Circles of Exclusion

The Politics of Health Care in Israel

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With a Foreword by Quentin Young, MD

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To my late father, David, and my mother, Sara, for their example of personal integrity, intellectual curiosity, and love

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Foreword

As I sat down to read Dani Filc's *Circles of Exclusion,* I expected to learn a great deal about the Israeli health care system. What I did not expect was to find that this tiny country enmeshed in a seemingly intractable conflict in the Middle East would have so many lessons for the world's most powerful nation—the United States. Several pages into this courageous book, it became clear that the issues Dr. Filc describes hold great relevance for those grappling with America's ongoing health care crisis. The crisis in Israel and that in the United States are the result of the impact of neo-liberal market policies that are currently being imposed on health care throughout the globe. In both countries we see a decline in concern and funding for public health and the exclusion of the poor racial and ethnic minorities from increasingly privatized health care systems in which the survival of profit-making enterprises seems to be the paramount concern.

Using the Israeli example as a case study, Dr. Filc raises questions about the very future of egalitarian notions of health and social services in affluent industrialized societies that have become more concerned with the wealth than the health of the species. And he does so by tackling a subject

that is of interest to anyone—Jew or non-Jew—who is concerned with the fate of the first and only Jewish state in the world.

Circles of Exclusion tackles these issues with both passion and scholarly rigor. Dani Filc is a practicing physician, and an Israeli citizen who has a firm identification with the Israeli state. He is also a scholar and a social justice/public health activist and advocate. Dr. Filc in fact emigrated to Israel from Argentina and was promptly integrated as a citizen and a professional under the Right of Return policy, which awards citizenship to any Jew who desires it. He knows what it means to have voluntarily chosen the land of Israel as his own. As someone who tried to serve the poor and underserved in his own native country, he was also deeply impressed with the commitment to egalitarianism and social solidarity he encountered when he first came to Israel several decades ago.

Today he is deeply concerned about how the current market-oriented health care theories are undermining the very ethical concerns and principles that were embedded in this early Zionist model. In spite of its collective roots, the Israeli health system now increasingly mimics some of the worst aspects of the American privatized system.

Dr. Filc grounds his analysis on classical public health theory. For the poor and elderly Jewish citizen, for the Bedouin in the unrecognized villages, for migrant workers, and for Palestinians in the occupied territories, myriad resources—financial allocations from the state, high-tech and tertiary facilities, safe water and sewage control, specialty services, roads and transport to medical facilities, as well as the social determinants of health such as education and decent employment—are all difficult or impossible to access.

For a public health advocate like myself, the message of this book is crystal clear. Obsessive preoccupation with free-market formulas are intensifying social and health care problems in industrialized countries, not resolving them. Of course, Filc shows us how this has happened in Israel, which because of its history puts a very specific spin on the problems of the poor, the old, racial and ethnic minorities, and the new migrant working class that crisscrosses the globe. Nonetheless, in Israel and elsewhere, preoccupations with profit are crowding out concerns for the classic social determinants of health and, as Dr. Filc points out over and over again, are not saving money but actually wasting it.

The final echoes contained in this book regard the inevitable lessons about the links between military occupation, health care, global health, and

global peace. Indeed, as Dr. Filc explores the close connection between the Arab-Israeli conflict and American military support, anyone who has been fighting for a more just and accessible health care system in the United States cannot help taking note. Not only does Dr. Filc elaborate how health care has become another weapon in a seemingly endless conflict, he also points out the tragic consequences of spending billions on military hardware and personnel rather than on the provision of social services that could become tools for peace rather than war making. The emergence of military checkpoints and creation of border walls that have made services available only in Israel inaccessible to patients in the Occupied territories, have also created another group denied access to health care—migrant workers recruited from global populations desperate for employment.

This book greatly adds to our knowledge of the consequences of neoliberal policies in health care. It is also a critical contribution to the scholarship on the development of the Israeli state. Although it contains a strong critique it also contains a message of great promise.

