoking. The lowest percentage of persons who had quit smoking was found among Arabs (11.4%),<sup>17</sup> pointing, perhaps, to differential stress levels or disparities in access to health education resources.

## Percentage of Regular Smokers in Three National Samples of Jewish Adults

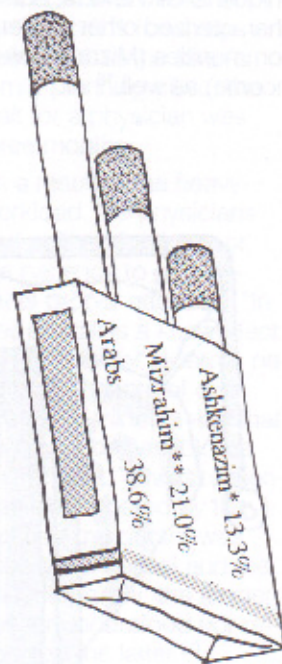


Source: Ben Sira, Z. 1983. *Smoking Among Adults and Young People*. Jerusalem: The Israel Institute of Applied Social Research (Hebrew).

### Country of Origin:

- Asia/Africa
- Europe/America

## Percentage of Smokers Aged 60 and Over Smoking 20 Cigarettes per Day or More, by Social Group



Source: CBS. 1990. *Survey of Persons Aged 60 and Over in Households 1985: Health and Use of Health Services*. Table 18.

- Notes:
- \* Includes European-born persons and a small minority of American and Israeli-born
  - \*\* Persons born in Africa or Asia



Individuals may lack medical insurance for bureaucratic as well as financial reasons. A 1986-87 study of 116 families with children and pregnant women in the town of Or Yehuda who were without complete health coverage found that as fees were incumbent upon the head of the household, defined as the husband, in cases in which husbands could or would not pay, and wives wished to pay, the latter were hampered by bureaucratic or financial obstacles. The researchers noted that those least equipped for coping with the paperwork and intricacies of the bureaucracy, were those required to fill out the most forms and go through the most complicated procedures, and that the problem was not unique to Or Yehuda, but characterized other similar communities (Mizrahi, low-income) as well.<sup>18</sup>

### Differential Health Care Services

Despite the small size of Israel, there are considerable disparities in health service provision: cities and suburban communities have more and better services than peripheral communities, Jews have more than Arabs, and veteran communities more than development towns.

Health care services and personnel, as well as the most advanced technologies and diagnostic equipment, are concentrated in Tel Aviv, Haifa and Jerusalem, and the suburban ring of Tel Aviv. Half of the physicians are located in the Tel Aviv region and in Jerusalem, and 90% of the dentists practice in the three big cities and the suburbs of Tel Aviv (the central district).<sup>19</sup> Residents of the central district and of the big cities have more health care workers of every kind than persons living in the North or South, and there are more hospital beds per 1,000 population in the suburban ring of Tel Aviv than in any other area.<sup>20</sup> With regard to hospital beds (see table below), the inner city of Tel Aviv is slightly better off than the northern and southern districts, but worse off than Haifa and Jerusalem; however, in some cases, residents of Tel Aviv may also utilize services located in the suburban ring.

The central district and Jerusalem have the most psychiatric and nursing care beds; the South, North and central city of Tel Aviv, the least. Again, residents of Tel Aviv sometimes have the option of utilizing services located

**Hospital Beds per 1000 Persons by Districts, 1980**

Type of Bed	North	Haifa	Tel Aviv	Center	Jerusalem	South
Internal	0.38	0.76	0.69	0.93	0.81	0.46
Surgery	0.30	0.52	0.39	0.43	0.63	0.33
Obstet/Gyn.	0.11	0.18	0.12	0.20	0.31	0.11
Pediatrics	0.92	1.11	0.76	1.14	1.28	0.82
Psychiatric	1.22	2.82	1.13	4.50	2.29	0.35
Nursing	0.39	2.62	0.60	3.22	1.04	0.33

Source: Ellenweig et al. 1986. "A Comparative Examination of the Proposed Programs for National Health Insurance in Israel." *Social Security*, April, No. 28, p. 9 (Hebrew).

in the central district.

### Variations in the Quality of the Service

Common complaints about the Histadrut Sick Fund — which services most of the population and charges the lowest fees — include the absence of evening and night service; the lack of specialists in most non-urban communities; the inefficiency of the referral process, including long waiting lines for consultations with specialists, for test results, and for operations; the shortage of medications in sick fund pharmacies, and the lack of dental and various preventive services.<sup>21</sup> Even in Tel Aviv, the wait for a consultation with an orthopedic surgeon may be as long as a month. Other shortcomings include a lack of sensitivity to the patient and to his or her privacy, time, and no freedom of choice in selecting a physician.<sup>22</sup> In Arab communities and Jewish development towns, the problems are much more acute.

Outside of the big cities, disparities exist between different types of communities; development towns, populated mainly by Mizrahi Jews, are on the short end. A basic inequality in service provision between veteran and development towns was revealed in a study of health service provision in 31 development and 24 veteran towns; the researchers found a ratio of 1 primary care physician for every 1,852 persons in the veteran communities, compared to 1 for every 2,326 in the development towns.

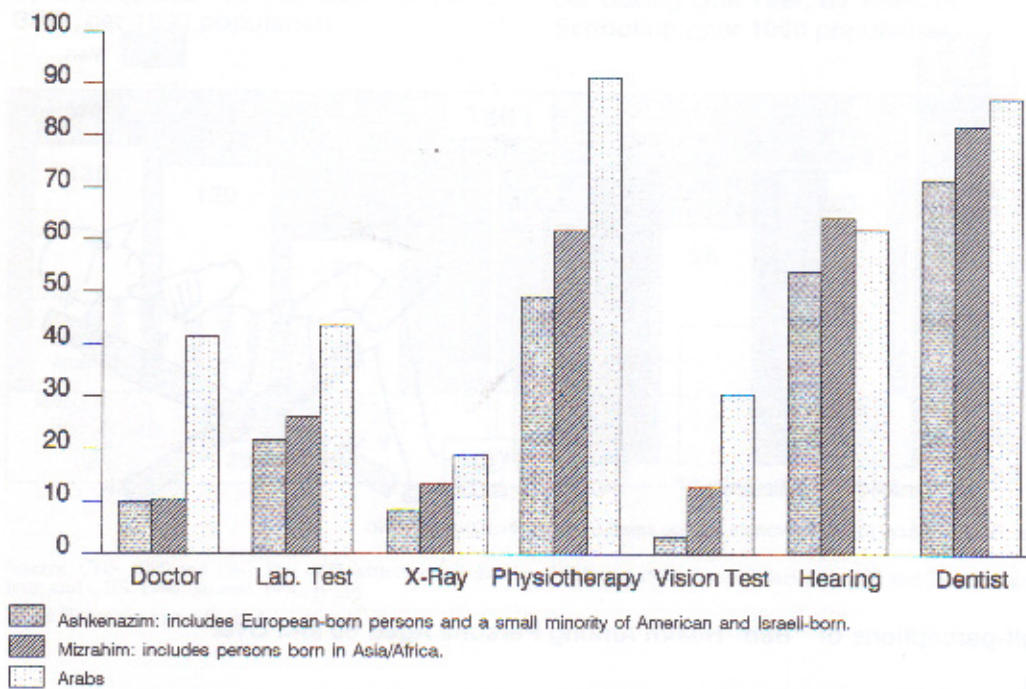
Breast cancer detection centers, occupational health centers, child development stations and cardiac resuscitation units were also less common in development towns (With the sole exception of Nazareth, these facilities are non-existent in Arab towns<sup>23</sup>). Nurses appeared to provide most of the daily care in the smaller towns. Higher ratios of both nurses and pediatricians were found in the development towns.<sup>24</sup>

Although like development towns, kibbutzim are often located at a distance from the big cities, their members are the recipients of high quality health services. All kibbutz members are covered by sick funds; in addition to the regular coverage, kibbutzim finance full dental care, psychiatric care, and the services of specialists for their members.<sup>25</sup> Kibbutzim have more mother and child, curative and dental clinics per 1,000 population than either development towns or cities.<sup>26</sup>

When the need arises, development town residents are referred to hospitals in their region — Eilat, Beer Sheva, Afula, Tiberias, or Safed — where the level of care is lower than in the big city hospitals. Members of remote



## Percentages of Persons Over Age 60 Reporting Elapse of a Year or More Since the Last Utilization of Medical Services



Source: CBS, 1990. *Survey of Persons Aged 60 and Over in Households 1985: Health and Use of Health Services*. Jerusalem. Tables 2, 6, 7, 8, 10, 12, 14.

kibbutzim are referred to the same hospitals, but their chances of having connections that can get them into better hospitals are much greater<sup>27</sup> and the likelihood of their being deterred by economic obstacles much smaller; the result is better care.

### Differential Utilization of Services

Health-promoting behavior depends on socio-economic factors, on the physical availability of services, and on awareness of health issues. Often those who are at greater risk are precisely those who have fewer health care opportunities; the affluent have the alternative of purchasing private services. The utilization of preventive services (with the exception of mother and child clinics) is correlated with socio-economic status.

Development town residents, whose average income and educational level are lower than those of veteran community residents, visit dentists and preventive care facilities less often,<sup>28</sup> probably because of the expense involved and the cultural and physical inaccessibility of the services; lower awareness of health-promoting behaviors may also play a role. Lesser use of preventive services often means fewer opportunities for enhancing one's health; early detection of diseases like cancer and heart disorders saves lives, re-

duces the rate of illness, and increases the quality of life.

Disparities among Ashkenazim, Mizrahim and Arabs in the utilization of services as measured by intervals since the last visit to a physician, the last laboratory test, the last x-ray, the last physiotherapy session, the last hearing and vision test, and the last dental visit were revealed in a 1985 Central Bureau of Statistics nationwide survey of persons aged 60 and over.

In almost every case, the proportion of Ashkenazim who had not used health services for a year or more was lower than that of Mizrahim and Arabs; the highest proportion not receiving health care for at least a year was generally found among Arabs (See table at top).

Infrequent use of health services does not necessarily reflect better health; the same survey found that Ashkenazim were the most likely to perceive their health as "good," and Arabs the most likely to view their health as "bad." Women consistently reported less good health and more poor health, with Arab and Mizrahi women the least likely to report "good health" and most likely to report "bad health" (see graph on page 6).

Breast cancer is the second leading cause of death among Israeli women. Since early de-

A case study of the health care delivery system in the development town of Kiryat Shemona found that curative services were characterized by low quality and by a long wait for a physician. The researcher attributed the low level of medical care to high turnover and to the fact that the physicians staffing the clinics (none of whom resided in the town) were young, inexperienced general practitioners or doctors who could not find employment anywhere else.<sup>29</sup> She also noted a shortage of specialists, especially pediatricians, dentists and child psychiatrists, and too infrequent visits of others — cardiologists, ophthalmologists and dermatologists. Thus, persons needing specialists, including urgent cases, had to wait from two weeks to three months for an appointment. In the town's family planning clinic, the wait for a physician was three months.

As a result of the heavy workload, the physicians had neither the time nor the patience to give patients proper attention: "In one clinic it is a known fact that the doctor receives patients at the rate of one every two minutes and that he prescribes antibiotics on the spot." This situation was exacerbated by the fact that the doctor was usually Ashkenazi and the patient Mizrahi; the former neither understood nor respected the latter.<sup>30</sup>

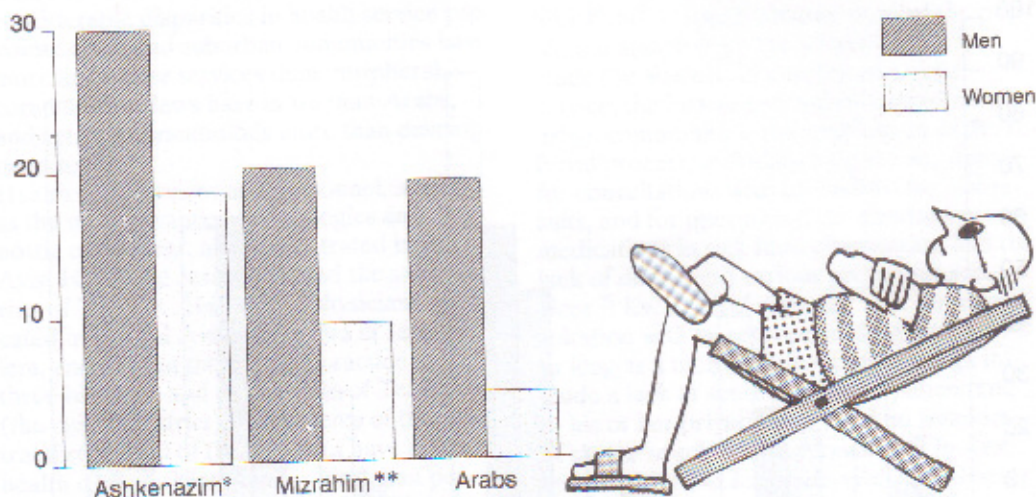


All Jewish development towns, but as has been noted, not all Arab towns, have at least one mother and child preventive clinic and one general curative clinic. If the service provided is of poor quality — residents are stuck with it, unless they have the means to obtain private services elsewhere.

