**National Health Insurance Law (1994) in Israel and the Nursing Profession:**

**A Historical Overview**

**Abstract**

**Background:** The initiative to legislate a National Health Insurance Law in Israel was first documented in 1925, when the Clalit (General) Health Fund, the largest Health Maintenance Organization (HMO) In Israel, suffered a severe economic crisis. The crisis was caused by the socialist approach that formed the basis of Histadrut policy at the time—payment according to ability and treatment according to need. Thereafter, the topic was alternatively raised and removed from the agenda. When another economic crisis threatened Clalit in the 1990s, the decision to separate between the regulator (Ministry of Health) and the entity supplying health services, alongside dissatisfaction with the manner in which services were being provided, prepared the ground for the enactment of the National Health Insurance Law in 1994.

**Objectives:** To examine the impact of the enactment of the National Health Insurance Law on the nursing profession in Israel.

**Methods:** The study was carried out using a historical method, based mainly on review of historical documents and previous studies carried out on the subject in Israel. Data collection was based on documentation and reports by nurses.

**Results:** The law was legislated in Israel during a period of health reforms in most developed countries worldwide. Often, the motivating factor was the cost of supplying services. Over the years, the role of the nurse changed in many countries, and nurses were given more authority, so that the work burden would be shared, and costs lowered. Parallel changes in self-awareness and academization in the profession influenced nurses’ aspirations for independence and autonomy. The health reforms provided fertile ground for improving the status and role of nurses in the system. These influences reached Israel, if somewhat delayed, and viewed with caution by the healthcare system and its partners. This article presents the process that developed following passage of the law.

 **Conclusions:** Two axes characterize the change in the professional field: the changing status of the client in the caregiver/client relationship and the influence of the cost-benefit approach characteristic of healthcare systems in recent decades. Understanding these trends and implementing practical approaches will facilitate the ongoing advance of the nursing profession in the coming years.

**Introduction**

Nursing is the largest and most dynamic profession in any healthcare system in the world. It is recognized as essential and as having an impact on healthcare systems and policy-making. Previous research has examined the extent to which this is the result of deliberate policies, but a systematic review of articles on this subject does not provide evidence that the nursing profession has been involved in creating legislation or the implementation of health laws. Promoting policy is a fundamental element of nursing’s social mandate, and has become a core role of nursing organizations around the world. However, the discourse has focused primarily on the activities of individual nurses, with little attention paid to the work of nursing organizations in advocating policy. Understanding the existing literature is necessary to identify areas that require further research in order to strengthen this critical function. A comprehensive review conducted among six databases examined the nature, scope, and range of research on policy promotion by nursing organizations, and yielded 4,731 articles, of which 68 were included for analysis and synthesis. The findings indicated that the literature has increased over the years, but most is not empirical (Chiu et al., 2021).

Most of the articles published in Israel since the enactment of the 1994 National Health Insurance Law, including those by the Nursing Division of Israel’s Ministry of Health, do not mention the reform enacted through this law as a motive behind nursing policy (Greenberger et al., 2014; Riba et al., 2004). One exception is a study on community nurses (Nissenholtz-Ganot et al., 2017).

The purpose of the current article is to examine the history of nursing in Israel, which was a pioneer in passing legislation guaranteeing health insurance for all citizens. Since the goal of providing free health insurance in Israel began many years before the establishment of the State, I chose to conduct an historical survey of this issue.

Israel’s healthcare system is unique in terms of the way it was established and the ideological concepts that shaped its origins. The State of Israel is considered a young country of only 75 years. Even before the State was established, the pluralistic nature of its current healthcare system had largely been shaped, based on values such as solidarity and mutual responsibility. Therefore, it is legitimate to ask what the nurses’ role in this effort was, and how these values and the legislation affected the profession, from the time when the National Health Insurance Law was enacted.

While the history of Israel’s healthcare services is unique, healthcare reforms were enacted in many other countries during those years and their impact on nursing was documented in many studies during this period. Analyzing such trends may help the nursing profession in planning its path and emphases for the future.

This article uses historical research methods to trace the historical processes and identify the trends and directions towards which the nursing profession should direct its activity in Israel.

**Historical Background**

The development of the current healthcare system in Israel began during the British Mandate period, and many of the same administrative methods still exist today. In contrast, the nursing profession was based on the American educational model, and from the beginning, it aspired to academization, thanks to the work of the American organization, Hadassah.