For Dr. Filc the early Zionist solidarity represented an assertion that health care is a human right as well as a deep commitment to the tenets of burgeoning knowledge about public health. He helps us understand the wisdom that public health and prevention yields far greater gains than an exclusive focus on either therapeutic or market-based medicine. Finally, he promotes the concept of health care as a human right and helps us understand that by expanding on this human right, health care itself can be a tool for peacemaking in a region whose future holds either peril or promise for the entire globe.

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In writing this book I am indebted to many people. My colleagues and friends at Physicians for Human Rights-Israel have been, and still are, an inspiration. In their ceaseless struggle against violations to the right to health they have formed a community to which I am proud to belong.

I am grateful to those teachers and colleagues at the university who have taught me to ask questions and seek answers. Whereas the list is a long one, I owe professors Uri Ram and Adi Ofir a special debt.

While the faults and errors you may find in this book are my own and entire responsibility, the book's completion owes much to the support, intelligence, patience, and enthusiasm of Suzanne Gordon, coeditor of the series. Anything I can say will not express how grateful I am for her help.

Finally, the most special debt I owe is to my family—my children, Gal, Ioni, Or, and Nir, who endured the period of the writing with love and humor; and my wife, friend, and companion, Myri, for all that I have learned from her and for many years of mutual love.

Circles of Exclusion

Introduction

Four Stories of Exclusion

My patient was as perplexed as she was outraged. "You can't do it? What do you mean, you can't do it?" she asked angrily. "I've been going there for years and years for my heart checkup! And now you're telling me I have to start all over again at a new office, with a new doctor? No way!" she exclaimed as she stormed out of my office.

Ms. Levana Malka,[1] a sixty-year-old retired assistant kindergarten teacher who lived in Givat Hatmarim—one of the poorer sections of Tel Aviv—had cardiac valve disease since she was a child and developed hypertension in her fifties. To monitor and manage her condition she needed periodic checkups. From the time she developed her illness, she was insured at Kupat Holim Clalit—the sick fund run by the General Workers' Union.[2] When she was a teenager, she became a regular patient at a cardiology outpatient office at a public hospital and had continued to visit the same office, year after year, decade after decade, ever since, and she felt safe there. As the medical director of her neighborhood's primary care clinic, I knew that she preferred to continue receiving care and follow-up in a place

where she was well known. But even though I understood her anger and felt as frustrated as she was, I couldn't do anything to help her.

Due to both changes in public hospitals' billing systems and financial pressures, Kupat Holim Clalit no longer allowed us to refer our patients to certain public hospitals for their follow-up. This meant that patients like Malka had to find a different cardiologist at a different institution. For Malka—whose life as a patient was centered at a particular institution, with its familiar staff, treatment, and follow-up—learning that she would be forced to change doctors, nurses, and her hospital was a shock that made it even harder for her to cope with her chronic illness.

The situation was especially frustrating for her because her condition and age prevented her from switching to a financially more stable sick fund with better access to specialists' care. Moreover, like most residents of the Givat Hatmarim neighborhood, Malka could not afford private care.

Givat Hatmarim is located in what used to be the city of Jaffa and has become part of the Tel Aviv–Jaffa municipality. Predominantly Arab, Jaffa is one of the few areas in Israel where—albeit with some segregation—Arabs and Jews live together. But it is also one of the poorest parts of the unified city. Except for those living on the sea—in a section that is being gentrified—most of its residents struggle to make ends meet. Public services are not well developed and public investment is scarce, which leads to severe social problems. Givat Hatmarim (the Hill of Dates) is predominantly Jewish, but its residents are not much better off than Jaffa's Arab population. Since the mid-1980s, cuts in public spending have intensified the preexisting problems of this largely low-income population and created a crisis in the public health care system.