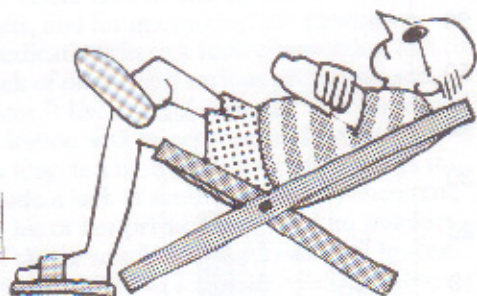
Indeed, Greenberg reports that most educated and affluent residents of Kiryat Shemona avoid the local clinic, either because they refuse to sit for long hours awaiting their turn, or because they have no confidence in the attending physicians.

If the matter is urgent, they go either to the local Magen David Adom Emergency Station (after first ascertaining which doctor is on duty), or to a doctor at one of the neighboring kibbutzim or to Safed, on a private basis. When they have serious health problems, they pull every possible string to see a physician in one of the major urban hospitals.<sup>31</sup>

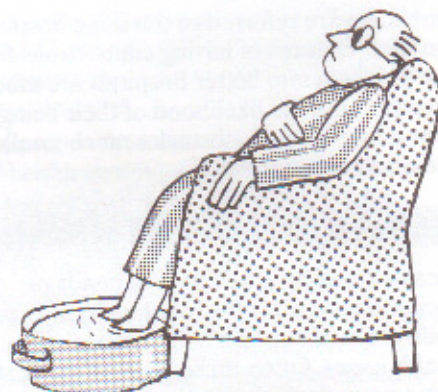
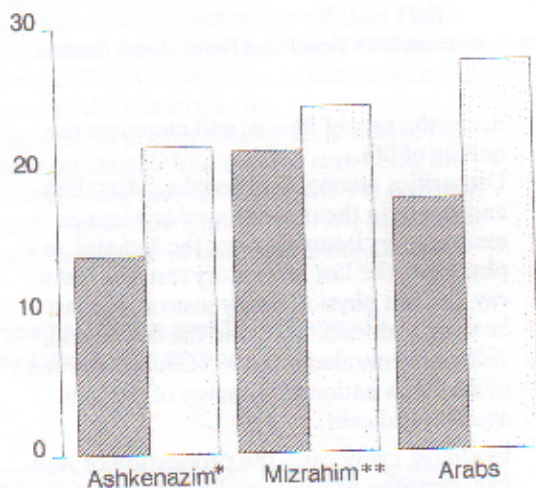
### Self-perceptions of "Good" Health Among Persons Aged 60 and Over



Note: The numbers for Arab women are too small to make the figure reliable.



### Self-perceptions of "Bad" Health Among Persons Aged 60 and Over



Source: CBS, 1990. Survey of Persons Aged 60 and Over in Households 1985: Health and Use of Health Services. Jerusalem. Table 1, pp. 52, 54, 56.

Notes:

- \* Includes persons born in Europe/America and a small number born in Israel.
- \*\* Persons born in Asia/Africa

tection and treatment greatly increase chances for survival, breast examinations constitute an important element of health care for women. The table on page 7 indicates that between 1977 and 1981 women's awareness of the importance of breast examinations increased considerably. However, the gap between Ashkenazim and Mizrahim remained stable, as did the gap between women with different levels of education.

### Primary v. Secondary Care

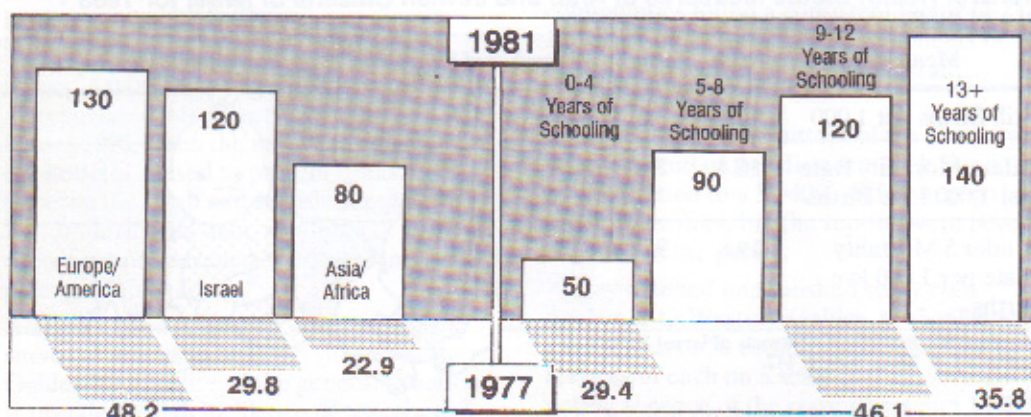
The World Health Organization goal of Health for All by the Year 2000 focuses on the improvement of primary health care, in an attempt to reverse the European trend of increasing expenditures on hospitals and decreasing investments in primary care.

In Israel, the proportion of the national expenditure on health devoted to primary care



**Jewish Women Aged 20+ Visiting Centers for Early Detection of Breast Cancer During One Year, by Continent of Birth, per 1000 population**

**Jewish Women Aged 20+ Visiting Centers for Early Detection of Breast Cancer During One Year, by Years of Schooling, per 1000 population**



Source: CBS. 1980 and 1983. *Use of Health Services Survey, 1977 and 1981*, Special Series No 639 and 717. Jerusalem; and CBS. 1988; Shuval. 1990. p. 295.

Note: Rates are age-adjusted.

has been in slow but steady decline, from 38.3% in 1962-3 to 31.9% in 1988-9, while the outlay on hospitals and research has grown, from 35.3% in 1962-63 to 40.4% in 1988-89, due primarily to the expansion of expensive high technology medicine (see table at bottom right).

In Israel primary care services have much lower status than hospitals, and the quality of health care is higher in the latter; hospitals have more and better equipment and employ doctors with higher qualifications. Hospital employment is more prestigious and more remunerative, due, among other things, to better wage agreements and the opportunity to work overtime. Thus it is not surprising that Israeli medical school graduates prefer to work in hospitals, and that physicians who immigrated to Israel in the 1970s and 1980s, a high proportion of whom were neither officially licensed or specialists, found positions mainly in community clinics. In fact, it was Histadrut policy to absorb as many immigrant physicians as possible into its primary care clinics.<sup>32</sup> Sick fund members, well aware of the differences in quality, often circumvent clinics by going directly to hospital emergency rooms for treatment. A recent decision by the sick funds not to reimburse members for such treatment is an effort to curtail the practice.

Since in development towns, sick fund clinics constitute the major medical service, one

might expect them to be larger than big city clinics; however, according to data collected by the Ministry of Health, in 1978 urban clinics had an average of 2.35 more rooms than development town clinics, and three times as many general practitioners, while the population of the big cities was only twice that of the development towns.<sup>33</sup> ■

**Percentage of National Expenditure Devoted to Public Clinics and Preventive Medicine, and to Hospitals and Research.**

Year	Clinics and Preventive Medicine	Hospitals and Research
1962-63	38.3	35.3
1965-66	38.4	35.0
1972-73	34.1	34.1
1975-76	28.6	33.9
1982-83	29.7	42.0
1985-86	32.5	42.7
1988-89	31.9	40.4

Source: CBS. *Statistical Abstract of Israel 1991*. Table 24.1, p. 677.



In contrast to other preventive services, mother and child clinics are frequented more by uneducated women than by educated ones,<sup>34</sup> who probably rely more on their sick fund pediatricians and gynecologists, or opt for private services.

A recent survey of 320 Arab women giving birth in 7 hospitals in the Acre district found a different pattern: not only did Christian women (whose general educational level is higher than that of Druze or Muslim women) consult more with private doctors; they also paid more visits to mother and child clinics.<sup>35</sup>

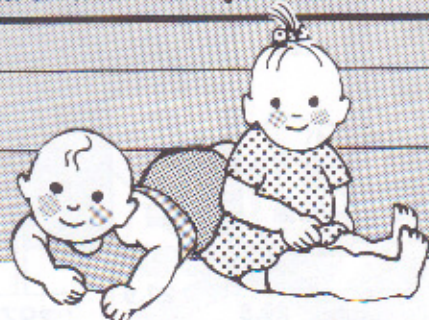


# A Closer Look at the Health of Arabs in Israel

Sanitation is a vital environmental determinant of health. Yet there are fewer than a dozen Arab communities with proper sanitation systems,<sup>36</sup> the most visible result of which is sewage flowing in the streets. This is in clear contrast to a specific target set in the Ministry of Health National Health Policy Plan: connecting all homes in Israel to proper sanitary installations by 1995. The inequitable distribution of budgetary allocations to Jewish and Arab local authorities is well documented and reaches relative ratios of 3-5:1 in favor of Jews, after having undergone considerable improvement in recent years.<sup>37</sup>

**General Health Status Measures of Arab and Jewish Citizens of Israel for 1988**

Measure	Arab	Jewish	Number of lives saved each year if levels were equal*
Still Births per 1,000	10.1	3.6	174
Infant Mortality Rate per 1,000 Live Births	16.4	7.6	236
Under 5 Mortality Rate per 1,000 live births	19.8	9.0	290



Source: CBS, Statistical Abstracts of Israel 1990, Tables 3.1, p. 101-5; 3.29, p. 142.

**Notes:**

\* Calculated by taking the difference between the 2 rates and multiplying it by the absolute number of live births, divided by 1000.

All figures are rounded to nearest decimal.

Arab citizens of Israel exhibit the lowest health status and enjoy the fewest health services. The above table compares the infant mortality rates, the under-5 mortality rates and the stillbirth rates for Arab and Jewish infants and children.

The combination of higher ratios of still births, infant mortality and under-5 mortality, and the higher fertility ratio among Arabs gives the Arab sector of the popula-

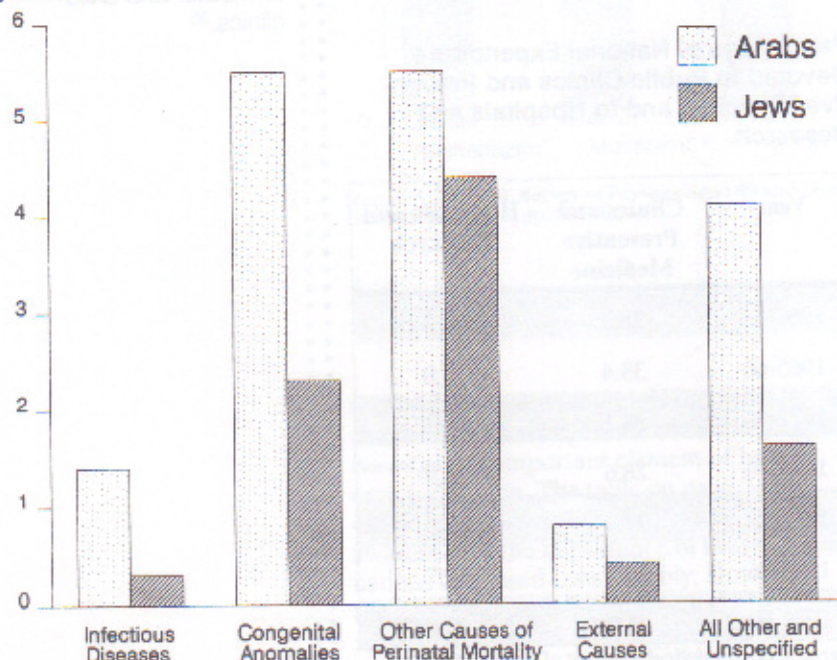
tion a much larger share of young casualties. In 1988, for example, 51% of all stillbirths, 41% of all infant deaths and 42% of all deaths of children under 15 years old in Israel were Arabs.

An analysis based on infant mortality data for 1977-80 found a clear relationship between socio-economic level, as measured by father's occupation, and infant mortality among Arabs. Other factors that were found to increase the risk of infant deaths were maternal age under 20 or over 35, and low maternal education. No association was found between birth order (4+ is considered a risk factor) and infant mortality.<sup>38</sup>

A more detailed consideration of the infant mortality figures (see table on the right) indicates the disease patterns of the two groups. Unlike other causes, the higher rate of mortality from congenital anomalies among Arabs has been ascribed to the interaction of genetic factors with cultural preferences for intrafamily marriages.<sup>39</sup> The highest relative risk of infant mortality among Arabs is from infectious diseases, a cause that is largely preventable.