Until Britain’s occupation of the Land of Israel (1917), responsibility for health services was in the hands of charities and religious institutions. In 1918, delegations of welfare organizations and medical professionals arrived in Israel from the United States, including the Hadassah Women’s Organization,[[1]](#footnote-1) which established the first nursing school in Jerusalem. A few years earlier, labor organizations established Health Medical Organizations (HMOs), the main one of which was Kupat Holim Clalit[[2]](#footnote-2) (Clalit Health Fund), established in 1911. Soon, it founded several hospitals, with affiliated nursing schools in each hospital.After the establishment of the State of Israel, the Ministry of Health also founded nursing schools in all state-owned hospitals.

This complex infrastructure affected the entire Israeli healthcare system for many years and continues to impact it today (Bin Nun et al., 2005).

By the time the state was established, it already had an infrastructure created by the British Mandate government and an established system of services provided by various organizations. From the beginning, there were disagreements about the nature of the healthcare system. Israel’s first Prime Minister, David Ben-Gurion, believed that national health services should be established, but he encountered resistance from political parties, and especially from the General Federation of Labour in Israel (the Histadrut), which supported the continued use of existing services, including the HMOs. Thus, the entities that existed before the establishment of the state were perpetuated to this day.

Two bodies that operated based on socialist ideology were responsible for the development of the healthcare services: Hadassah and the Histadrut. The Histadrut, joined by the Clalit Health Fund, had an affinity with the ruling party at that time (Shvarts, 2003). However, legal regulation of the provision of services was delayed until 1994 for political reasons and lack of resources. This situation changed, as detailed in this article, only when Clalit, the country’s largest health fund, was in financial crisis.

**Table 1:**

*Development of the Healthcare System in Israel*

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| --- | --- | --- |
| **Year** | **Event** | **Comments** |
| **1911** | Establishment of the Clalit (General) Health Fund for workers | The health fund was established as mutual medical assistance system, offering voluntary insurance |
| **1912** | Establishment of the Hadassah Women’s Organization in New York | The organization nominated Henrietta Sold as its leader |
| **1913** | The first delegation of Hadassah nurses arrives in Israel | The nurses leave when World War I began |
| **1917** | Establishment of the British military government in Israel (Palestine) | End of the period of rule under the Ottoman Empire |
| **1918**  | Establishment of the first nursing school by Hadassah  |  |
| **1920** | The Clalit Health Fund joined the Histadrut |  |
| **1923** | Establishment of the civilian British Mandate government | The British administration lasted until May 1948, with the establishment of the State of Israel |
| **1925** | The Clalit Health Fund applies to the British government for the establishment of national health and welfare insurance | Yitzhak Kanievsky was the inspiration behind this movement |
| **1948** | Establishment of the State of Israel, its government, and the Ministry of Health | The Ministry of Health adopts laws and procedures from the British government |
| **1994** | Passing of the National Health Insurance Law in Israel |  |

The intention and efforts to pass a mandatory health insurance law in Israel were first documented in 1925, when the Clalit Health Fund experienced its first serious economic crisis. According to Shvarts (1997, p. 81) this crisis stemmed from the Histadrut policy at that time, based on the socialist approach of “from each according to his ability, to each according to his needs.” By that time, insurance policies had already been instituted by the Histadrut in pre-state Israel for illness and healthcare, as well as for work-related injuries, obligating employers to pay compensation to their employees. The Histadrut asked to participate in discussions on this issue with the British government, but their request was rejected (Kanievsky, 1932, pp. 28-29).

In the decades following World War II, most Western countries underwent a similar process of healthcare reform. From 1945 until the 1980s, a socialist approach prevailed in healthcare systems worldwide. The World Health Organization endorsed a global strategy of Health for All by 2000. In Israel, prior to the implementation of the 1994 law, about 95% of the population was covered by one of the four health funds. The differences between the health funds led to a deterioration in Clalit’s situation and to severe financial deficits in the entire healthcare system. By the 1990s, the Clalit Health Fund was once again threatened by economic crisis.

These factors prepared the ground for the enactment of the National Health Insurance Law of 1994. As a result of the enactment of this law, the health funds became more competitive, with an approach based on economics, and the services provided to patients improved (Bin Nun et al., 2005, pp. 200-201). This provided a basis for changing and developing new roles in the healthcare system.

An in-depth examination of these trends raises several questions: To what extent was there awareness within the nursing profession of its central role in healthcare? To what extent was the profession an initiator in the reform process? Was the nursing profession merely drawn into the process, due to global social, economic, and political circumstances?