* * *

I signed the petition without too much hope. Physicians for Human Rights–Israel, a human rights organization composed mostly of health care workers, was demanding that the state ministries connect the houses of two sick old men—Mr. Ahmad al Atrash and Mr. Shauki al Sana—to a source of electricity. Sixty-nine-year-old Ahmad and seventy-eight-year-old Shauki are Israeli Bedouins who reside in the unrecognized villages in the Negev desert, and both suffer from chronic obstructive pulmonary disease (COPD). Some 84,000 Bedouins live in forty-five villages

unrecognized by the Israeli state as a result of a conflict about ownership of their land. Bedouins have lived on their land for centuries, yet the Israeli state does not recognize the Bedouins' ownership claims of significant areas of the Negev desert and has tried to pressure residents in these forty-five villages to move to seven Bedouin cities and renounce their claims to any ownership rights to the lands on which their villages were built. To pressure the Bedouin population to move, the state does not provide the villages with basic infrastructure, such as electricity, water, and sewage.

For Ahmad and Shauki this means that they will not receive the treatment their lives depend on. To manage their COPD, they must use bilevel positive airway pressure (BiPAP) treatment. Twenty-four hours a day, a machine provides artificial positive pressure that keeps the pulmonary alveoli open and thus helps to overcome the intrinsic positive pressure that hinders breathing. Their doctors have stated that they need BiPAP therapy to survive. Obviously, BiPAP cannot function without electricity, but the inhabitants of the unrecognized villages are not connected to electricity, and neither Ahmad nor Shauki can afford a generator. If the two men lived in one of the villages the Israeli government has recognized, getting this treatment would be no problem. As citizens of Israel, both Ahmad and Shauki are covered by National Health Insurance and are entitled to BiPAP. Lack of electricity, however, represents an insurmountable obstacle in their care. Physicians for Human Rights petitioned the Israeli government to connect both patients' houses to electricity. Our petition was refused, and their clinical situation deteriorated.

* * *

Alejandro's mother smiled wearily. She looked at me, trying to find some faint glimmer of hope. Alejandro, a slightly plump ten-year-old, was born in Israel to Colombian parents. He spoke both Spanish and Hebrew fluently and had become his mother's Hebrew translator. Despite the fact that he was born in Israel, due to the structure of citizenship in Israel he could not become an Israeli citizen and thus enjoy full access to all the benefits of the Israeli health care system. For Alejandro this was a devastating problem. He suffered from Legg-Calve-Perthes' disease—a disease that affects the femur bone in children. It begins with a limp, as the bone suffers a process of necrosis, and it can cause an irreversible deformation of the femur's

head, which would result in a permanent limp. His condition required surgery. However, in the late 1990s, the National Health Insurance law did not cover children of migrant workers, even if they were born in Israel. Unlike many migrant workers, his mother managed to purchase private health insurance, but the plan did not cover chronic conditions such as Alejandro's. For noncitizens, the costs of hospitalization in the Israeli public health care system were prohibitive, especially for migrant workers employed in low-wage service work.

Alejandro came to Physicians for Human Rights' Open Clinic for migrant workers for regular checkups, while we tried to find a public hospital that would agree to operate on him for a low fee. In the meantime, Alejandro's limp, as well as his prognosis, was getting worse. Finally we reached an agreement with the Ichilov hospital: They would operate for a significantly reduced fee. The agreed-on costs still represented a real burden for Alejandro's mother.