Although disease-specific rates are no longer published for all age groups, episodal information indicates that certain diseases are more common and less well treated in the Arab sector. An outbreak of measles in the Negev in the winter of 1990-91 led to hundreds of hospitalizations of Bedouins, especially children and young adults, and resulted in 9 deaths. Those deaths, occurring among Arabs only, point to extreme inequi-

**Infant Mortality Rates of Arab and Jewish Infants per 1000 Live Births by Cause, 1985-1988**



Source: CBS, Statistical Abstracts of Israel 1991, Table 3.32, pp. 148-9.



tics in the level of health care, as well as in the entire life experience of the Bedouin community of the Negev: deaths from measles are the outcome of lack of immunization, poor nutrition and poor access to or inadequate health facilities.

The excessive rate of infectious disease among Arabs was a regular feature of almost all reportable infections (except for malaria) before 1990, when the monthly **Epidemiological Bulletin** ceased to present breakdowns between the Arab and Jewish populations. As for nutritional data, a number of surveys show a preponderance of anemia and rickets among Arab children.<sup>40</sup>

Although conducted over a decade ago, a survey of infants in an Arab village in the Galilee is indicative of the general situation. It revealed a high incidence of anemia and signs of rickets in 6 out of 10 infants aged 4-12 months.<sup>41</sup> A more recent study of Negev infants found anemia in 1/2 of the Jewish and 3/4 of the Arab infants examined; it is notable that the Jewish towns in the sample had a high preponderance of residents of low socio-economic status.<sup>42</sup>

### Health Services in Arab Communities

A 1985 study comparing the curative and preventive services to 8 Arab and 8 Jewish communities found a consistent factor of 2 to 1 in favor of the Jews in all components of the system: doctors, nurses, total staff, rooms, and clinics.<sup>43</sup>

Special internal committees of the Ministry of Health and of the Histadrut Sick Fund later admitted to a 30-40% difference in the levels of services, but the reports were never released to the public.

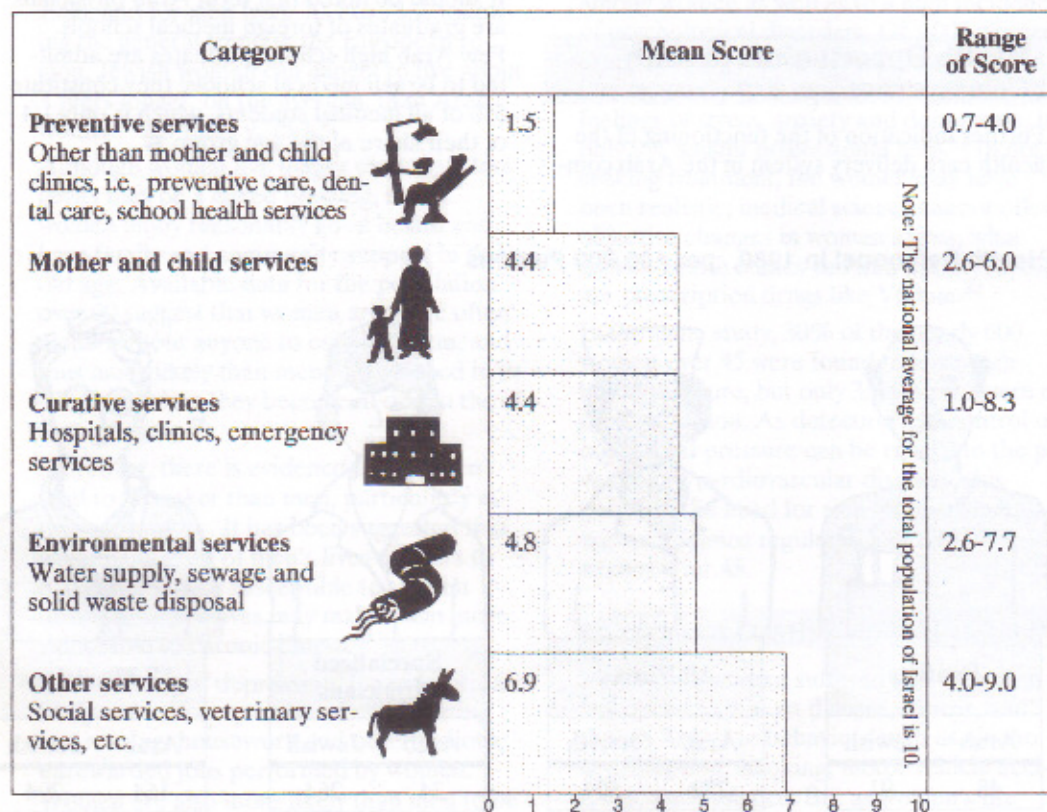
A very detailed unpublished study conducted in 13 Western Galilee Arab villages gave scores to 50 components of the health services in each on a scale of 0-10, zero denoting absence of the component and 10 denoting its being at the average national level. The scale assigns a score of 10 to the national average for the total population of Israel, thus by definition giving a score of greater than 10 to the level of service of each component in Jewish communities. The inequity factor ranges from about 1.5:10 to 7:10 (see table below).



In Umm el Fahm, a city of 27,000, 30% of the residents are not connected to the sewage system. The Histadrut Sick Fund, which has 18,000 members in the city, sends a surgeon only twice a week for half a day. The Fund's 2 clinics have only 3 pediatricians, despite the large number of children; 1 gynecologist during whose absences no replacement is sent; no ear-nose-and-throat specialist, cardiologist, neurologist, ophthalmologist or urologist.

There are no evening or weekend services and there is only 1 ambulance driver. Mental health services, a child development center, genetic counselling services, x-ray, scanners and ultrasound devices are also lacking. Persons needing these services are referred to the hospital in Hadera, 20 kilometers away. While electrocardiograms are performed and blood and urine samples taken in the local clinics, they, too, go to Hadera for diagnosis.<sup>44</sup>

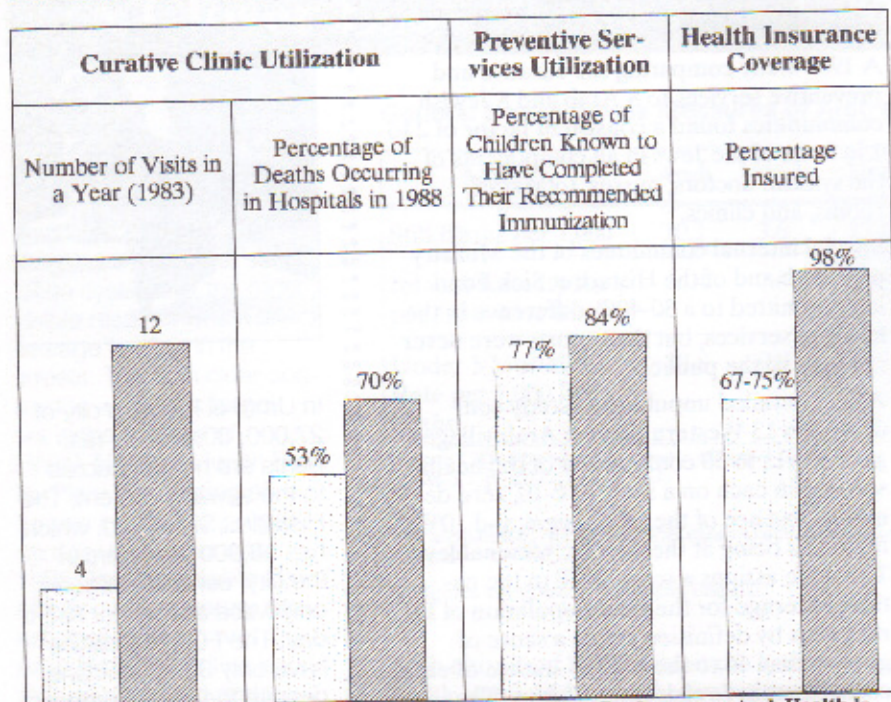
### Scores of Health Services in 13 Arab Villages



Source: Kanaaneh, D. 1988. A Descriptive Survey of Health Services and Related non-Health Services of 13 Arab Villages in the Galilee. Thesis for the Degree of Master of Public Health, Hadassah School of Public Health, Jerusalem.



## Health Service Utilization



Sources: Kanaaneh, Hatim et al. 1987. *Proceedings of the First Conference on Arab Health Issues*. Ramat Galilee Society for Health Research and Services, p. 71 (Arabic); CBS. *Statistical Abstract of Israel 1991*, Table 24.12, p. 685; Ministry of Health Immunization Report, 1990; Kanaaneh, Hatim. 1990. Testimony on behalf of the Galilee Society for Health Research and Services before the Netanyahu Commission.

Note: All figures rounded to nearest whole number.

□ Arabs  
■ Jews

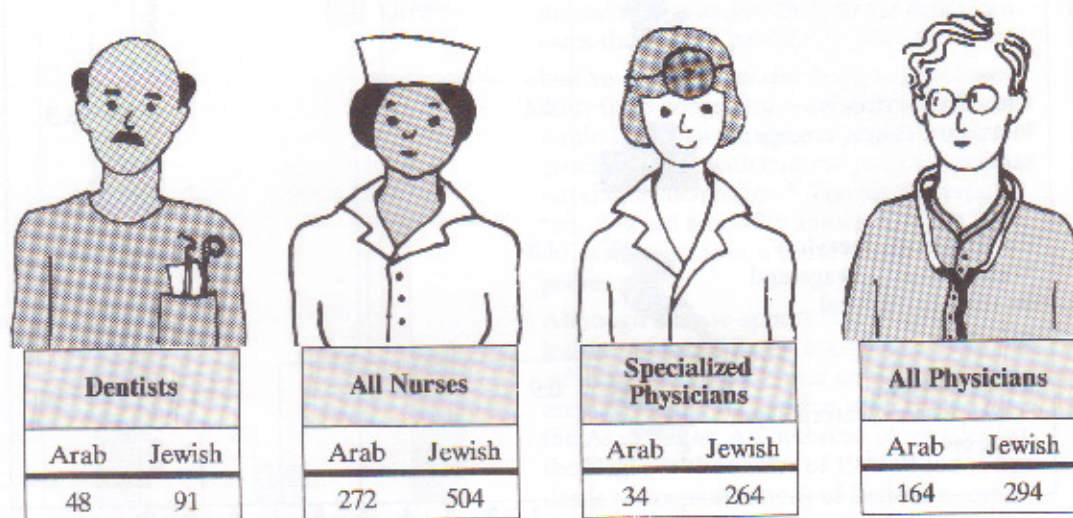


The Israel Ministry of the Interior refuses to grant formal recognition to some 110 Arab villages. This means that about 50,000 Arab citizens of Israel are outside the parameters of the public health care delivery system. Several of those villages lack not only health care services, but also drinking water.

### Health Opportunities in Arab Communities

Further indication of the functioning of the health care delivery system in the Arab com-

### Health Personnel in 1989, per 100,000 Persons



Source: Kanaaneh, Hatim. Paper presented at the Second Conference on Arab Health Issues, held in Nazareth in October 1991. The Proceedings are in preparation for publication in Arabic.

munities can be gleaned from the level of service utilization.

As the table on the left shows, the average number of visits to a sick fund curative clinic is 3 times higher for Jews than for Arabs: 12 visits per year, compared with 4. While it has been noted that Jews tend to overuse curative clinics, which in some cases serve social as well as medical functions,<sup>45</sup> the difference is nevertheless indicative of the relative accessibility of clinics for citizens living in Jewish and Arab communities.

The disparity in the percentage of deaths occurring in hospitals, 53% for Arabs, compared with 70% for Jews, is not necessarily indicative of a cultural preference for tending the ill at home; research indicates that among Arabs, the small demand for nursing care beds for the aged is related to the lack of availability and accessibility of such services, and that the distance between hospital and home and cultural inappropriateness are what render existing services inaccessible.<sup>46</sup>

Of even greater value to a community in terms of its ability to meet its own health needs and actively participate in controlling them is its human resources in health care. The table below compares the number of medical practitioners in the two groups.

It should be noted that most Arab physicians are graduates of foreign medical schools. Few Arab high school graduates are admitted to Israeli medical schools; they constitute 5% of all medical students, which is only 1/4 of their share of the age group. ■



# Major Issues in Women's Health

The health of women is affected not only by their socio-economic status and the quality and availability of health care services, but also by the nature of the encounter between client and physician. This is all the more so because many female life cycle events that were once considered natural and inevitable have become "medicalized" or redefined as grounds for medical intervention, even if they do not involve disease in any medical sense: childbirth, menstruation, contraception, fertility, pre- and post-natal care and menopause.