**Nursing and the National Insurance Law**

Studies describe nursing as an independent profession with a centuries-long tradition of helping and caring for the vulnerable, which has always given the profession a broad basis for its work. Nursing leadership has promoted the development of professional nursing and focused on the needs of the individual, and how it is perceived in the community. Caring for human beings comprised the basis for nursing (Bradshaw & Bradshaw, 1995; Hendel, 1997; Odem, 2002).

In the 1990s, when healthcare systems worldwide entered an era of reform and change based on cost-benefit analysis and limited resources, but those in the nursing profession were not yet ready for changes in the structure of their work. For the first time, nurses were exposed to a field that was new to them, and in some cases even contradicted the professional education they had acquired. This created inherent conflicts and ethical dilemmas (Spitzer et al., 1995).

In an article based on previous studies, Spitzer and Golander (2001) noted the three main stages that the nursing profession in Israel underwent, as a result of the changes in the healthcare system and with reference to the reforms:

1. **Awakening**. Nurses became increasingly aware of the impact of the reform on their profession.

2. **Sectorial introspection and organization**: Changes occurred in the way nurses perceived their profession. The redefinition of nursing demanded increased professionalization and training in clinical and academic programs (Teitler, 2000).

3. **New initiatives**: New treatment methods emerged within evidence-based practice and use of professional guidelines and treatment charts. The medical world moved away from treatment based on personal experience toward controlled and established management processes. Reports could be prepared and presented giving economic justification for the chosen directions for treatment. Clinical nurse specialists were suited to implementing care management and disease management, and were adapted to the new work environment (Spitzer et al., 1995, n. 8).

Recent research on nursing has examined the context of leadership, care management by nurses, and patient outcomes. A meta-analysis of studies found that nursing is based on professional achievements, not on hierarchies and historical power roles. This trend has been strengthened by the development of patient-centered care, which requires greater flexibility in work methods and the organization of services. Nurses have clearly proven themselves to be effective in a variety of roles throughout the course of treating illness and injury. It may be cautiously concluded that the care provided by nurses is as effective as that provided by physicians. In areas in which care provided by nurses is preferred, their treatment may even be more effective than medical care by physicians, as reflected in patients’ satisfaction, response to the treatment, and adherence to care plans. In fact, it seems that nurses add value in terms of patient satisfaction, and are able to create therapeutic relationships with patients that may promote patients’ understanding of their illness or injury and increase their motivation to manage their condition (Coster et al., 2018). In other meta-analyses, researchers have described the importance of the involvement of nurses and nursing organizations in promoting policy.

Policy advocacy is often accepted, without question, as a key function of many nursing organizations. As a result, it has not been subject to much critical examination or empirical investigation. This review has provided an overview of the nature, extent, and range of scholarly work focused on examining policy advocacy undertaken by nursing organizations. The findings lay the groundwork for future areas of inquiry and suggest that a more focused and critically reflective body of knowledge is required to help challenge current approaches, identify areas for improvement, and offer new insights into how these institutions can best meet the needs of nurses, the public, and health systems. To continue to strengthen the policy influence of nursing globally for the betterment of societies and healthcare systems, the focus must extend beyond the advocacy undertaken by individual nurses to ensure that the capacity of nursing organizations is effectively mobilized to have optimal impact on policy, practice, and society (Chiu et al., 2021).

Shamian and Ellen (2016) noted that the input and involvement of nurses, that is, appropriate nursing care, is essential for achieving positive results at the patient and system level. For a successful return on investment in nursing, there must be essential building blocks to support the nurses in their work. The number of nurses, their attitudes, their education, together with the factors in the process as described in the Magnet Model are the optimal combination. In their opinion, if these structural inputs or process factors are present, nursing has an advantage (Shamian & Ellen, 2016).

anhtu show that after an adjustment period, nursing changed drastically. Managers understood the importance of training highly skilled professional nurses, and of their contribution to economic efficiency and improvements in the quality of medical processes.

While Judith Shamian was the president of the International Council of Nurses, she found that, despite changes in the global economy, the status of women, and other areas, there is insufficient awareness of the ability of nursing to contribute to scientific and professional policy-making for global change (Shamian & Ellen, 2016). This is in contrast to the recognition of the contribution made by the nursing profession to patient care, where the nurses’ main impact is in hospitals and the expectations of them are related to their daily activities. In the meantime, nurses are making a significant contribution in terms of clinical medicine. Shamian cited research conducted in the US that showed a decrease of mortality in surgical wards where the rate of college-educated nurses was high (Shamian & Ellen, 2016).