* * *

Before entering Kalkilya, in the West Bank, part of the Occupied Palestinian Territories (OPT), our taxi passed by Azoun, a village a few kilometers south of Kalkilya. The crossroad connecting the road to Azoun with the main road leading to Nablus was closed by a fence with a heavy padlock, blocking Palestinian cars coming from Azoun from access to the main road. Ambulances taking patients to the hospital in Nablus had to travel across unpaved roads. To reach the hospital, a patient needed not just one ambulance but two—one to carry the patient from his or her house to the blockade, and a second, which waited at the other side of the blockade, to take the patient to the hospital, some twenty miles away. As we were watching, the drivers lifted the patient out of the first ambulance and carted the patient over the blockade, from one ambulance to the other. Unmanned fences and blockades exist not only at Azoun but all along the West Bank, limiting patients' access to health care services as well as the access of health care personnel to their patients. Ambulances are delayed at the checkpoints; people in need of treatment are denied the permits required to travel from their village to city hospitals. Doctors cannot reach the hospitals they work in, nor can they get to their patients in the villages. Obstacles in access to health care add to the already poor living conditions.

As a result, the health status of the Palestinians in the OPT is much worse than that of the Israelis.

* * *

The four stories described above exemplify the ways in which citizenship, occupation, and the use of neoliberal, American models shape the delivery of health care in Israel and the Occupied Territories. They illustrate the health care boundaries that encircle both Israeli Jewish citizens and non-Jewish citizens living inside Israel as well as those that surround Palestinians living in the Occupied Territories. This book is a journey inside those circles of exclusion that now determine how health care is delivered in Israel and influence whether citizens, residents, and workers in Israel and the Occupied Territories are healthy or sick. The innermost circle surrounds older and poorer Israeli Jews impacted by the neoliberal transformation of their health care system. In the second circle are the Arabs. Migrant laborers who are essential to Israeli's growing global economy are in the penultimate circle, and in the outermost circle are Palestinians in the Occupied Territories.

Readers who are not Israelis may wonder what makes the exclusionary nature of the Israeli health care system unique. The health care systems of most industrialized countries exclude as well as include. Some—such as the U.S. health care system—have become world renowned for how many of their citizens do not have health insurance. Migrant workers—particularly undocumented ones—have difficulty gaining access to health care services all over the world. Similarly, Native Canadians, Americans, and Australians—like Bedouins in Israel—suffer from histories of oppression whose legacies are etched into the policies and practices of contemporary health care systems. And, of course, war and conflict wreak havoc all over the world.

So why should a reader care about this tiny country, Israel, and read about the trials of its health care system?

This question has several answers. The problems that Israel now encounters do not reflect only local health care trends and dilemmas but global ones. As we witness the outrage and frustration of Malka as she fights for continuity of care in an increasingly neoliberal, pay-as-you-go Americanized health care system, we have before us a critical example of

the power of the neoliberal model that is now seducing medical and political establishments in industrialized countries across the globe. The fact that Israel has been seduced by this model is particularly interesting.

Although many industrialized countries such as France, the United Kingdom, and Sweden established universal, single-payer health care systems after World War II, the Israeli health care system is one of the world's earliest and most impressive social experiments in group solidarity. As we will see in chapter 1, its roots were planted in the late nineteenth century, when Zionists first came to Palestine. These settlers created a social system in which residents—and then, after the establishment of the state of Israel, citizens—could not conceive of putting their individual health care needs above the needs of a collective defined religiously, ethnically, and ideologically. Their commitment created a health care system that rivaled any in the industrialized world. Despite these collective roots, the Israeli health care system now increasingly mimics some of the worst aspects of the U.S. privatized health care system.

In 1950, as we shall see in chapter 1, the American preoccupation with choice was so foreign to the Israeli imagination that a sick person wouldn't consider visiting a physician or hospital that was not an integral part of his or her political or social community. By the 1990s, many Israeli thirty-somethings were abandoning their sick parents to "inferior" sick funds (the Israeli version of the health maintenance organization) while ensuring that they got a better standard of service in "superior" ones. The gradual evolution of the Israeli health care system from the community to the market holds lessons for any country dealing with neoliberal challenges to social programs.

The Israeli case is important for a second reason. Work migration is a global phenomenon, and the arrival of migrant workers in significant numbers is common in rich, industrialized countries. This influx of migrant workers inevitably raises the question of how—and even whether—they are going to access health care services. The answer to this question differs from country to country. The Israeli case is of special interest because of its restrictive definitions of citizenship and thus social entitlement—which largely depend on ethnic characteristics.