Thus women have become dependent on doctors when they are healthy as well as when they are sick, while men come into contact with the medical system primarily when they are ill. Moreover, it is women who utilize the health care system most frequently — as the "brokers" between family members and medical institutions.

## Health Status Indicators for Women

Life expectancy for Israeli women has risen from 73.2 years in the early 1970s to 77.5 in 1988, and for men from 70.1 to 73.9, following the general trend in the European region. Jewish women can expect to live about 3 years longer, on the average, than Arab women: 78.0 years v. 75.1.<sup>47</sup>

Although women live longer than men, longevity may be a mixed blessing, unless women enjoy reasonably good health and have family and community support in their old age. Available data for the population over 60 suggest that women are more often alone without anyone to care for them, and thus more likely than men to be placed in institutions when they become ill due to the effects of aging.<sup>48</sup>

Moreover, there is evidence that women tend to be sicker than men, particularly as they grow older. It has been suggested that while the nature of men's lives appears to make them more susceptible to sudden death, women's lives may make them more vulnerable to chronic illness.<sup>49</sup>

Exhaustion and depression, for example, are likely to be consequences of childbearing and rearing, housework and other tedious, unrewarded jobs performed by women. Women are also more likely than men to be raising families alone or living on their own due to divorce or widowhood, and they bring

home lower wages than men for the same work. These factors contribute to higher rates of poverty and higher risks of illness.

The tendency of women to be sicker than men, particularly as they grow older, is supported by a longitudinal study of 360 married couples over a 10-year period conducted in Jerusalem.<sup>50</sup> In 1965, ill health resulting in some functional limitation was observed for twice as many husbands as wives in families classified as fully or partially "deprived."

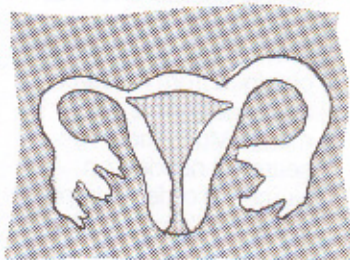
Ten years later, the women reported a 350% increase in illness, compared to 58% for men. Moreover, the women were characterized by greater multiplicity of illness. The factors cited by the women most often as contributing to illness were frequent pregnancies and childbirth. Other factors were the lasting side effects of previous illnesses and surgery, and family and household stress. In other words, chronic illness was associated with women's biological and social roles.

A recent survey conducted by the Histadrut Sick Fund also points to multiple illnesses among women as well as to a high incidence of psychological disorders. Of 1,000 women examined, 1/4 suffered from 2-5 symptoms of illness; nearly 40% reportedly experienced feelings of stress, anxiety and depression, but only 9% sought professional help.<sup>51</sup> In not seeking treatment, the women may have been realistic; medical science cannot offer objective changes in women's lives; what mental health clinics can and usually do offer are prescription drugs like Valium.<sup>52</sup>

In the same study, 30% of the nearly 600 women over 45 were found to have high blood pressure, but only 35% were aware of their condition. As detection and control of high blood pressure can be crucial to the prevention of cardiovascular diseases, this points to the need for sick funds to encourage and finance regular check-ups for women over 45.

## Causes of Death

In the past, women suffered less than men from coronary heart disease, cancer, and threats linked to behaviors such as alcohol consumption, smoking, motor vehicle accidents, and violence. But as women's life styles have come to resemble men's, they have also become increasingly vulnerable to



Modern medicine tends to view women's reproductive organs as mechanical systems in need of maintenance by medical experts,<sup>64</sup> while the family, clan or state often perceive them as subordinate to the collective goals of population growth or decrease. For Jewish women in Israel, family planning is underdeveloped and fertility treatment overdeveloped. The abortion laws are liberal, but they fall short of abortion on demand and are under constant threat of erosion.

While hysterectomies are not performed at the excessive rate they are in the United States (the figures for 1986 are 75 per 100,000 for Israel, compared with 280 per 100,000 for the U.S.<sup>55</sup>), the tendency of Israeli medical practice is to consider female sexual and reproductive organs expendable once their reproductive functions have been fulfilled. For women over the age of 45, hysterectomy involves the routine removal of the fallopian tubes and ovaries, even if the latter are healthy, despite their contribution to female sexuality and well-being.



Despite differences in the etiology of heart disease in women and men, most clinical decisions for managing heart disease in women are based on data obtained from research and clinical trials with men.<sup>56</sup> Much more research is needed on women in order to improve diagnosis, early treatment and, above all, preventive care.

- some of the same causes of death.<sup>53</sup>
- For Israeli women as well as men, cardiovascular (heart) disease, cancer and cerebrovascular disease (stroke) are the principal causes of mortality.
- Heart disease, accounting for 47% of all female deaths, is the leading cause of death for both Jewish and Arab women; cancer is the second leading cause among Jewish women and the third greatest killer of Arab women.
- Mortality rates for heart disease and cancer have been rising among Arab women.<sup>57</sup>
- **Heart Disease**
- Israeli women are more likely than men to die after their first heart attack or during heart surgery, they show poorer recovery

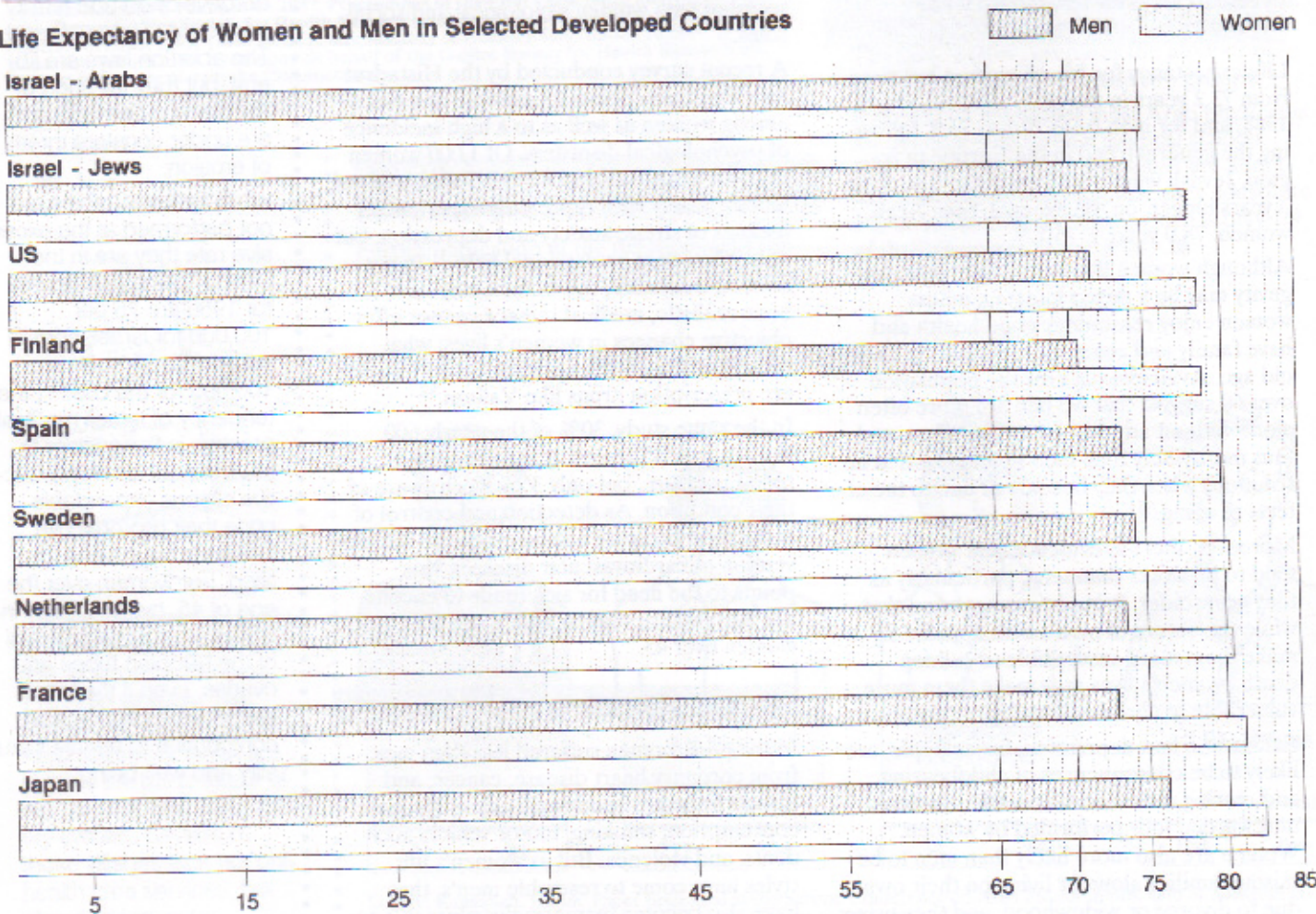
rates following surgery, and they are slower to return to normal routine.<sup>58</sup> Doctors often argue that this is because heart disease affects older women. But the trends also lend support to a growing body of American research that attributes gender differences in mortality to the fact that physicians often ignore early signs in female patients, whom they believe are protected against the disease by female hormones.<sup>59</sup>

Thus doctors may not treat women's symptoms with the same seriousness they do men's. If a man complains of chest pains, he is immediately sent to the treadmill; women with the same complaint are not usually referred for tests.

Although women outlive men almost everywhere, it is notable that the difference in life expectancy at birth between Israeli men and women is small relative to that found in many other developed countries: 3.8 years for Jews, and 2.7 years for Arabs, compared with an average of 7 years, as shown below. In fact, the life expectancy of Israeli women is rela-

tively low, ranking 19th in the 1990 WHO World Health Statistics Annual survey of 29 countries in the European region, compared with men, who rank 6th in longevity, raising questions such as: Are Israeli men in better health than men elsewhere, or are Israeli women in relatively worse health? The answers are unknown.

**Life Expectancy of Women and Men in Selected Developed Countries**





As a result, opportunities for preventive care and early treatment may be missed, and by the time women receive treatment, they are generally sicker than men.

Although women are most likely to develop heart problems in their 50s and 60s, those in their 40s are not immune. The increasing incidence of heart disease, particularly among younger women in developed countries, has been attributed to increased cigarette smoking — a major cause of heart disease in men.

Another potential risk factor, found more commonly in men than in women, is the behavior pattern characterized by aggressiveness, competitiveness, hostility, a chronic sense of time urgency, and a strong drive to achieve.<sup>60</sup> Thus, a contributing factor to the increased mortality of women from heart disease in Israel may be that their life style is becoming more like men's.

An additional factor that increases the risk of heart disease is the oral contraceptive pill, if taken by women who suffer from high blood pressure, high cholesterol, or liver disorders, or if taken by those over 35. The risk of heart disease is also significantly higher if contraceptive pills are combined with smoking.

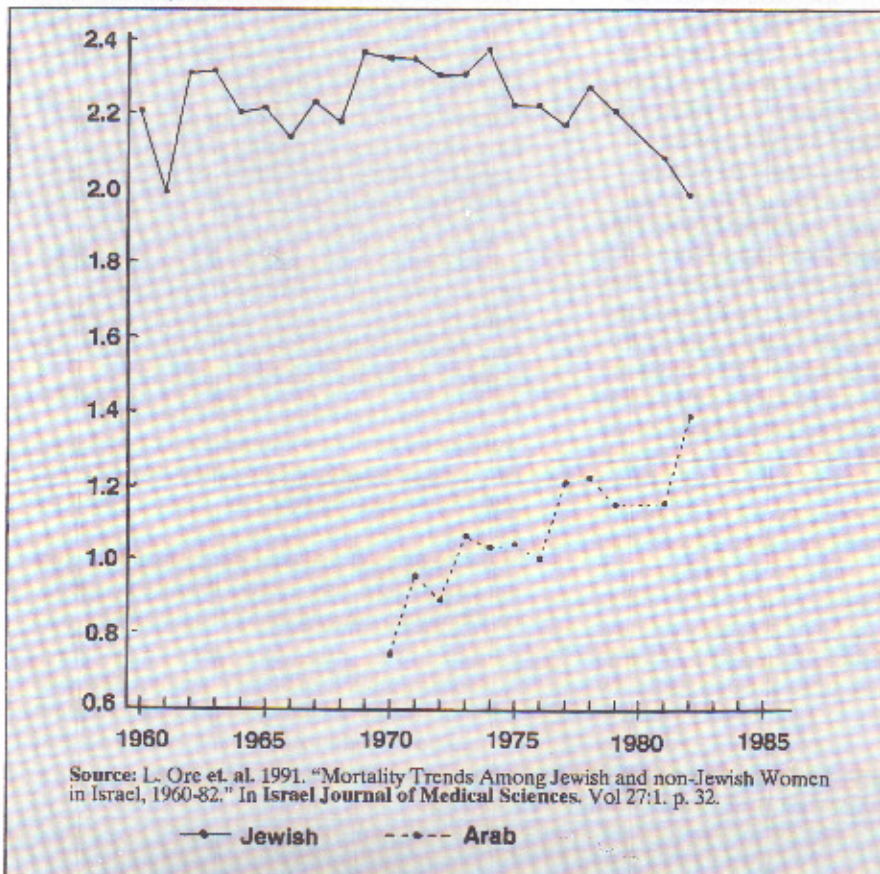
Finally, as in other forms of illness, social support and a sense of belonging play an important role in prevention as well as recovery from heart disease, while loneliness, isolation and lack of support from significant others increase the risk factors. The evidence is that women are more likely than men to be without a spouse when illnesses occur.