These findings indicated that nurses play a key role as team members and as leaders of the patient-centered approach. Nurses have significantly increased economic effectiveness, without any reduction in concern, compassion, respect, representation, and social justice in their medical contribution. Not only can nurses take more responsibility that will lead to further increases in flexibility and effectiveness, they can also directly influence the social benefit to the community. Shamian and Ellen (2016) put forward their opinion that nurses should also be more involved in setting policy.

Another important study conducted in eight European countries found a significant connection between nursing staff and care outcomes such as mortality and patient satisfaction. Aiken and her associates found that increasing nursing staff reduced mortality by 7% within 30 days of admission to hospital. In 2011, the Institute of Medicine published their findings after examining the role of nurses as part of the reform (Aiken, 2009). Linda Aiken, a leading scholar of nursing, discussed the relationship between human resources and care outcomes. She noted that the cost of hospitalization in the US was $59 billion in 2004-2005, and the public’s awareness of safety and risk management issues indicated a need for a change in the attitude to nursing. In an economic budget-oriented marketplace, nursing is precisely the field that can provide a scientific basis for nursing practice and bring about improvements in the staffing levels and nursing work force (Aiken, 2009).

Recent studies have shown that the efficacy of nurses in the community is comparable with that of physicians (Horrocks et al., 2002). Other studies compared quality indicators in hospitals that employ registered nurses versus unskilled auxiliary personnel, and related the development of expertise in nursing to higher levels of specialization, such as Clinical Nurse Specialists in hospitals and Advanced Nurse Practitioners in the community(Dunn, 1997).

International studies present a clear-cut picture of the processes in nursing that have been impacted by the healthcare reform. In Israel, only a few studies have thus far examined the impact that the 1994 National Health Insurance Law has had on health professions in general and on nursing in particular in recent years. This is despite the importance attributed to the matter by scholars in the field.

The National Health Insurance Law of 1994 was based on the recommendations made by a national commission that the government established on June 14, 1988 to examine the functioning and efficacy of Israel’s healthcare system. The commission heard testimonies from nurses during its deliberations, but nurses were not represented among its members. In its recommendations, the commission discussed human resources in nursing, and recommended reducing the proportion of registered nurses. This move necessitated the addition of unskilled auxiliary staff. The commission also determined that the development of high-tech services, the transition to community care, and the emphasis on preventive medicine and health education would require the addition of n extensively trained nursing staff. The commission recommended strengthening the independence of the nursing workforce and giving it more powers, which could attract more people to the profession (Israel State Comptroller, 2008, p. 366).

 Surveys of human resources in the years following the passage of the law showed contradictory trends: the demand to reduce professional staff created a need to develop new positions (Nirel & Paryente, 1999).

Shahaf’s (2014) historical analysis of nursing in Israel between 1960 and 1995, noted that technological changes were included in the professional debate on changes in the nursing profession. This encompassed changes and advances in information and medical technology, specialization and academization of nursing, and the introduction of new measurement methods and indices. However, she noted that the increasing professionalism and specialization in nursing did not change the position of nurses in Israeli society (Shahaf, 2014, pp. 197–203).

Of particular note, by virtue of its uniqueness in Israel, is a pioneering study by nurses led by Spitzer and Golander (2001), under the auspices of the National Institute for Health Services and Health Policy Research. In 1998-1999 groups of nurses were interviewed regarding their knowledge, attitudes, and experience about the National Health Insurance Law and the healthcare reforms. This study focused on four aspects: changes in workplace and work environment; changes in the profession; changes in the nature of the client; and changes in the self-perception of the nurse as an individual, against the backdrop of parallel processes in the US and Europe.

Spitzer and Golander examined the knowledge and attitudes of nurses in the various sectors in Israel regarding the law and the reform in health services. In this pioneering study, hospital, community, public health nurses, and nurses in education were questioned about their knowledge, attitudes and familiarity with the content of the law and the recommendations of the Netanyahu Commission. They found that nurses in Israel had low to medium levels of knowledge of the reform and the law. Follow-up studies were conducted among nurses in geriatric hospitals, community nurses, and mental healthcare nurses, and those working with elderly invalids (Levy, 2002; Manor, 2000; Odem, 2002, n. 7; Teitler, 2000, n. 9; Re’em, 2002).