The confluence of global processes with local, communitarian conceptions of inclusion and entitlement produces—as the story of Alejandro exemplifies—complex forms of access to, or exclusion from, health care.

Thus, from the Israeli case we can learn more about the specific ways in which global processes interact with local institutions, practices, and beliefs, thereby enhancing our understanding of the interplay between the global and the local.

Israeli treatment of migrant workers is also interesting given the collective history of migration of the Jewish people. It is a sad irony that a country founded as a response to the suffering of constant migration, exclusion, and expulsion partially reproduces, in its health care system and wider society, an exclusionary approach to today's global migrants.

The Israeli practices that structure citizenship also shape the limited ways in which the Bedouins in the unrecognized villages access health care. Even though Israelis would claim that their ancestors were "the first nation" in the ancient land of Israel, the contemporary example of Bedouin exclusion is yet another case of how settler societies deal with first nations. The discussion of who is, in fact, the "first nation" is at the core of how the country treats non-Jewish Israeli citizens.

Finally, questions about health care in Israel inevitably touch on Israel's position at the center of one of the globe's most controversial conflicts. Although this conflict has been depicted as a "clash of civilizations," it is really a clash of some of the most critical contemporary issues—questions about democracy, fundamentalism, nationalism, and colonialism. The prolonged Occupation of the Palestine territories is unique. Its global significance is well known. What is less well known is the major role that issues associated with health care and the health care system play in the dynamic of the conflict. As we saw in the examples above and will learn more about in chapter 5, health care has been structured as an instrument that reinforces the ongoing Occupation. Moreover, the Israeli case helps us to understand the ways in which violent national conflicts interact with and reinforce the neoliberalization of society and the exclusionary characteristics of the citizenship structure. If, for example, the United States maintains an extensive presence in Iraq, the Israeli case, which illuminates how abuse of Palestinians' right to health fuels regional conflict, will contain necessary lessons about the global ramifications of local conflicts.

The Israeli case, which illustrates the many ways in which social structure and politics limit access to health care and prevent various groups from fulfilling their potential to enjoy good health, also provides a lesson about the importance of the right to health. The *right to health* has been

defined in several ways. Some of those definitions are very limited. For example, some would define the right to health as having equal rights to the integrity of the body. Others would define the right to health, as neoliberalism does, only as the right to choose a health care provider (provided that you can pay for his or her services). The definition that inspires my approach is an egalitarian, universal understanding of the right to health. This conception is based on a recognition of our common vulnerability as human beings. It asserts our equal worth as human beings and assumes a basic fact: that good health is a precondition for the fulfillment of our capacities and rights. Poor health severely impairs the possibility of enjoying or taking advantage of such rights as freedom of movement or the right to political participation.

An egalitarian and universalist definition of the right to health states that every person has a claim to the amount of services and goods—including health care—needed to provide a level of health equal to another person's health, when inter-individual differences in health are the product of social organization or can be reduced by treatment; and every person has a claim to equal health care for equal needs in those cases in which individual differences in health result from natural, biological variations for which there is no treatment.

In this book I use a "right to health" perspective to analyze the different circles of exclusion in Israel and the OPT. I do so because this perspective allows us to move beyond the particular case of Israel and to critically examine not only health care systems but, more generally, social structures and social organization in different countries. The analysis of the different ways in which exclusion from health services and limitations to the right to health are structured in Israel provides us with important insights about the ways in which major global trends function both alone and in combination. These trends include the adoption of neoliberal recipes that erode the welfare state, the privatization of health care, the erosion of solidarity; ethnocentrism and nationalism; the securitization and militarization of society, prolonged military conflicts, and prolonged occupation. Each process by itself and in combination structures differential access to health care and limits people's right to fulfill their potential to enjoy good health.