### Cancer

Although mortality due to cancer is higher for men than for women in most countries and over most of the age span, in Israel the situation is different: Israeli women under 55 are more likely than men to die of cancer, and the rate of new cancer cases detected in younger women is over 50% higher than in men.<sup>61</sup> Much of this difference is accounted for by the high incidence of breast cancer, which, together with uterine and cervical cancer, represent 50% of all cancers found in women under 55.

While in the early 1970s, one out of every 13 women could expect to develop breast cancer sometime during her life, in the 1990s the odds are 1 in 10. Although Ashkenazi women are at higher risk (70 cases per 100,000 persons per annum in 1977-81), than Mizrahi women (43 cases per 100,000), most of the increase among Jewish women is due to rising rates among Mizrahim.

### Age-Adjusted Mortality Rates per 1000 from Cancer in Jewish and Arab Women, 1960-82.



Arab women are far less likely than Jewish women to develop breast cancer (14 per 100,000), but the incidence of cancer is rising more rapidly among Arab than among Jewish women.<sup>62</sup> Moreover, mortality rates from all types of cancer, which were 3.2 times higher among Jewish women in 1970, were only 1.4 times higher in 1982.<sup>63</sup> (see above graph).

Diets rich in fruits, vegetables and cereals, as well as low age at first birth, are known to decrease the risk of breast cancer, while fat intake, alcohol consumption, and obesity increase the risk. Thus the rise in the incidence of breast cancer and the different mortality rates among population groups may be associated with variations and changes in diet and fertility. It has been suggested that mortality from breast cancer is associated with exposure to environmental pollutants, such as those pesticides and other toxins which accumulate in fat tissue.<sup>64</sup> Despite the incidence of breast cancer among women in Israel, there is little public and professional awareness of the importance of early detection.

Between 1975 and 1986, the death rates of Israeli women from breast cancer dropped 8% overall and 34% for women aged 25-34, while age-adjusted death rates in all Western countries rose by as much as 45%. The decrease in Israel occurred despite a rise in known risk factors, and despite the reduced intake of fruits, vegetables and fiber. Westin and Richter suggest that this decrease may be due to an abrupt drop in residues of organochlorine pesticides in breast and cow milk, following the ban on their use; organochlorines act to promote cancer after initial exposure has occurred.<sup>65</sup>





The Israel Cancer Association operates centers for manual breast examinations, but these facilities are underused and poorly advertised.<sup>66</sup> In 1981, only about 10% of Jewish women over 20 availed themselves of these services, primarily better-educated, Ashkenazi or Israeli-born women.<sup>67</sup> Physicians who study in Israel receive no specialized instruction in the technique of breast examinations during their professional training.<sup>68</sup>

Mammography, an x-ray technique that provides specialized pictures of the breast, is the most reliable method for detecting small tumors, years before they can be felt by self-examination or by a physician. Studies conducted in Europe and the U.S. have shown that screening asymptomatic women reduces mortality from breast cancer by 30-50% among women over 50.<sup>69</sup> However, in Israel doctors do not routinely perform breast examinations, nor do they usually refer women over 50 for mammograms unless a lump or breast change is suspected. As a result, the 37 locations where low-dose mammography is available have been underused. Despite the prevailing notion that Jewish women are somehow immune to cervical cancer, each year some 80 new cases are detected and 20 women die from the disease, with the highest frequency among those over 55. Women over 55 are also more prone to uterine cancer; the risk for this disease is significantly higher among Ashkenazi Jewish

women than among Mizrahi women. Some 200 cases are detected annually and close to 80 women die.<sup>70</sup>

The question arises whether more women could be saved if pap smears and other programs for early cancer detection were routinely carried out among women in high risk age or ethnic groups. Pap smears are simple, painless tests that can detect precancerous changes in the cervix years before most cancers develop. Research in other countries<sup>71</sup> has shown that screening of women between the ages of 30 and 49 reduces incidence and mortality by 30-40%.

The battle against cancer requires tremendous emotional and psychological resources. Research points to the crucial role of family support in the recovery process. However, there are indications that the support provided by women when their partners undergo cancer treatment exceeds the level of support they themselves receive from spouses when they require treatment.<sup>72</sup>

### Cerebrovascular Disease

This is the third highest cause of death among Israeli women, accounting for some 165 deaths per 100,000 among Arab women and 119 per 100,000 among Jewish women in 1982 (see table on the left). High blood pressure, more common among women than men, is an important contributing factor, particularly for Arab women, who consistently exhibit higher rates of mortality than Jewish women, and for Mizrahi Jewish women.<sup>73</sup>

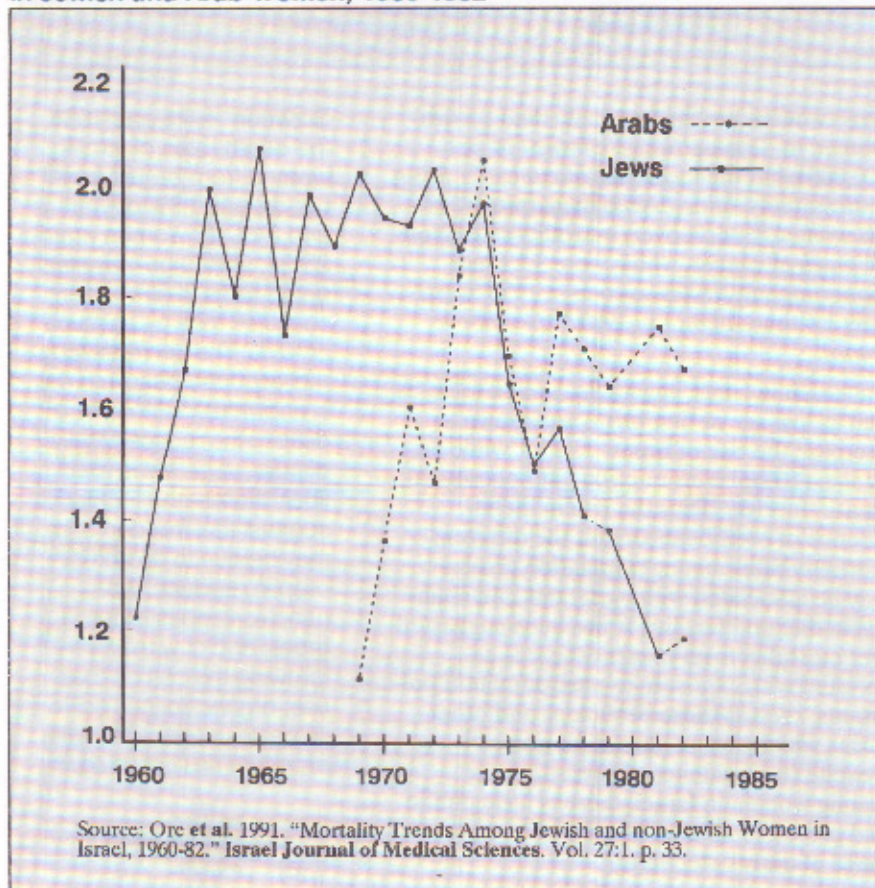
High blood pressure is often associated with nutrition based on fats and sugars and with psychosocial stress; genetic factors may also be involved.<sup>74</sup>

### Violence

Violence is now recognized as a major factor in women's health, and the home as the most frequent site of violence. In 1991, 35 Israeli women died at the hands of men; 25 were killed by a family member. Commentators tend to pin the blame on the Gulf War and to view the violence as the result of male frustration at being stuck on the home front.

Although it is true that many of the assaults occurred during and after the war, statistics point to a trend of increasing violence in recent years. In 1990, no fewer than 27 women were killed, 22 of them by a family member. Many other Israeli women are victims of assault or survivors of domestic violence, incest and rape.

**Age-Adjusted Mortality Rates From Cerebrovascular Disease in Jewish and Arab Women, 1960-1982**





## Reproductive Issues

In Israel, concern over differences in Arab and Jewish birthrates, euphemistically referred to as "the demographic problem," as well as the Orthodox religious establishment's opposition to birth control, have given rise to pro-natalist policies, including anti-abortion laws, child allowances, housing subsidies, and numerous other benefits for families "blessed with children," the Israeli term for large families.

In the 1950s, the government offered cash prizes for women bearing their 10th child (as the primary beneficiaries were Arab women, the program was quietly discontinued in 1959). In 1967, Prime Minister Levi Eshkol established a Center for Demography mandated with "encouraging and stimulating natality."<sup>75</sup>



In keeping with the pro-birth climate, inexpensive pre- and post-natal care is provided through a nationwide network of mother and child clinics. In vitro fertilization, an expensive and highly technological service, is also available (to married women who have not gotten pregnant after trying for a year) at no fewer than 20 IVF clinics. Israel has the highest population/IVF clinic ratio in the world. In the U.S., for example, there is one clinic per 4 million inhabitants.<sup>76</sup>

In contrast, comprehensive family planning has remained conspicuously absent from primary public health care. Family planning clinics are not an open, institutionalized part of the health care delivery system; sick funds do not offer reimbursement for contraceptive prescriptions or devices.

Despite the lack of comprehensive family planning services and the prohibition against

abortions for other than medical reasons prior to 1977, the Jewish birth rate has decreased dramatically, primarily due to a steep decline among Mizrahi women, from an average of 6.3 children in 1950, to 4.0 in 1970 and close to 3.0 today.

Fertility among Ashkenazi women has remained fairly constant over the last decade, at around 2.8. In the absence of modern birth control methods, it may be assumed that fertility was controlled in the 1950s and 60s by illegal abortions. In contrast, the birth rate among Muslims increased during the same period as a result of improvements in health care and reductions in infant mortality.<sup>77</sup>

### Abortions

Research in the 1970s revealed a high dependence among Jewish couples on relatively ineffective methods of contraception, with backup abortions when necessary.<sup>78</sup> An estimated 20,000-30,000 abortions were performed annually, or approximately 1 for every 2 live births — the same as the abortion rate in New York City.<sup>79</sup> The performance of abortions by physicians in their private clinics was also common practice.

An increased demand for abortions is predicted for the coming years, due to the recent wave of immigration from the Soviet Union, which in 1990-1991 included 90,000 women of childbearing age. Given their preference for small families and the economic difficulties they face, it is unlikely that the new immigrants will adopt Israeli childbearing norms. Sabatello estimates that these factors will produce an increase of about 30% in abortion requests by the mid 1990s.<sup>80</sup>

### Family Planning

Women interested in contraceptives usually request them from sick fund gynecologists, who routinely prescribe pills for women who have not given birth and fit IUDs for women who have. Physicians do not ordinarily counsel women about contraceptive alternatives; more often than not, they have had little or no training in the field. Among gynecologists there is a definite bias in favor of pills and IUDs over barrier methods. Since contraception is not regarded as an essential service, women must bear the expense of pill prescriptions or IUD fittings. Women who can afford to pay a private doctor often do so for what they consider better quality service, but even private visits do not usually include counseling about the options available and the importance of fitting of birth control methods to individual needs.

De facto abortion arrangements were legitimized in 1977 by an amendment to the abortion law which permitted termination of pregnancy if carried out in a recognized institution and approved by a Committee for the Termination of Pregnancy. These Committees, made up of medical specialists and social workers, were authorized to approve abortions if (1) the woman was under 17 or over 40, (2) the pregnancy was the result of rape, incest or relations out of wedlock, (3) the foetus might be physically or mentally handicapped, (4) continuation of pregnancy might cause physical or mental harm to the woman, or (5) it might have negative consequences for the woman or her family due to social conditions, including the number of children in the household. While a coalition agreement between the Likud and the religious parties led to the 1980 repeal of the controversial fifth "social clause," it did not affect the number of legal abortions performed — 14,500-17,000 annually, or 15-17 per 100 live births since the late 1970s.<sup>81</sup>



There is no ideal method of contraception; each involves some risk of pregnancy, side-effects and contraindications, but bringing these to women's attention is not usually part of the service in Israel. Women's complaints of pain, spotting, or excessive menstrual bleeding after IUD insertion are often minimized, and alternatives are not ordinarily suggested.<sup>82</sup>

• Since the late 1970s and early 1980s, a number of family planning services have been launched on the local level by municipal public health departments, mother and child clinics, hospitals and private organizations, primarily in the large urban areas.