Based on the findings of the studies cited, I have chosen to discuss the following aspects:

1. Clients and the nurse-client relationship.

2. The nursing profession.

3. Promoting the interests of nursing through leadership, research and academic education.

4. Nurses as an individual and their work environment.

**1. Clients and the Nurse-client Relationship**

The practitioner-patient is anchored in the National Health Insurance Law (1994) and the Patient’s Rights Law (1996). Recent decades have seen increased consumer awareness among health services clients and the emergence of various layers of health insurance to complement the “Health Basket” – the services established by law. For most of the Western world, especially after World War II and until the late 1980s, providing health services was a social obligation. The health of the individual was perceived to be beyond any debate and cost.

From the 1980s, the social terminology changed. First, “sick people” became “patients,” then the public campaign against medical paternalism turned HMO members into “clients” with rights and expectations for quality and accessible service. HMOs are expected to bring in new clients, while also dealing with budgetary issues. As a result, HMOs began to develop programs to promote health and prevention, focusing on a healthy lifestyle, even though this field is not included in the “Health Basket.” For the first time, indices of medical quality were determined by the HMOs and published. The information is accessible and available, sent to clients by post or email. The right to receive a second opinion and the obligation of medical staff to cooperate in such cases have made the healthcare field more transparent and competitive than ever before. The language of healthcare services now includes terminology such as “client experience,” “patient-centered,” and “client-centered quality indices.”

Krulik (2003) noted that consumption of healthcare services is influenced by a kaleidoscope-like reality, reflecting demographic changes characterized by an increase in longevity and in the number of patients with chronic conditions. A second aspect is the change in the nature of morbidity: infectious diseases that had been eradicated have returned in more virulent forms. Experts believe, on the other hand, that the main causes of disability in the future will be heart disease, road accidents, and depression. The World Health Organization predicted an increase of 400% in the rate of invalids by 2020. Technological changes will have an impact on health. Imaging and diagnostics, as well as genetics and bio-technology developments, will affect healthcare professions and lead to an increase in healthcare expenditure.

Additionally, trends are emerging indicating that resources are decreasing and while social needs are increasing during this era of migration, loss of social cohesion, and deterioration in social support systems and the structure of the nuclear family (Krulik, 2003). There has also been a constant increase in client participation in the financing of healthcare services and in ever-increasing payments that citizens are forced to make from their pockets. Policy-makers and planners for the nursing profession will be needed to handle these changes, together with the changing nurse-client relationships. In many cases, these changes have reduced the accessibility to the benefits provided by the law for specific groups, and their ability to gain from the objectives of the law as determined in its enactment.

**The Nursing Profession**

The studies mentioned above used a range of definitions when describing professionalism in nursing. They all, however, refer to three characteristics of nursing – a profession that is learned, service oriented, and autonomous. Scholars describe a professional environment characterized by ambiguity and change.

In Israel, a number of steps were taken by the nursing leadership during this period. Faced with unfamiliar ethical dilemmas and issues, the nursing profession in Israel established a Bureau of Ethics within the Israel National Nurses Association, and updated the nursing Code of Ethics. In 2004, a conference of senior nursing leadership was initiated by the Head Nurse of Israel, Dr. Shoshana Riba, to discuss the issues. Efforts to legislate the Nurses’ Law (which has yet to be enacted) were accelerated, and led to the establishment of the Nursing Council, with representation from the various levels of nursing in Israel. Nursing in Israel as a profession is undergoing transition, including planned and initiated changes, and changes stemming from global social and political trends.

As mentioned, various scholars have found that nurses are currently going through professionalization, technological development, and specialization. There is a consensus among professionals and office-holders regarding the need to develop additional fields within nursing. The consensus on this issue is constantly expanding and is highlighted by the adoption of cost-benefit terminology and in the profession’s adaptation to new trends of client expectations, patient empowerment, self-care, and health promotion.

Attention can be given to more informed use of healthcare and to ensure the quality of care. A managed environment has benefited nurses, both personally and organizationally (Joel, 2002). Nissenholz et al. (2017) investigated the changes in the role of nurses in the community. They found that the nursing leadership, together with the great majority of nurses (85%), felt the nature of their work changed significantly during the relevant years. The main changes included a transition from responsive to proactive work processes, specialization, transfer of tasks from hospitals to the community, and greater autonomy. Their main areas of activity today include treating chronic patients, promoting health, and providing ongoing care. Four out of five nurses were satisfied with their work to a great or very great extent, and three out of four felt that they had independence in their work to a large or very large extent.

According to the interviewees, the barriers to the continued advances in the role of nurses include the conservative attitudes of some of the doctors and nurses, the scarcity of specialized nursing positions, and insufficiently attractive salary levels. Nurses have clearly and consistently worked to promote their professional status. The various researchers recommend the continued academization of nurses, based on the empirical findings of their studies. In my position as the Head Nurse at Clalit Health Services during this period, we held workshops for hospital and community nurses in which they identified accepted work practices and examined whether they were optimal within an evidence-based research model.