In examining the Israeli case, this book is critical of the ways in which the prolonged Occupation, aspects of the Israeli institutional structure, and the adoption (and idealization) of a neoliberal, U.S.–like socioeconomic

model negatively affect access to health care. Although it is a critique of certain aspects of Israeli society, my book does not, in any way, intend to question Israel's legitimacy. Quite the contrary, I write as someone profoundly identified with Israel and its society. I have chosen to live in Israel and am a deeply committed member of Israeli society. But I am convinced that, in the spirit of the Jewish people through all its history, identification and belonging cannot and should not silence the critic and undermine the longing for *tikkun*—which means to heal, to repair, to make better. Criticizing from within is a form of belonging, an expression of deep identification. Using a medical analogy, people generally raise a critical health issue—say heavy drinking or smoking—with a loved one or a friend only if they care deeply about that person. Suggesting that someone stop smoking or change his or her drinking habits is a risky business that highlights one's sense of obligation and conviction that one must speak out to help modify behaviors that are jeopardizing that person's well-being.

Although this book is an analysis of the history and contemporary realities of these circles of exclusion, it is also a personal account of my own journey and struggle—as a physician, social activist, and policy analyst—to overcome the results of these exclusionary policies. Although I am a Jew and enjoy the full benefits of Israeli citizenship, I write this book as someone who has witnessed the full weight of what poverty, prejudice, and political oppression can do. I was born in Argentina and came of age during the military Junta's dictatorship in the 1970s. I studied medicine in the Buenos Aires public university, and as a medical student I made my clerkships at different public hospitals. There I could appreciate the dedication of the medical personnel but also the severe limitations of a health care system composed of an unhealthy mix of both private and impoverished public services. I came to Israel as a member of a Zionist-Socialist youth movement group. During my first years I was a member of Zikkim, a kibbutz south of Ashkelon, where we hoped to be part of an egalitarian commune. As a kibbutz member, I worked as a physician in Ashkelon's Barzilai hospital. A few years later I moved to Tel Aviv, and in 1990, when I finished my military service, I began to work at the Kupat Holim Clalit's clinic at Givat Hatmarim. Two years later, in 1992, I became its medical director. As medical director, I witnessed firsthand how the bonds of communal solidarity were slowly eroded so that people began to experience an "Americanization" of their society and their health care system.[3] For

someone born in Argentina and familiar with the characteristics and consequences of a health care system built on the differential access to health care based on social class, this was particularly disturbing. Although I was born in Argentina and became Israeli by choice, the Occupation, and the ways in which structured social injustices penetrated the health care system, made me feel torn between my deep sense of belonging to Israeli society and the shame I felt (and feel) because of this kind of inequality. This book is a product of my effort to cope with these feelings, addressing the different levels of exclusion in the Israeli health care system through study, analysis, and political activism.

Because of my own experience, I know that decent health care is embedded in and determined by political and social realities and choices. As a physician, it's not enough to have loyalty to individual patients and to abide by a code of professional ethics that is limited to dealing with such individual cases. I have seen quite clearly that an individual ethical perspective should be complemented by a broader, political conception of health as a basic human right. Because of this, I joined Physicians for Human Rights (PHR)–Israel, a nongovernmental organization (NGO) working for a universal and egalitarian implementation of the right to health. PHR–Israel began as an organization denouncing the violations to the right to health in the Occupied Territories and broadened its scope of activity to address all violations to the right to health in Israel. Yet, I was convinced that political activism, however important, should also be complemented by understanding of the social processes and structures that underlie the unequal access to health care that some of us, at least, are grappling with in Israel. This book is an attempt to identify and analyze the structural changes whose effects I was experiencing as a physician and the way they are combined with the exclusionary citizenship regime and Israel's policy in the Occupied Territories. In writing this book, I have been undoubtedly influenced by my years of activism in PHR–Israel. The universal, egalitarian approach that characterizes the organization's activities has helped shape my own approach, and in that sense I am indebted to all those people (volunteers and staff members) with whom I have shared, and still share, years of common struggle.