• In Jerusalem, family planning services are offered at 10 out of the 30 mother and child clinics operated by the municipality; in Tel Aviv, at 6 such locations. However, these services are no more than "IUD clinics." A number of so-called Family Planning Clinics are found at major hospitals, but they are sporadic, poorly integrated into the general health care system, and not widely publicized. Several community-based services have been set up by voluntary associations.

• In the Arab villages of the Galilee, family planning, which involves essentially IUD insertions and follow-up, is available in local mother and child clinics as part of the routine services to mothers. On the first interview of a pregnant woman, the availability of the device is mentioned, and this is repeated at the time of the postpartum visit. The physi-

cian also makes recommendations during the post-natal examination. Occasionally tubal ligation is suggested, especially for women with many children and those requiring caesarian births (It should be noted that this option is never offered to Jewish women). Infertility counseling is not part of the service.

Due to lack of specialist clinics in Arab towns and villages, women may consult with gynecologists in hospital outpatient departments concerning family planning. However, the physicians are likely to be Jewish males, so that cultural and communication barriers reinforce the usual tendency for such consultations to be limited to the mechanical examination of reproductive organs.

### Women in Medicine

While women are entering medical schools in increasing numbers, they remain a minority in the more prestigious and high paying fields. ■

**Percentage of Women in Israel Medical Schools**

Year	Total Number of Students	Percentage of Women
1969	168	24%
1975	203	29%
1984	277	35%
1989	365	46%

Source: Notzer, N. 1992. "Women Entering the Field of Medicine: Cause and Effect." In *Women's Health in Israel. Consultation Proceedings*. Jerusalem: Israel Women's Network.

**Percentage of Women in Different Areas of Specialization, 1989**

Specialization	Total Number of Students	Percentage of Women
Internal medicine	899	29%
Surgery	376	13%
Psychiatry	279	46%
Gynecology	278	19%
Pediatrics	384	36%
Family medicine	250	44%

Source: Notzer, N. 1992. "Women Entering the Field of Medicine: Cause and Effect." In *Women's Health in Israel. Consultation Proceedings*. Jerusalem: Israel Women's Network.



"Health Care in Israel"

Error: On p. 17, the title of the graph should read:

Percentage and Amount of Expendable Monthly Income of Urban Households Spent on Health, According to Income Decile, 1986-87.

The word "Expendable" was inadvertently omitted.

✓





# The Growth of Private Health Care

The prosperity that followed the 1967 war increased the ranks of the middle class in Israel, while further entrenching the existing middle and upper classes. The general rise in the standard of living was accompanied by increased demands for consumer goods and services, among them health care. These demands were met by the Maccabi sick fund, which, in contrast to the Histadrut Sick Fund, offers members choice of doctors, appointments rather than the queue, specialist consultations without referral from a general practitioner, and more efficient supportive services; and by private commercial health services that mushroomed in the 1980s, including medical centers and diagnostic clinics, nursing homes, ambulance services, and centers for alternative medicine.

The 1980s saw a trend of decreasing government outlays and increasing household financing of health services; that is, a shift of the burden from the government to the consumer. This shift involves increased outlays not only by the affluent but also by low-income groups; the direct government subsidy to the Histadrut Sick Fund declined from 30% of the latter's budget in 1978-79 to less than 2% in 1987-88,<sup>83</sup> necessitating an increase in membership dues.

The increase of the national expenditure on health as a percentage of the GNP — it was 7.8% in 1989-90, compared to 5.5% in 1962-63<sup>84</sup> — was accounted for by outlays on the part of households and non-profit organiza-

tions. Whereas in 1984-85, 31.9% of the national expenditure on health was financed by households, in 1989-90, the figure was 48%.

The same year the contribution of the government and local authorities to the national health bill was 47%, compared with 53.6% in 1973-74, and 52.0% in 1984-5.<sup>85</sup> While in 1977 the parallel tax, a type of "second income tax" paid by employers, accounted for 1/3 of government financing and general revenues for 2/3, by 1988 the proportions had been reversed; i.e., direct government outlays had been reduced by 50%.<sup>86</sup>

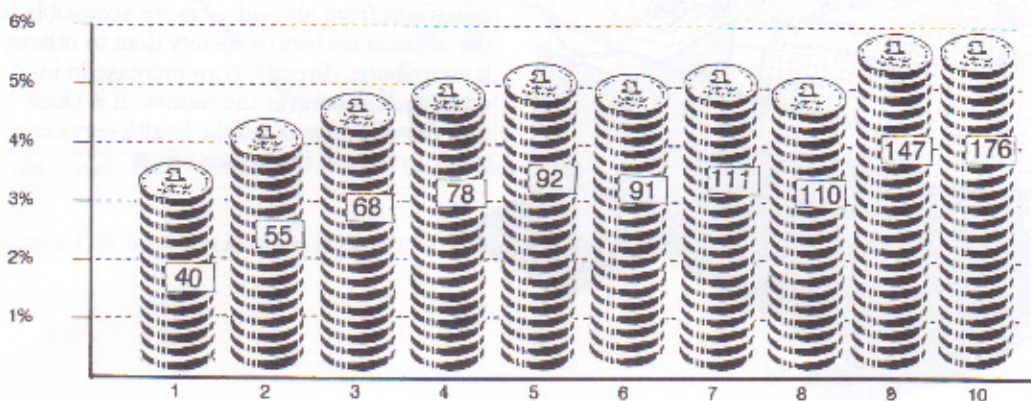
The proportion of the national expenditure on health going to private medicine rose from 18.1% in 1970-71 and 18.7% in 1980-81 to 22.2% in 1987-8. The largest single expense was dental care, which amounted to 12.7% of the total national expenditure on health; the proportion going to private physicians rose from 2.6% in 1980-81 to 4.5%.<sup>87</sup> Private hospitals increased their (mainly surgical) admissions from 5,138 in 1981 to 20,611 in 1986.<sup>88</sup>

An examination of the proportion of monthly household expenditures devoted to health by income decile reveals the general trend: the outlay as well as the proportion increases with income. Households in the highest decile spend more than 4 times that of those in the lowest decile; it should also be noted that households in the lower deciles have more persons (*see table below*).

As expenditures on private health care correlate with socio-economic status, the more the burden is shifted to the consumer, the greater will be the inequality in utilization of health services. Between 1979-80 and 1986-87, the average proportion of household expenditures devoted to health care increased from 4.2% to 5.2%. The highest rise was in a category that included expenses for private physicians, vision care, convalescent homes, medicines and medical accessories.<sup>89</sup>



**Percentage and Amount of Monthly Income of Urban Households Spent on Health, According to Income Decile, 1986-87**



Source: CBS, Statistical Abstracts of Israel 1991, Table 11.1, p. 290-91.

Note: Amounts rounded to nearest shekel.



## Privatization of Public Services

Public health care is undergoing a process of increasing privatization. Sick funds once sold members medicines at a nominal cost; today, more than half of the medicines are more expensive at the Histadrut Sick Fund pharmacy than at the local druggist.<sup>90</sup> Another development is the institution of fees for services formerly performed free of charge, like ambulances, diagnostic tests, and hospital emergency room visits. Yet another is the contracting out of certain services, like ambulances and nursing homes.

Further indication of the trend is the Private Medical Services (Sharap) arrangement, now provided by three Jerusalem hospitals, under which physicians employed by the hospitals may see private patients in separate rooms and utilize hospital facilities for treatment. Hospitals regulate and collect Sharap fees, from which they deduct taxes and their own charges.

This arrangement can be viewed as an attempt to control "black market" medicine, in which patients paid hospital physicians under the table in order to be operated on by the surgeon of their choice and to advance to the head of the waiting list, by institutionalizing the practice. The Ministry of Health plans to extend the same service to other hospitals around the country.

On January 1, 1992, a process was initiated whereby 5 government hospitals (Tel Hashomer, Rambam, Nahariya, Assaf Harofe, and Ichilov) are to be reorganized as self-sustaining public corporations.

There is danger that the drive for profit may conflict with the principle of equity in the provision of medical services, and lead to a preference for income-producing services and clients at the expense of others.

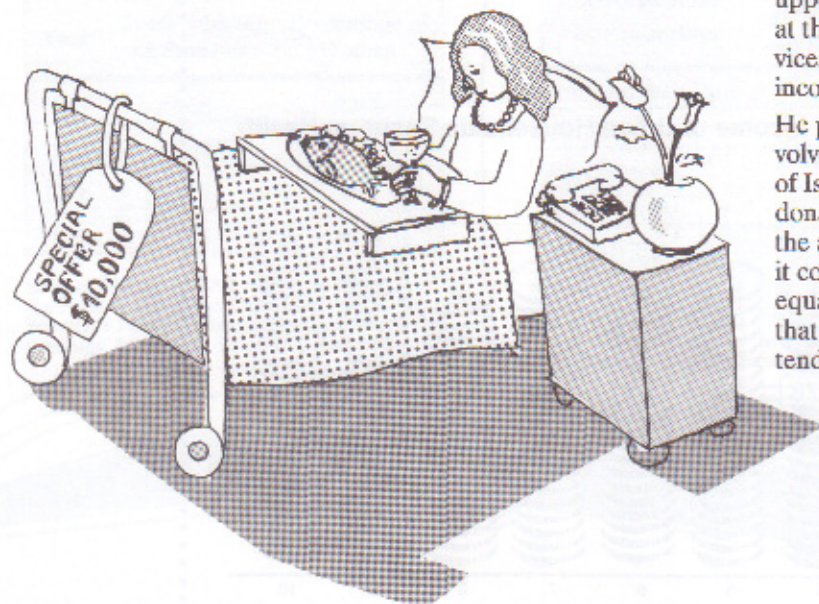
The question is how privatization affects equity in health care. In most democratic states, social services, including health care, are financed by a combination of the government and the consumers. Whereas government financing reflects a commitment to meeting the health needs of citizens which would not be met if health care was sold on the open market like any other commodity, decreasing government financing and increasing privatization reflect a retreat from that commitment. While health subsidies operate to increase the income of the lower deciles and therefore increase social equity,<sup>91</sup> privatization has the opposite effect.

Another effect of private as opposed to government provision of public services that increases inequities is "creaming," that is, concentration on clients who are easy to treat and who can afford to pay, and neglect of "difficult" clients who cannot pay,<sup>92</sup> for example, expansion of cosmetic surgery and expensive technologies, to which only those able to pay will have access, at the expense of geriatric care.

Shuval notes that "privatization carries the potential danger of a two-tiered system of medical care in which higher quality service and equipment are drawn into the private sector by the promise of greater financial rewards".<sup>93</sup>

Doron argues that one of the undeclared goals of the political-economic establishment of Israel in its drive towards privatization of social services is to consolidate the advantages conferred by the private market on the upper strata, who are willing and able to pay, at the expense of the quality of the public services provided to the low and intermediate income groups.

He points out that since privatization involves making facilities — which in the case of Israel were built with public monies and donations from abroad — more accessible to the affluent sectors of society than to others, it contributes directly to an increase in inequality.<sup>94</sup> Whatever the motive, it is clear that privatization of public health services tends to benefit the better-off. ■





# Past and Present: Are the Gaps Disappearing?

Is Israel moving towards the World Health Organization goal of Health for All by the Year 2000?

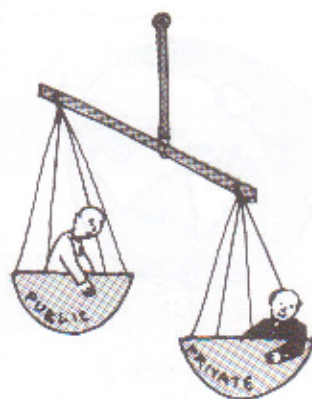
An examination of basic health status indicators like the infant mortality rate, the ratio of still births, and life expectancy at birth (see table below) reveals that infant mortality and still births have decreased considerably and that life expectancy has increased for both Jews and Arabs in Israel. For Jews, the infant mortality rate declined from 27.2 per 1,000 live births in 1960 to 7.9 in 1990; still births were reduced from 13.0 in 1960 to 3.7 per 1,000 live births in 1989. Life expectancy at birth increased from 72.1 to 76.7, adding an average of 4.6 years to life.

The health status of the Arab population of Israel, as shown by the same indicators, also improved, but the gaps remained stable for infant mortality and life expectancy, and they increased for stillbirths. The number of still births decreased from 11.9 in 1960 to 8.4 per

1,000 live births in 1989, compared with a decline of more than twice as great for Jews. Infant mortality decreased from 48.0 in 1960 to 14.6 per 1,000 live births in 1990, and life expectancy at birth increased from 69.5 to 74.3, adding an average of 4.5 years to life.

