**Commercialization of Health Care in Israel –**

**An ethno-class inquiry of patient narratives[[1]](#footnote-1)**

**Abstract**

This study discusses the subjective-cultural aspects of the commercialization of health care from an ethno-class perspective. Using narrative analysis of 20 patient stories to extract “key plots” and Bourdieusian concepts, like “field” and “habitus,” the paper explores the extent to which a “neoliberal” conception of self has penetrated the different echelons of Israeli society – from upper-middle- (mainly Ashkenazi Jews) to lower-middle- (mainly Mizrahi Jews) and working- (mainly Arab) class levels.

The findings paint a complicated picture. While a wide and deep commodification of health is evident in all narratives (along with negative impressions of the public system related to long wait times, low quality, and bad attitudes), there are important variations. The “ideal” neoliberal self appears quite clearly among upper (mostly Ashkenazi Jewish) middle-class respondents, who typically hold both private and supplementary insurance in addition to the universal public coverage. Some of their narratives express a hero-quest story of a self-assured patient enjoying choice.

The Mizrahi lower-middle-class and the Arab working-class accounts present a different narrative, perhaps even a different habitus. Although they too tend to describe the public system negatively, they do not despise it and tend not to celebrate the use of private insurance, instead expressing some nostalgia for the public system of the past. Both groups seek personal solutions by using supplementary insurance and family assistance. Arabs tend to use a network of social contacts to bypass the public routes. With public healthcare systems declining worldwide, this research offers insights that would benefit from further mix-methods research.

**Introduction**

This paper discusses ways in which different ethno-class groups navigate a semi-commodified healthcare system in the neoliberal age.[[2]](#footnote-2) Using Israel as a case study, we explore the complex ways in which subjectivities are expressed using the qualitative method of narrative analysis (Harvey, 2005; Mol, 2008; Rasooly et al., 2020; Sweet, 2018), particularly among middle and lower social strata (Adut et al., forthcoming).

We begin by defining the ethno-classes discussed and providing a brief overview of Israel’s class structure. The second section describes the Israeli healthcare system(s) and the complex interrelationship between its public and private sectors, while the third section broadly outlines the scholarly literature on the subjective-cultural aspects of health commercialization in developed countries.

**Class and the popular classes**

We understand class as a social group or a web of social groups sharing a common material ground (the relationship to capital and its practices) and linked into power relationships with other classes. Class is also defined by shared practices: shared spatial spaces, practices of consumption, partially shared culture, forms of individuation and, sometimes, common political worldviews and/or practices. All coalesce in the way a certain social group defines the boundaries between itself and other social classes.

We define the popular classes as the subaltern classes, in its original Gramscian sense (Galastri, 2018). For Gramsci, these classes possess agency and voice, and a certain degree of autonomy, in spite of their subordination to capital[[3]](#footnote-4) (Thomas, 2018). Subalterns have consciousness about their condition, are able to organize themselves and even challenge the hegemonic model or promote their interests as a peripheral part of the hegemonic historical bloc. As a collective and as individuals, they stand in a constant tension between their subordination to capital and their autonomous agency. We use this concept in plural – *popular classes* – because, following the literature on the topic (Bernard et al., 2019; Beroud et al., 2016; Pasquier, 2018; Pizzorno, 2018; Schwartz, 2011), we consider that it better reflects the changes in class composition of the late 20th and early 21st centuries, and the heterogeneity and internal differences characterizing the subaltern social groups.[[4]](#footnote-5)

In line with this conceptualization of social class and the popular classes, we view Israeli society as divided into three main classes: capital owners, the new service class (linked to capital by formal and informal contracts), and the popular classes. The popular classes are characterized by the subaltern position vis a vis the two dominant classes (Adut et al., forthcoming).[[5]](#footnote-6) The latter are a heterogenous and plural class, characterized by vertical and horizontal divisions (Adut et al., forthcoming; Bernard et al., 2019; Beroud et al., 2016; Schwartz, 2011).

Along the vertical axis are three hierarchical sub-classes: the popular middle classes, the traditional working class, and the marginal popular classes. Along the horizontal axis we see differences according to ethnicity, gender, sector, or level of autonomy (wage-earners vs. independent workers). The popular classes are divided into three main sub-classes: the popular middle classes, the traditional working class, and the marginal popular classes. The latter is a sub-class within the popular classes characterized by low income, routine and low-skilled jobs, with very low – if any – autonomy in work, and lacking job and social security (precariat).