**Promoting the Interests of Nursing Through Leadership, Research, and Academic Education**

The nursing profession strives to influence the advancement of its professional perception and vision, and must act on several levels to promote its positions. Does nursing in Israel have the necessary means to do this? Has this profession learned to promote its standing and cooperation among policy-makers in order to achieve these goals? Is the nursing leadership partnering in the macro processes currently influencing health policy?

A nurse was elected to the Knesset (Israel’s parliament) for the first time in 2003. Ilana Cohen, member of the 16th Knesset, is the secretary of the Nurses’ Association, and has spearheaded many struggles in the past. Nurses who belong to professional organizations, such as the Association of Public Health Nurses and Schools of Public Health in Israel, advance the interests of nursing in the Knesset and its committees through professional lobbyists. The professional struggle finds political expression in the deliberations of the Knesset committees.

Shulamit (Shuli) Mualem-Rafaeli, a member of Knesset until 2019 and a nurse by profession, also promotes a professional agenda such as the appointment of nurses to hospital ethics committees. In recent years, she has been noted for her sponsorship of Nurses Day in the Knesset, during which debates on the subject of nurses and nursing are held in the various Knesset committees. This trend shows an increase in clear-headedness and readiness to play by the accepted rules of the political game (Antrobus, 2004).

The 1994 National Health Insurance Law not only assured medical coverage for all Israeli residents, the reform also led to fundamental changes in the structure of the health system as a whole, including nursing. Nurses were given roles that they had not conducted prior—care management, disease management, and case management. It was in these realms that nurses found full expression and utilization. Nurses excelled in the advances and efficiency they brought to health management in terms of cost-benefit and achievement of optimalclinical outcomes. The most prominent change was in the role of nurses in the community. Health costs continued to rise, and care for the chronically ill constitutes 70-80% of all expenditures, so optimal utilization of resources is indispensable. Managed care provides advantages in the organizational, clinical, and economic domains, alike. Most programs where nurses were appointed to manage patient/clientcare were successful. It was found that nurses with suitable training bring improvement in clinical measurements and lower costs (Megnazi et al., 2010).

Encouraged by these trends, the leaders and the Nursing Division in the Israel Ministry of Health promoted a plan for nursing specialization and courses in relevant fields such as care management for heart failure, palliative care, and prescription management as complementary services in the work of nurses in the community. The Ministry of Health’s Nursing Authority operated in a number of directions to bring about full academization including opening nursing programs at regional colleges. Between the years 1995-2010 eight study programs in nursing were opened at colleges and for retraining university graduates for careers in nursing with study grants and shortened study programs

Another research area found that academization has expanded and this is reflected in publications in prestigious journals and an increase in the number of researchers with PhDs and professorships. This is thanks to prominent academic leadership and the struggle for academization that began before the establishment of the state. Nurses such as Hava Golander, Tamar Krulik, Freda DeKeyser Ganz, Chaya Greenberger, Miriam Hirschfeld, and others are conducting prominent research in the field of nursing in Israel and serve in academia. Notably, Prof. Rebecca Bergman won the prestigious Israel Prize for her work in nursing and for establishing the first academic nursing department in Israel.

The practice of nursing in Israel is multileveled. From a professional standpoint, there are licensed practical nurses (LPNs), registered nurses (RNs), RNs with post-basic certification, and nurse practitioners. Each, naturally, has a different scope of practice. RNs hold a diploma (BA/BSN, MA/MSN, or PhD). Nurse practitioners must have an MA at a minimum and complete a specialty residence. A decade ago, despite the nursing shortage, the Nursing Division (ND) of the Israel Ministry of Health took the bold step of phasing out educational programs for LPNs. Despite opposition by the National Nurses’ Labor Association, a third of whose members were LPNs at the time, the ND team successfully convinced the Health Ministry that raising the entry level into the nursing profession would ultimately translate into better care. Today, LPNs comprise 19% of the workforce, and their numbers are steadily declining as these nurses retire. Most nurse managers only hire RNs, and many will only hire those with a BSN.

The goal of the ND is to gradually phase out diploma programs and make nursing a full-fledged academic profession, with BA/BSN as its entry level. In 2012, BA/BSN graduates in Israel numbered 1,050, in comparison with 750 graduates with diplomas. An additional 712 upgraded from RN to BSN.