In addressing this task I combine my eighteen years' experience as a primary care physician and as an activist with the theoretical knowledge I acquired at a master's program in political theory and in writing a doctoral

thesis on the Israeli health care system. My goal was to put my everyday personal experience as a physician into a broader political and social context. As I explored health care in Israel, I wanted to understand the different levels of exclusion and their interrelation. I wanted to look at health care through a lens that also captures the social determinants of health—nutrition, water, and housing—and that views health care as an important, but not the only, element of the right to health. Poor health does not depend only on lack of access to health care, but results from complex causes including relative poverty, work insecurity, poor education, poor nutrition, unclean water, and poor housing conditions. Exclusion, segregation, discrimination, and the resultant inability to get a good education, find a good job, and live in a safe neighborhood, create or exacerbate health problems. Health problems caused by a lack of resources are aggravated by limited access to health care services.

To look at health care in Israel more broadly, I focus on the following questions.

- What were the historical roots and original promise of the health care system in Israel?
- What caused the profound changes of the Israeli health care system—changes that are, paradoxically, both logical extensions of and departures from these roots?
- What were the main features of the process?
- How had the financing, ownership, and management of the Israeli health care system changed?
- How had such changes affected the doctor-patient relationship?
- What was the relationship among the neoliberalization of the Israeli health care system; its growing dependence on the United States; the structure of citizenship and the Occupation?

These questions structure this exploration of the Israeli health care system. As the book will make clear, some of the circles of exclusion in this system are unique to the Israeli context; others are not but have an Israeli twist. The obstacles in access to health care that have resulted from the adoption of a more market-oriented, neoliberal version of health care as well as the exclusion of migrant workers, especially undocumented ones, are common features in rich Western countries. Israel's case is especially interesting because access to health care is also structured by the way Israeli

society was born and how the ideologies and social expectations of the original settlers have determined the contours of the health care system. We see this particularly when we examine how health care has been affected by the prolonged Occupation and the conflict between Israelis and Palestinians; and the geopolitical role Israel plays, especially as this has been influenced by the intricate web of relationships with the United States in which Israeli society is enmeshed. As this book reveals, one of the less known and less considered aspects of this conflict is how it impacts the health care not only of Palestinians but also of foreign workers employed in Israel and Israelis themselves.

In this book the structure of the Israeli health care system is viewed as an element within a version of Zionism that came to dominance before Israel became a state and has continued to provide the framework for the consolidation of the Israeli society and state. This view of Zionism produced a society with a strong sense of internal solidarity and a republican philosophy that drew a stark set of exclusionary boundaries (Peled 1992; Peled and Shafir 2005). The combination of the prolonged conflict between Israelis and Palestinians and the ways in which a particular view of Zionism—known as constructivist Zionism—implemented the idea of a Jewish state, defined concentric circles of belonging and exclusion that shaped the structure of the health care system and the different degrees of access to health care. As we shall see, and as Ms. Malka's case reflects, when it came to health care and other social services, this sector of social activity was determined by need and freed from the discipline of the market. Although this was a great benefit to Israeli Jews, it also created a fragmented system where status, ethnicity, and political affiliation defined different levels of inclusion and access.

Since the mid-1980s, Israel has become an integral part of the process of neoliberal globalization. As a consequence, Israeli society changed profoundly. It became wealthier (with a gross domestic product [GDP] per capita that corresponds to the developed world), but inequality increased as economic growth benefited only a small sector of the population, and the sense of republican solidarity that characterized the country eroded. The weakening of the Israeli sense of intra-Jewish solidarity, something that made Israel one of the most unequal countries in the developed world, did not dramatically alter the exclusion of non-Jewish groups. In the mid-1990s certain policy changes—such as the broadening of entitlement to children