The occupations within this sub-class include agricultural workers, ancillary workers, and low-skilled service occupations. In Israel, this class is also divided according to citizenship status (Israeli citizens/migrant workers and asylum seekers), and according to ethno-national lines (Jewish/Palestinian citizens; and within Jewish citizens, immigrants from the former USSR, Mizrahim, and immigrants from Ethiopia). We focus here on Israeli citizens or formal residents – Israeli Jews and Israeli Arabs,[[6]](#footnote-7) since being a legal resident is the prerequisite for full access to the public healthcare system. Our analysis of the popular classes will cover mainly the popular middle classes and the working class, both composed primarily of Israeli residents.

**The Israeli Healthcare System**

The Israeli healthcare system is complex and relatively fragmented. Its base is a universal basket of services to which every resident is entitled. Two mandatory taxes – health and income – are its main financial sources. In fact, the “system” operates as a mixture of public and privatized insurance(s) as well as commercialized medicine of different sorts. If there was a “commercialization index,” Israel would have been graded high, probably higher than the UK (see below).

The Ministry of Health (MOH) is responsible for the system’s planning and supervision, including public health services, and runs several hospitals. Four non-profit health maintenance organizations (HMOs), called health funds locally, are responsible for providing a basic “healthcare basket” as defined by law to their members. These HMOs administer and provide primary and secondary care, and finance (and sometimes provide) hospitalization services. Alongside the public system, and intermingled with it, is a growing private sector.

In 1994, the National Health Insurance Law (NHIL) created a single payer universal system providing broad coverage. Nonetheless, over the last 25 years Israel has experienced a steady, gradual process of privatization of financing and ownership of health care, accompanied by a cumulative erosion of publicly provided healthcare services. As shown in Figure 1, rising costs, driven by demographic changes and rising healthcare prices were not matched by increased public financing, causing a cumulative deficit of about 26%, a shortfall of about NIS 20 billion in the HMOs’ budgets (Levi & Davidovich, 2022).

**---Place Figure 1 Here ---**

Various strategies were employed to compensate for the diminishing public budget (among the lowest, per capita, among OECD countries). The government introduced significant increases in copayments for medications and specialist care. In addition, the HMOs were allowed to sell “supplementary” insurance products. They also now own medical imaging and laboratory facilities, and some hospitals. Moreover, since the 2000s, budget constraints have pushed hospitals to develop a range of private initiatives to bring in needed revenues (Filc & Davidovich, 2022).

In 1997, healthcare expenditures represented 3.8% of total household spending, rising to nearly 6% in 2021. This increase is attributed primarily to out-of-pocket purchases of supplementary or private commercial insurance and to expenses associated with increasingly privatized medicine (e.g., copayments), given that spending attributable to mandatory taxes remained quite stable. The decrease in government financing that precipitated these changes has been reflected not only in the growing share of health expenditures in overall household spending, but also in the growing numbers of people among the poorer 20% of the population who forgo treatments. forgoingsocioeconomic status (SES)Israel now has one of the highest private health insurance ownership rates in the world, reaching close to 90% of the population. Not surprisingly, between 2000 and 2021, the revenues of private insurance grew more than fourfold, from NIS 700 million to NIS 3.1 billion.

The private health insurance products are highly diversified and stratified. Whereas 86% of the entire population purchases some sort of voluntary insurance (supplementary or commercial), within the lowest quintile, 33% have only public and no private insurance. Among the Arab population, 54% have some voluntary insurance (mostly supplementary) and almost half have only public insurance. Surprisingly, among the Haredi (ultra-Orthodox) population, which has a relatively low socioeconomic status (SES), 84% have insurance beyond what is provided publicly, mostly supplementary.

The other Jewish population sectors, reasonably presumed to be mostly in the middle-classes, obtain additional insurance at very high rates (90%) and more than half (56%) have both the more expensive commercial insurance and the health funds’ supplementary insurance. All indications allow us to suggest that the non-Haredi Jews who obtain both private and supplementary insurances are mostly in the higher SES layers of the middle-class (Ash Committee, 2022). Indeed, government statistics show that higher SES households obtain commercial insurance at five times the rate of households with lower incomes (Davidovitch & Filc, 2022).