In Israel, academic education is under the auspices of the Council for Higher Education, which approves and budgets all academic programs. This has facilitated the establishment of nine new faculties of nursing in colleges around the country since 2007, joining those which previously operated in four of the country’s six universities. It is hoped that these will keep the nursing shortage at bay. Israel currently has 5.7 nurses per 100,000 residents—less than in most OECD countries.

As a bridge to full academization, BA/BSN has been made a prerequisite for admission to all 20 post-basic certification programs. An additional incentive to pursuing nursing, specifically on an academic level, are scholarships currently awarded to BA/BSN students committing to two years of service in a public health facility. These scholarships are available (as of 2010), thanks to successful lobbying of the Finance Ministry by the ND (Greenberger et al., 2014).

In 1996, the European Nurse Directors Association (ENDA) set three main goals: a. To strengthen the contribution of nurses to policy-making and healthcare management; b. To develop knowledge and skills in nursing leadership and management; c. To establish formal links between nurse directors and nurse leaders across Europe to support a communication network of experts (Filkins, 2003).

However, excessively rapid changes can risk destabilizing the profession, unless the necessary resources are available. Following a reform in the British National Health System, nurses in the United Kingdom were given an important role in the planned change. Nursing leadership in the UK warned against rash, accelerated development without the necessary resources (Chambers, 2002).

The American Nurses Association (2009), which represents the interests of four million registered nurses, stated its belief that it has a role in influencing healthcare policy. The organization directs its efforts towards the policy-makers and entities whose decisions will affect patients and those who care for them. The organization asserts that it has a duty to ensure that voices from the nursing profession are heard at all levels where such decisions are made. However, if this organization has been involved in the committees and forums that planned the healthcare reforms in the US, we have not found any article or study describing such involvement.

Nursing leaders today must build on research studies in order to identify the areas in which they operate and can be of influence, to establish research groups, and encourage loci of excellence and recognition in research and academics (Keighley, 2004; Rafferty & Traynor, 2004).

**Nurses as Individuals and their Work Environment**

These changes in the healthcare system have affected both the immediate and the broader sphere of nursing. Healthcare managers have noted that the reasons for the scarcity of nurses and the high level of nurses who leave the profession, problems throughout the Western world, fall into two main categories. The first pertains to elements affecting the sphere closest to nurses, such as demanding and changing technological requirements, risk management processes, and the increased ease of litigation. The second is and social trends in the broader sphere of the nurses’ environment, such as nurses’ increased exposure to public debate in the media, or issues of transparency.

By contrast, other studies show that nurses’ loyalty to their workplace is linked to their level of clinical interest and professional fulfillment in their work. These findings show, on the one hand, the importance of challenging and interesting nursing work, and on the other hand depict a work environment that is becoming increasingly complex and demanding. Leadership and vision make the difference between coping and avoidance. Good leadership creates an atmosphere and a work environment that enable growth and involvement in policy-making (Goldberg & Benor, 2004).

Studies that examined the factors affecting stability among nurses in their workplace found that while wages and benefits are important, they are not a top priority. The opportunity to give direct patient care and role development have greater impact on loyalty. A correlation was found between the quality of care and the satisfaction of the nurse who provided the care. The Magnet Hospital Recognition Program was launched in the US in 1990 along these lines. Hospitals found to be magnets for nurses, were those offering direct, quality care to their patients. Hospital personnel were involved in the definition and development of professional activity and this included the economic management of the department. The Magnet Model offers professional identification and significance while further empowering nurses, to keep nurses in the workplace and prevent burnout.

A study conducted ten years after the enactment of Israel’s National Health Insurance Law (Missri, 2011), followed up on Spitzer and Golander’s pioneering research (2001), which, as noted, examined the attitudes towards the reform held by nurses in various clinical fields. In the absence of further studies on the subject of nurses and health reform, we will present Missri’s main findings.

Encouragingly, Missri found that while nurses’ knowledge about the achievements of the law was low, their knowledge of the law’s significance for the nursing profession was high (about 80%) in all sectors. Missri recommended that action should be undertaken in the field of research and in the involvement of nurses in policy matters. In my position as the Head Nurse at Clalit during the years 2008-2018, we promoted the Magnet Model in Clalit hospitals.