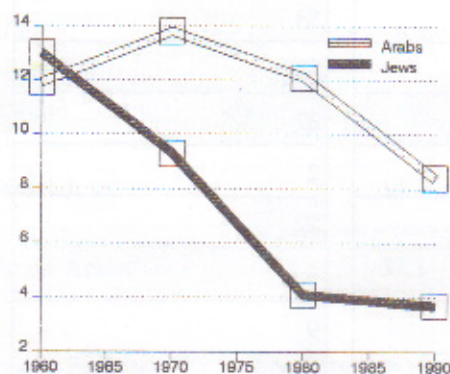
The general increase in life expectancy and the decrease in infant mortality rates since the establishment of the state can probably be attributed to improvements in diet, hygiene, and the expansion of primary health care, developments which are egalitarian in nature, and to the rise in the general standard of living.

However, the 1980s marked the beginnings of a departure from policies based on the principle of equity — like the investment in high-tech, hospital-based medical care and the privatization of public health care, a departure that may contribute to an increase rather than a decrease in class differences in health care, and, consequently, in life expectancy and the quality of life. ■

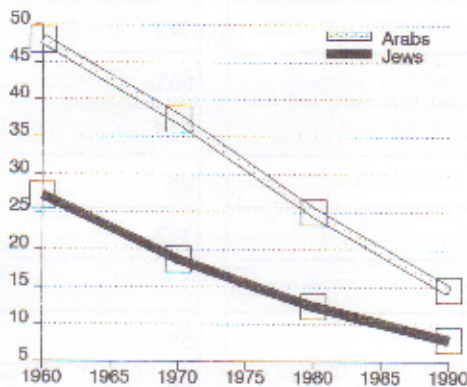


## Changes Over Time of 3 General Health Status Indicators of Arab and Jewish Citizens of Israel

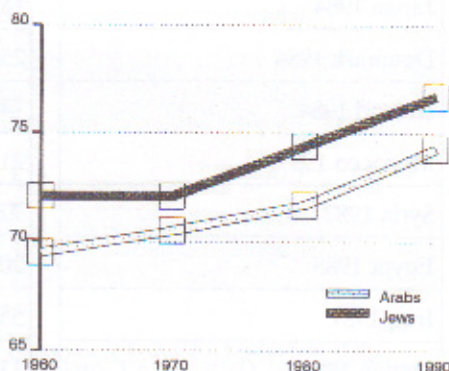
Still Births per 1,000 Live Births



Infant Mortality Rate per 1,000 Live Births



Life Expectancy at Birth in Years



Sources: CBS. *Statistical Abstracts of Israel* 1991. Tables 3.1, p. 104-108 and 3.24, p. 138; Figures for 1960: CBS. 1980. *Society in Israel*.



# Israel in International Perspective



When it comes to recognized indicators of the general level of health services, like the number of physicians, nurses and dentists per 100,000 population, Israel resembles many countries of the European region and far surpasses the neighboring Arab states. In 1980-83, its ratio of physicians, nurses, and dentists was higher than that of the European average.

For both Arabs and Jews in Israel, life expectancy at birth is much higher and the infant mortality rate much lower than those in the Arab states. The average life expectancy of Israeli citizens in 1989 (76.0) and the increase in the average life span since 1970 was greater than those for many of the European member states of the World Health Organization.

Israel's figures were similar to those of countries like the Netherlands, Denmark, and Ireland, and higher than those recorded for the

U.S.S.R. and Morocco. However, the relative advantage of women vis-a-vis men is considerably lower in Israel than in other developed countries: life expectancy at birth is 3 years longer for women in Israel, while it is more than twice that in many other developed countries.

The average infant mortality rate in Israel was and still is lower than the average for the European region. While in 1970 Israel's infant mortality rate for both Jews and Arabs was higher than that in the Netherlands, the United Kingdom and Denmark, its rate of decrease over time has been much greater (see table next page). Israel's infant mortality rate was and still is much lower than that in Morocco and the neighboring Arab states. The average life expectancy at birth for both Arabs and Jews in Israel is among the highest in the WHO European region. ■

**Physicians, Nurses and Dentists Per 100,000 Persons in the WHO European Region and in Selected Countries, 1980-1987**

Country	Physicians	Nurses	Dentists
Europe 1980-83	278	392	41
U.S. 1984	214	830	59
Netherlands 1985	224	n.a.	49
United Kingdom 1981	164	325	31
Japan 1984	151	492	53
Denmark 1984	251	561	88
Ireland 1984	147	715	32
Morocco 1987	21	95	2
Syria 1987	77	112	22
Egypt 1985	20	27	n.a.
Iraq 1987	55	58	9
Jordan 1984	114	99	24
Israel 1983	290	360	71

Sources: WHO, 1986. *Evaluation of the Strategy for Health for All by the Year 2000*, Seventh Report, Volume 5, European Region, Geneva.; WHO, 1988 *World Health Statistics*, Geneva. Tables 2-5, pp. 44-62; 1990. U.N. *Statistical Yearbook for Asia and the Pacific*, Bangkok, pp. 183 and 199 — calculations by B.S.

Note: The number for nurses in Jordan includes midwives.



**Infant Mortality Rates and Life Expectancy at Birth for the WHO European Region and for Selected Countries, 1970 and 1989**

Country	Infant Mortality Rate		Life Expectancy	
	1970	1985-1990*	1965-1972*	1985-1990*
European Region	49.3	n.a.	69.4	n.a.
U.S.	19.8	10.0	70.8	76.0
U.S.S.R.	24.4	24.9	69.0	68.1
Japan	13.1	5.0	71.7	78.0
Netherlands	12.7	6.8	73.5	77.1
United Kingdom	18.5	9.0	71.7	75.5
Denmark	14.2	8.3	73.4	75.1
Ireland	19.5	9.2	70.6	74.4
Morocco	140.0	82.0	52.9	61.0
Egypt	n.a.	65.0	52.7**	59.0
Syria	n.a.	48.0	n.a.	65.0
Iraq	n.a.	69.0	51.6	64.0
Jordan	n.a.	44.0	n.a.	66.0
Israel-Jews	18.7	7.9	72.1	76.7
Israel-Arabs	37.3	14.6	70.5	74.3

Sources: For Israel: CBS, *Statistical Abstracts of Israel 1991*, Table 3.1, pp. 104-108 and 3.24, p. 138. For other countries: WHO, 1986, *Evaluation of the Strategy for Health for All by the Year 2000*, Seventh Report, Volume 5, European Region, Geneva, Table 2, p. 223; Table 3, p. 224; WHO, 1991, *1990 World Health Statistics Annual*, Geneva, pp. 104-109; U.N. 1991, *1989 Demographic Yearbook*, New York, Table 15, pp. 342-346; Population Division of the Department of International Economic and Social Affairs, U.N. Secretariat, "U.N. World Population Chart 1990"; U.N. 1972, *1971 Demographic Yearbook*, New York, Table 28, pp. 668, 671, 669, and Table 34, pp. 754, 756, 746, 756; UN 1972 *Demographic Yearbook*, Table 21, p. 505.

Notes:

- \* Latest available figure.
- \*\* Figure is for 1960.



## Prospects for the Future

The trends seem to be clear; the 1990s will witness the continued expansion of private medical services and the increasing privatization of public medical services through both contracting out and incorporation. Household expenditures on both private and public health care will continue to grow. A February 1992 decision by the sick funds to institute a supplementary compulsory insurance fee for members, in order to provide coverage for additional services, is further evidence of the trend.

The present decade will also see the continued development of high-tech medicine in both the private and the public sector, and the utilization of these services by those with the means to pay for them. The health package of sick fund members will probably exclude many expensive, high-tech services.

In the coming years curative care can be expected to maintain its precedence over preventive medicine. The trends show that governmental and private investments will continue to be channelled to hospitals. Lip service will continue to be paid to environmental factors like air and water pollution and life style factors like diet, smoking, and physical activity, while minimal funds are expected to be allocated to environmental research, the alleviation of pollution or the alteration of life styles.

There is no evidence that the idea of community participation in health care will be encouraged by national bodies. For example, upon joining the European Region of the World Health Organization (WHO) in 1985, Israel complied with the preliminary requirement of defining a national health plan in line with the goal of Health for All by the Year 2000. The first aim of the Health for All campaign was greater equity, and one of the main principles to be employed in its achievement was community participation.<sup>95</sup> However, it is notable that only two Arab health professionals, both employees of the Health Ministry, were included in Israel's 63-member planning team (Arab citizens constitute 18% of the population of Israel). Moreover, repeated appeals to the Health Ministry to allow for an input in any form, direct or indirect, from the Arab community-based professional forum, the Follow-up Committee on Arab Health Issues, were denied over the two-year period of the deliberations.

Finally, at the present time, there is no evidence of a strong commitment to equity in health care. The Health for All by the Year 2000 national health policy document, submitted to the Minister of Health in 1989, does not deal with the basic prerequisites for health outlined by the WHO, several of which, including sanitation, have not been fulfilled for the Arab minority in Israel. While the document acknowledges the existence of socio-economic and geographical disparities and recommends reorganization of the health care delivery system on a regional basis,<sup>96</sup> under conditions of increasing privatization of the public health care delivery system, it appears that peripheral regions will have fewer resources to develop services and fewer financial incentives to offer medical personnel. Although women participated in the design of both the WHO and the Israeli policy documents, no mention is made in either of the special health needs of women. ■