The overall picture shows that health care as it has evolved since the universal health law was enacted in 1994 has resulted in a three-tiered system that differentiates between three types of insurance coverage (public, supplementary, and private commercial) distributed across roughly three population layers: those with public insurance only, those holding the supplementary the public health funds sell, and those additionally holding private commercial insurance. While this represents the overall picture, as the case of the Haredi population shows, there are more nuances. Generally, patients receiving care through the public system are deprioritized in terms of access, waiting times, and the attending specialist’s seniority compared to patients owning private insurance. Furthermore, most of the new private services within the public system are provided in the country’s central area (around Tel Aviv and Jerusalem), thus increasing existing inequalities in service provision between the center and the periphery.

While private ownership of healthcare facilities has increased over the period, the main contributor to healthcare services’ privatization has been the expansion of different forms of public/private mix which blurred the boundaries between the public and private sectors. The private share of Israel’s health expenditures has grown mainly due to the impressive expansion of supplementary insurance sold by the HMOs: in 1999, 49% of the population purchased such supplementary coverage, increasing to 80% by 2021. Supplementary insurance covers services that are not publicly provided, including certain diagnostic procedures and pharmaceuticals. It also covers alternative and cosmetic medicine. However, the main reasons driving people to buy this kind of insurance policy are the ability to choose surgeons, and, primarily, to skip or shorten wait times.[[7]](#footnote-8)

Not surprisingly, among other effects, the rise in private healthcare expenditures has affected equality in access to services. Household expenditure on health was significantly higher for the more affluent 20% of the population than for the poorer 20% of the population – by 2.9 times in 1997, increasing to 3.5 times in 2001, and 4 times in 2021. While forgoing health services rose between 1999 to 2021 from 6 to 12% among the general population, it rose from 11 to 19% in the lower SES quintile.

Neoliberal practices include those that expand the logic of the market to everyday life, and the constitution of a neoliberal subjectivity, by which we act in every social situation as “consumers.”. The neo-liberalization of Israeli society as a whole, and the gradual privatization of health care has resulted in the commodification of health care, expressed in two primary ways: the privatization of services reflecting an institutional-structural outcome; and the more subjective adoption of a consumerist approach among healthcare service users, not only when purchasing private healthcare services, but also when using the public system. This is a two-way process, in which both the public healthcare institutions and the system’s users see users as customers who must use market instruments (private insurance, informal payments) and market strategies to navigate the system Rasooly, Davidovitch &Filc, 2020; Michael, Filc & Davidovitch, 2022; Niv-Yagoda, 2020).

**Cultural Research on Semi-Commercialized Health**

Since the 1990s, several studies have been published in Great Britain on the patterns of use of health services, including the inequality in health services between the center and the periphery (socially and geographically). These studies have employed extensive use of qualitative and integrated research methods, including cultural research tools (Popay et al., 2003; Williams, 2003).

Scholars in western welfare countries soon noticed the growing expansion of what Mol, in the Netherlands, characterized as “the logic of choice,” which began to dominate “the logic the care,” which had been the founding principle of the public health systems of the mid-20th century (Gabe, Harley & Calnan, 2015; Mol, 2008;). Based on ethnographic observations of patients with diabetes in the Dutch public-private system, Mol provided a phenomenological analysis of “choice” as the main symbolic axis of a consumerist discourse in which health is a marketized commodity, patients become an aggregate of individuals (rather than a social group), and patient actions are conceptualized as the actions of rational individuals.[[8]](#footnote-9)

Mol suggested that the *choosing patient* may suffer from the heavy load of personal responsibility for his/her choices. Mol postulated that while this sense of burden might affect patients who are upper-middle class, highly educated individuals possessing a high degree of “Cultural Health Capital” (CHC) – a Bourdieusian cultural capital which Shim applied to the health field (Shim, 2010) – it would more strongly affect patients from a lower SES. Such patients might be lower in CHC and more likely to get lost in the health “maze” created by the increasingly complex public-private mixture (Collyer, Willis & Lewis, 2017).

Shim’s and Mol’s analyses are illuminating, making the case that fully understanding commercialization processes requires more refined analytical tools enabling the tracking of the meeting point between the objective (conditioning) and the subjective (agency) aspects of patients’ encounters with the healthcare system. This challenge was met by Australian scholars whose healthcare system seems to better resemble Israel than the oft-cited British system. Australia’s former universal health coverage is today layered horizontally, with some 30–40% of residents (the more upper middle-class strata) insured by private insurance while residents in lower-class strata still rely on public healthcare coverage (Harley et al., 2011).