Nissenholz et al., (2017) found that, in general, nurses working in the community felt their work had expanded, that they have autonomy, and that for, the most part, they were satisfied with their work. Nurses said that they believed in the future and in the further development of their profession. However, they noted significant difficulties and barriers, such as the opposition of family physicians’ organizations to nursing expertise discussed in 2018. Further, decentralization was found to be an effective solution for improving satisfaction, professional autonomy, and organizational commitment (Acron et al., 1997; Nevdjon & Ericson, 2001).

The nursing profession is now the largest sector of the healthcare system. As nurses serve on the front lines, they can be significant in addressing the rapid changes occurring in the system. The barriers preventing them from responding effectively must be removed to assure that nurses are positioned to spearhead the changes to be implemented in the healthcare system following the legislation and reforms. Nurses work in many care environments including hospitals, schools, long-term clinics, private homes, the military, and community health centers. They have differing levels of education, from RNs working in direct patient care to research nurses who study and evaluate more effective ways of providing nursing care and promoting health (Institute of Medicine?, 2010).

The Nursing Division has led a process of licensing Nurse Specialists in key clinical fields. Expert nurses in the field of nursing policy and nursing management, whose ranks I joined during the initial stages of the process, are fully familiarized with the reform, and teach and act to advance its principles and implementation. In my view, this is the way forward, to open a much-needed discourse in order to lead the profession on the frontline of healthcare.

The World Health Organization announced 2020 as the year of nurses and midwives. Professor Sheila Tlau served as the co-chair of the Nursing Now Global Campaign and Global HIV Prevention Coalition of the WHO, which aims to raise the status and profile of nursing for Universal Health Coverage. Tlau has stated that “with health services under severe strain everywhere, there is a growing consensus that we need to move from a ‘bio-medical’ focus on treating disease to a more people-centered approach, collaborating with the patient to focus on disease prevention and healthy living. Nurses are already leading this paradigm,” (Thorne, 2019, pp. 1-2). Recognizing the value of nursing’s contribution to the law will improve both the profession’s positioning and its ability to implement the principles of the reform.

**Conclusions**

This historical overview followed the development of nursing in Israel, and illustrates the central role that nursing played in achieving a high level of medical care and public health in the country. This study leads to the conclusion that while the nursing profession promoted and carried out healthcare policy, and even brought about results, it did not participate in determining this policy. Further, analysis of studies on nursing policy in Israel found no links to the legislation, but rather to the policy of the Nursing Division and its leaders. Given this absence of top-down influence in the context of the law, this article described bottom-up processes, such as community nurses who, after passage of this law, received new roles in managing care and in this way brought about a policy change regarding the division of roles and the scope of the workforce, including the position of nursing in the healthcare system (for example, the training of clinical nurse specialists). The studies conducted by Spitzer and Golander (2001) and subsequent studies indicated that this change did not result from awareness within the profession, and that the nurses in the field supported the reform and wanted to promote their profession, but were not involved in preparing the legislation beforehand. Analysis of the selected articles revealed four aspects, as noted above: (1) clients and the nurse-client relationship; (2) the nursing profession, (3) promoting the interests of nursing through leadership, research, and academic education, and (4) nurses as individuals.

None of these four of these aspects of change were directed or managed within the framework of making preparations prior to passing the law.

 This reform has presented new challenges and opportunities. These challenges open the path for the nursing profession to take on new roles in the healthcare system, and encourage joint activity with peer professions to develop efficient teamwork that serves the needs of the patients. The situation in Israel today demands new thinking about the role of nurses and how the contribution of nursing will affect the clients and the healthcare system in the best possible way. No less important, innovative thinking is needed for nursing to be able to plan ahead and prepare for the future. This requires familiarity with the past and an analysis of the historic processes, in particular those processes that have either furthered or hindered the development of nursing, necessitated by the 1994 legislation and healthcare reform.

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1. Hadassah, the Women’s Zionist Organization of America, was established in 1912. In 1913, Hadassah sent two nurses to provide maternity care in Jerusalem. The Hadassah nurses’ station was closed in 1915 due to official pressure. In 1918, Hadassah established six hospitals in Palestine and founded a nursing school to train local personnel and create a cadre of nurses in Jerusalem. [↑](#footnote-ref-1)
2. Kupat Holim Clalit (Clalit Health Fund, now called Clalit Health Services) was established in 1911 with the aim of insuring medical services for workers. The organization was established as a workers’ organization with a cohesive ideological concept of mutual assistance. In 1920, with the establishment of the Labour Federation, (the Histadrut) all the HMOs were consolidated into the Clalit Health Fund as part of the Histadrut. In 1994, as part of the National Health Law, the Clalit Health Fund was separated from the Histadrut. [↑](#footnote-ref-2)