## References

1. Israel Ministry of Health. 1989. *National Health Policy of Israel: Targets for the Year 2000*. p. 8 (Hebrew).
2. Central Bureau of Statistics (CBS). *Statistical Abstracts of Israel 1991*, Table 3.1, p. 104 and Table 3.24, p. 138.
3. Reiss, N. 1991. *The Health Care of the Arabs in Israel*. Boulder, Co: Westview Press. p. 111.
4. *Ibid.* p. 88.
5. Reiss, *ibid.* p. 124.
6. *Ibid.* p. 124.
7. Barell, V., et al. 1991. "Minors and Pregnant Women Without Health Insurance." In *Society and Welfare Social Work Quarterly*, Vol. 11, April. pp. 258-272 (Hebrew).
8. Giraldes, M., et al. (eds.). 1991. *Socio-Economic Factors in Health and Health Care, Literature Review*. Brussels: Commission of the European Community.
9. Westcott, C., et al. (eds.). 1985. *Health Policy Implications of Unemployed*. Copenhagen: WHO.
10. CBS. *Statistical Abstracts of Israel 1991*. Tables 22.1, p. 605; 22.2, p. 606; 11.4, p. 294; 12.26, p. 352; 12.27, p. 353; % blue collar workers calculated from tables 12.18, p. 344 and 12.9, p. 346; CBS. 1983. *Educational Characteristics of the Population and Languages Spoken*. Census Publication No. 10, Table 1, pp. 91, 87, 88.
11. CBS. 1990. *Socio-Demographic Characteristics of Infant Mortality*, Special Series No. 871, p. XIV.
12. Barell, V. 1985. "Israel: The National Program for Reduction of Infant Mortality." In *Proceedings of the International Collaboration Effort on Perinatal and Infant Mortality*, Vol. 1. Hyattsville, Md: U.S. Department of Health and Human Services, National Center for Health Statistics; and Barell et al. 1988. "Analysis of Geographic Differentials in Infant Mortality Rates. The Or Yehuda Community." In *American Journal of Epidemiology*. Vol. 128:1. pp. 218-230.
13. Shuval, Y. forthcoming 1992. *Social Dimensions of Health: The Israeli Experience*. New York: Praeger.
14. Ginsberg, G. 1991. "Standardized Mortality Ratios for Israel 1983-86." Jerusalem: Department of Data Analysis, Statistical Division, Ministry of Health.
15. Shuval, 1992.
16. Ministry of Health. 1989. *National Health Policy in Israel: Targets for the Year 2000*. p. 24 (Hebrew).
17. CBS. 1990. *Survey of Persons Aged 60 and Over in Households 1985: Health and Use of Health Services*. Table 17, p. 148.
18. Barell, 1991. *op. cit.*
19. Shuval, 1992.
20. Shuval, J. 1990. "Health in Israel: Patterns of Equality and Inequality." In *Social Science and Medicine*. Vol. 31:3, p. 293.
21. Reiss, *op. cit.*
22. Rosen, B. (ed.) 1991. "The Netanyahu Commission Report: Background, Contents and Initial Reactions." Jerusalem: JDC-Brookdale Institute and JDC-Israel, p. 3.
23. Unpublished data. Galilee Society for Health Research and Services.
24. Shuval, 1992.
25. *Ibid.*
26. Ministry of Health. Unpublished data. Calculations by B.S.
27. Greenberg, *op. cit.*
28. Shuval, J. 1990. "Health in Israel: Patterns of Equality and Inequality." In *Social Science and Medicine*. Vol. 31:3, p. 295.
29. Greenberg, O. 1989. *A Development Town Visited*. Tel Aviv: Hakibbutz Hameuchad Publishing House and The Jerusalem Institute for the Study of Israeli Society. pp. 56-57 (Hebrew).
30. *Ibid.* p. 52.
31. *Ibid.* pp. 54-55.
32. Shuval, 1992.
33. Ministry of Health. 1978. *Profile of Health Services in Israel. Survey of Preventive and Ambulatory Services by Community*. Jerusalem.
34. Shuval, 1990.
35. Shahab, Sh. 1990. *An Investigation of Pregnant Women's Utilization of and Satisfaction with Preventive Health Services in Family Health Stations Among the Non-Jewish Population in the Acre Sub-District*. Thesis for the degree of Masters of Public Health, School of Public Health, Hadassah Medical School, Hebrew University, Jerusalem (Hebrew).
36. Galilee Society, unpublished data.
37. Al-Haj, M. and Rosenfeld, H. 1989. *Arab Local Government in Israel*. Boulder, Co.: Westview Press.
38. Lusky, A. et al. 1990. *Socio-Demographic Characteristics of Infant Mortality Among Minority Populations in Israel*. National Task Force for the Reduction of Infant Mortality, Health Services Research Unit, Ministry of Health. p. 11.
39. Reiss, *op. cit.* p. 160.
40. *Ibid.* pp. 172-73.
41. Zaharan, Y. 1980. *Nutritional-Deficiency Rickets Among Children of the Arab Village 'Ibillin in the West-Galilee* (Hebrew). Masters of Science Thesis, Department of Nutrition, Hadassah Medical School, Jerusalem.
42. Sofer et al. 1986. "Frequency of Anemia Among Jewish and Bedouin Infants in the Negev." *Harefuah*. Vol 61:9 (Hebrew).
43. Kanaaneh et al. 1986. *Proceedings of the First Conference on Arab Health Issues*. Nazareth (Arabic).
44. Survey by Elgazi, Y., published in "To Be Ill in Um el Fahm," *Haaretz*, 11.11.91 (Hebrew).
45. Shuval, Y. et al. 1970. *Social Functions of Medical Practice*. San Francisco: Jossey Bass.
46. Weil, H. a.d. *Welfare Services for the Aged in the Arab Sector in Israel*. Jerusalem: ESHEI, the Association for the Planning and Development of Services for the Aged in Israel (Hebrew). p. 23.
47. CBS. *Statistical Abstracts of Israel 1990*. Table 3.32, p. 145.
48. CBS. 1983. *Use of Health Services Survey 1981*. Special Series 717; and 1990. *Survey of Persons Aged 60 and Over in Households 1985: Health and Use of Health Services*. Special Series 868.
49. Doyal, L. 1985. "Promoting Women's Health." Address at Conference on Women's Health in a Changing Society. Adelaide.
50. Salzberger, I. 1990. *Socio-Familial Deprivation Over Time*. Ph.D. Dissertation. Jerusalem: Hebrew University (Hebrew).
51. Eshed, H. 1992. "Morbidity Factors Among Women: Research Findings." In *Women's Health in Israel: Consultation Proceedings*. Jerusalem: Israel Women's Network (Hebrew).
52. Swirski, B. 1984. *Daughters of Eve, Daughters of Lilith: On Women in Israel*. Givatayim: Second Sex Chapter 15 (Hebrew).
53. U.N. 1990. *The World's Women 1970-1990: Trends and Statistics*. UN Special Series K.
54. Amir, D. 1991. "Socio-Cultural Risk Factors in Women's Health." Paper presented at the IWN Consultation.
55. Data courtesy Gary Ginsberg, Ministry of Health.
56. Society for the Advancement of Women's Health Research. 1991. *Women's Health Research: Prescription for Change*, Annual Report. Washington, D.C. p. 4.
57. Ore, L. et al. 1991. "Mortality Trends Among Jewish and Non-Jewish Women in Israel, 1960-82." In *Israel Journal of Medical Science*. Vol 27: 1.
58. Tsivoni, D. 1991. "Heart Disease in Women." Paper presented at the IWN Consultation: Women's Health: Policy, Research and Practice.
59. Kahn, S. 1990. *Annals of Internal Medicine*. April 15. Cited in "Is Heart Disease Overlooked in Women?" in "Digest of Research on Women's Health." Vol. 3:5. Newbury Port: Ma.: Skol Publications.
60. Wingrad, D. 1982. "The Sex Differential in Mortality Rates — Demographic and Behavioral Factors." In *American Journal of Epidemiology*. Vol. 115:2, pp 205-216; Waldron, I. 1986. "What Do We Know About Causes of Sex Differences in Mortality? A Review of the Literature." Department of International Economic and Social Affairs, U.N.
61. *Statistical Abstracts of Israel 1990*. Table 24.17, p. 681.
62. Peretz, T. 1992. "Women and Cancer in Israel." In *Women Health in Israel. Consultation Proceedings*.
63. Ore et al. *op. cit.*
64. Falck, F. et al. 1992. "Pesticides and Polychlorinated Biphenyl Residues in Human Breast Lipids and Their Relation to Breast Cancer." in *Archives of Environmental Health*. Vol 47 (2. March/April).
65. Westin, J. and Richter, E. 1990. "The Israeli Breast-Cancer Anomaly." In *Trends and Cancer Mortality in Industrial Countries*. New York: The New York Academy of Sciences.
66. Schonbrun, M. 1987. *Reporting Breast Symptoms in a Jerusalem Hospital*. Thesis for the Degree of Masters in Public Health, California State University, Northridge, California; Klein, M. and Jedid, Ch. 1981. "The Israel Cancer Association's National Program for the Early Detection of Breast Cancer." In *Israel Journal of Medical Science*. Vol 17:9-10, pp. 822-826.
67. Shuval, 1990.
68. Schonbrun, *op. cit.*
69. Howard, J. 1987. "Using Mammography for Cancer Control: An Unrealized Potential?" In *Cancer Journal for Clinicians*. Vol 37. pp. 33-48.
70. Peretz, T. 1992. "Women and Cancer in Israel." In *Women's Health in Israel*.
71. Pettersson et al. 1985. "Evaluation of Screening for Cervical Cancer in Sweden: Trends in Incidence and Mortality 1958-1980." In *International Journal of Epidemiology*. Vol. 14:4. p. 521.
72. Peretz, *op. cit.*
73. Ore et al. *op. cit.*
74. Reiss, *op. cit.*
75. Hazelton, L. 1977. *Israeli Women: The Reality Behind the Myth*. New York: Simon and Schuster; Avgar, A. 1985. *Integrating Work and Family Role*, Doctoral Thesis, Hebrew University, Jerusalem.
76. Landau, R. 1992. "Women and Fertility." In *Women and Health in Israel*.
77. Salzberger et al. 1991. *Patterns of Contraceptive Behavior Among Jerusalem Women Seeking Pregnancy Counseling: 1980-1989*. Jerusalem.
78. Nadel-Shneor, O. et al. 1971. "The Influence of Selected Demographic Attributes on the Use of Contraceptive Methods." In *Harefuah*. April; Friedlander, D. 1973. "Family Planning in Israel: Rationality and Ignorance." In *Journal of Marriage and the Family*. February. pp 119-124.
79. Basker, F. 1980. *Belief Systems, Cultural Milieu and Reproductive Behavior: Women Seeking Abortion in a Hospital in Israel*. Ph.D. Dissertation. Jerusalem: Hebrew University.
80. Sabatello, E. 1992. "Immigration from the USSR: Implications for Abortion Rates in the 90's." In *Women's Health in Israel*.
81. CBS. *Statistical Abstracts of Israel 1990*. Tables 3.25 and 3.26, p. 140.
82. Swirski, *op. cit.*
83. Rosen, B. 1989. "The Public-Private Mix — Israeli Health Care." Jerusalem: Brookdale Institute Research Report, pp. 15-17. The figure of 2% does not include indirect subsidies in the form of lower charges for inpatient services in government hospitals, as well as the parallel tax, which some contend should be classed as a government outlay.
84. CBS. 1991. *Statistical Abstracts of Israel 1991*. Table 24.1, p. 677.
85. *Ibid.*
86. Rosen. 1989. pp. 18-19.
87. CBS. 1991. *Statistical Abstracts of Israel 1991*. Table 24.1, p. 677.
88. Ministry of Health. 1990. "Health and Health Services — Israel 1990." Jerusalem. p. 82.
89. Shuval, 1992.
90. Doron, A. 1989. "Privatization of Welfare Services: A New Arena for the Fight Over the Nature of Israeli Society." In *Social Security*. Vol. 34, p. 24 (Hebrew).
91. Shaul, Y. 1988. "The Effect of Crediting Public Health Expenditure to Family Income on Income Distribution." In *Social Security*. Vol 32, pp 74-89 (Hebrew).
92. Doron. *op. cit.* p. 26.
93. Shuval, 1992.
94. Doron. *op. cit.* pp. 31-32.
95. WHO. 1985. *Targets for Health for All*. WHO Regional Office for Europe. Copenhagen.
96. Israel Ministry of Health. 1989. *National Health Policy in Israel: Targets for the Year 2000* (Hebrew).



## Honorable Mention

### The following organizations work for greater equity, women's health needs, and environmental safety

**The Galilee Society for Health Research and Services**, a community-based organization formed in 1981 by Arab health professionals, is dedicated to closing the gaps in health opportunities between Arab and Jewish citizens of Israel.

**The Israel Women's Network Health Committee** is committed to promoting better health care for women through legislation, advocacy and grass-roots activity. It recently organized a conference on women's health.

**The Na'amat Health Department** supplies information to both women and men on health issues, educates consumers to be assertive in their contacts with the medical establishment, and works on policy issues, like family planning and patients' rights.

**The Women's Counseling Center** is a collective of feminist mental health professionals who provide individual and couple counseling as well as group therapy and workshops for mental health professionals.

**The Pregnancy Counseling and Follow-up Service** of the Hebrew

University's Paul Baerwald School of Social Work and the Histadrut Sick Fund has been providing crisis intervention and contraceptive counseling for pregnant women in crisis since 1980.

**Shilo Pregnancy Advisory Service** is a walk-in counseling center for adolescents on the subjects of contraception, sexuality, and unwanted pregnancies. In operation since 1977, Shilo is staffed by volunteer professionals; its counselling services are free of charge.

**The Israel Family Planning Association** is committed to promoting reproductive health, safe motherhood, family planning, and prevention of unwanted teenage pregnancies and sexually transmitted diseases. It has "Open Door" counseling services for teenagers in Tel Aviv, Haifa, Kfar Saba, Migdal Haemek, Upper Nazareth and Eilat.

**The Women's Health Information Center** provides information and assistance to women regarding available medical services, specific

medical problems, and alternative treatments.

**The Women's Health Project of the Woman to Woman Haifa Feminist Center** collects information on women's health issues and services and conducts educational programs for diverse women's groups.

**The Health Services Research Unit of the Sheba Medical Center** works on the regional level, examining the fit between needs and services, promoting integration between hospital and community, locating disparities among population groups and designing intervention policies aimed at reducing disparities, like the National Program for the Reduction of Infant Mortality.

**The Unit for Environmental and Occupational Medicine at the Hebrew University-Hadassah Medical School** initiates projects and provides consultation for government agencies, municipalities, community and worker groups, and individual patients on policy, legislative and clinical issues concerning exposure hazards, risks and control.

## Special Thanks

Adva Center wishes to thank **Professor Judith T. Shuval** of the Hebrew University, **Dr. Nira Reiss** of Haifa University, **Ms. Pnina Zadka**, Director of the Health Department of the Central Bureau of Statistics, and **Ms. Sarinah Kalb** of the Women's Health Information Center for their comments and criticisms; responsibility for the content of the report lies solely with Adva Center.

This report was written by a team:

**Barbara Swirski**, M.A., Director, Adva Center

**Hatem Kanaaneh**, M.D., M.P.H., Director and Chairman, Galilee Society for Health Research and Services

**Amy Avgar**, Ph.D., Co-Chair, Israel Women's Network Health Committee

**Michal Schonbrun**, M.P.H., Certified Health Education Specialist, Co-Chair, Israel Women's Network Health Committee

Design and Graphics: **Miri Dahan**  
Typesetting: **Shlomo Perets**

This report was published with the aid of grants from the Worldservice of the Reformed Churches in the Netherlands and from U.S./Israel Women-to-Women.

The work of Adva Center is supported by The New Israel Fund.

Text, graphs, and figures are meant to be quoted and copied, but please credit **The Israel Equality Monitor**.