These researchers suggested a Weberian-inspired class analysis, mostly adapting Bourdieu’s terms: *field*, *habitus* and forms of *capital* to suggest that seemingly individual, isolated action (choice) is in fact rooted in a field which is the social structure in which different types of capital are (re)created and interplay. In their view, the healthcare field in fact “contests between the dominant ‘position-takings’ … those of the corporations of capitalism … the capitalist state … and those of subordinate actors” (Collyer et al., 2015, 690). Applying this approach, Willis and Lewis (2020) interviewed 78 Australian residents to analyze their experience of commercialized choice. Some of them were persuaded by insurance and government appeals and bought private insurance and some did not. Their finding shows that the choice discourse penetrated deeply into diverse strata and even reached to the core of the patients’ habitus, even among the poorer patients.

**Methodology**

This study was conducted as part of a larger mixed methods study on the public-private mix in health care. Aiming to assess the influence of the “neoliberal” discourse of commercialized health within varying class and ethno-class positions by exploring patients’ perspective, it is based on a narrative analysis of semi-structured interviews with 20 respondents, along with several informal talks with informants.

The texts were analyzed to identify common themes and values, narrative patterns, and interpretation of reality. Transcripts were then analyzed using several concepts developed in class-cultural research. In the tradition of narrative analysis, we assume that an individual account of a seemingly isolated personal event might actually imply a grain of a “key-plot,” or a collective “story” that encapsulates the experience and repertoire of the whole group (Bruner, 1991, 2004; Spector-Mersel, 2010).

Each semi-structured interview began by asking the respondent's occupation, education, age and their general ethnic attributes (See Table 1). It then moved to questions regarding personal experience, values, and views on the mixed private-public healthcare system. The interviews were all conducted in Hebrew by two qualified researchers (one is credited above, and the other is one of the authors). Haredi Jews, a social group situated in the lower echelons of Israeli society, is missing from this analysis because there time and resources were lacking to make the required special arrangements, such as hiring and training Haredi interviewers.

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**---Place Table 1 Here---**

**Findings**

Three major themes emerged from the narrative analysis: 1) the reactions across two major class echelons to the public healthcare system; 2) confusion and chaos around supplementary and public insurance; and 3) the unique care pathways employed by the working-class Arab community. Each is illustrated with quotes from the study’s respondents.

**Theme 1. Reactions to the Healthcare Experience across Class**

***The Middle-Class Neoliberal Self***

Ronny is a 77-year-old Jewish-Ashkenazi insurance agent with an academic degree, residing in a city urban center, clearly a member of the upper-middle class:

I had a back problem. I ran around in circles [and went] to the best consultants. None recommended any course of surgery, but rather [they recommended] all kinds of treatments, which I call “acts of sorcery.” Nothing relieved me from the suffering…. until I ran into a young doctor who just came with a certain specialty in surgery after studying in Pittsburgh [USA]. He examined me. I handed him an MRI I took, and he told me “Dear Sir, I am not working with the public system on this matter because they don’t want me there. You are invited to the private system.” In two minutes and twenty seconds, all the documents from the insurance company were transferred to the hospital. I didn’t pay a single penny for the surgery. He operated on me and I danced my way out of surgery.

Rony said that he trusts the public doctors, but he despises the system – citing bureaucratic barriers, lack of credit for talent (not wanting the “young doctor”), low availability, and the final outcome, that is, low quality of treatment. His story is an individualistic one of salvation, a sort of hero quest in which he is the hero for finding a solution as much as is the operating doctor. He “zigzags” between public and private until eventually finding his solution in the private.

 Other respondents who can be characterized in Israeli ethno-class terms as upper-middle and middle-class subjects tell similar stories. While not all are hero quest stories, they always, like Ada below, express a harsh critique of, even contempt for the public system, and a very strong assertion of the existential need to “zigzag” to private providers.

Ada’s occupation is lower-middle-class, but she is a kibbutz member, which, in Israel, situates her culturally in an upper-middle-class community in ethno-class terms. Perhaps that is why Ada feels obligated to express her values in support of the public health system, despite the fact that her stories deliver a totally different message. She shares a deep mistrust of the public system and continues to turn to the private insurance which the kibbutz provides in full. As Ada related about her mother:

My mother has a problem with her eyes ... She was blind in one eye and then, in the other eye, she suddenly had some kind of hemorrhage, and she couldn’t see. We went to doctors in [a public hospital in the periphery]. They tried and said, “There’s nothing we can do…She won’t see anymore.” [After this,] she sat at home for three months … no TV, no books, nothing. Four walls and that’s it. … We were looking for a [private] specialist doctor [and] we found [someone] through the internet. [I suggested to the public doctors to use] Avastin shots, do something! They said, “No, she doesn’t meet the standard, she isn’t entitled to it”… We went to her [private doctor]. [After] three injections, [my mother} sees and reads. Since then, [the public eye doctors] are erased for me. This department is deleted for me ... It was really wrong, really, really wrong.

***Lower-Middle and Working Class Negative Impression of the Public System***

Ira, a 72-year-old retired accountant who immigrated from the former Soviet Union (FSU) in the 1990s, lives in a peripheral city in Israel’s southern region. For her, as for many 1990s FSU immigrants, poverty is a vivid memory associated with her to immigration, deskilling, and unemployment. While today she lives in her own comfortable private house, she is chronically ill with many medical needs. She observed:

I think that the health system does not work for the… ordinary person. Our health system only works [for] people who have money. If you have money, you will get really good quality treatment. If you don’t have money, well, that’s where the story starts. Queues, for example ... you can’t get [appointments] easily. You can get it with “protektzia”[[9]](#footnote-12) or privately. Money. Pay money [for] surgery. That’s what we did.

Like Ronny and Ada, Ira went to privatized medicine for a healthcare solution. Unlike Ronny or Ada, however, her story is not a “hero quest” and lacks any expression of contempt. Choice, according to her, was forced upon her. She told of hardships and despair, and longs for the days when she felt she could just trust the system**.**

Rivi is a Mizrahi woman, a retired factory worker from a small town in the periphery. She began by expressing echoing Ira’s statement about the connection between money and health:

When it’s about money, then everything is in order [“Hakol Beseder”]. But when you have to go through a professional doctor in the [HMO], then it’s…problematic because the waiting is are long … This is very bad, and those without money are. They fall through the cracks. I’m telling you – I went to a gastro [private specialist]. I hardly sat down, and he already called my name. Isn’t it surreal? It’s very surreal. And [meanwhile] many people wait in line. Surreal!

Rivi’s account testifies to the deep commodification of health which is presented as a fact of nature (health=money). Yet it, too, does not relate a narrative of privatized medicine’s victory or express any contempt. Like Ira, Rivi does not celebrate this situation, but seems to lament it and is in wonderment (“its surreal”).

Nora, a Mizrahi retired factory worker from a semi-cooperative village (moshav) in the periphery recounts:

I called a family doctor [and was told], “No, there are no appointments today.” … I had an urgent need. I felt pain in my side, and I couldn’t help myself and I cried to her on the phone, and she tells me “No, no, no!” What could I do? I went to the clinic and confronted her. I told her, “Listen, I’m down and out. No. I’m not leaving your clinic until you help me!” It took hours until I received an appointment with a family doctor.

In her account, Nora suffers to the point of humiliation. She related that in the public system you are treated badly: “It’s like Yalla [“hurry up” in spoken Arabic], like a gaggle of hens.” Later, Nora moved to the (semi-) privatized system made available with supplementary insurance.

Yossi, a middle-aged Mizrahi locksmith from a relatively poor Jewish town in the periphery told another story relating to a work injury:

I haven’t worked because of my ankle for almost six months ... So, here there are two doctors: one is blabbering, and the other listening. The first one talks to the other ... Really, they are not interested in treating you.…Eventually, he writes something to himself [and says to me], “Okay, take this [medicine] and leave.” I didn’t like it that much ...

Later, Yossi needed an operation, but refused:

Why? Because I was afraid that they will bring in an apprentice. Sometimes the doctor stands still and brings in an apprentice. And I don’t want him to instruct [the apprentice] at my expense. I went to a private doctor because he knows. I said to him: “Are you doing [the surgery]?” He told me: “Yes.” And it was the most important [surgery] I’ve had ... We paid what was needed to be paid and we did it.

Yossi too used the word “Yalla” to convey humiliation. The orthopedic doctors “treats you but [does] not really treats you. Yalla, Yalla! Finished? Send in the next [person] in line! … It’s like a factory, a conveyor belt.” Again, Yossi’s story conveys no sign of victory, contempt. or mockery of the public system. The story starts with a frustrating experience, bordering on humiliation, and ends with privatized medicine that carries a price tag.

Ja’far, a middle-aged working-class Arab construction professional and a building team manager told another story about a work injury:

My worker was wounded by a nail at work ... I went to the clinic. They told me: “You must go to [another clinic in town]; he needs trauma [care].” … So, I took the guy and went there. At this clinic there was this disgusting doctor. He’s a trauma doctor, for cases like this, [but] he didn’t agree to see him ... because he stained the entire clinic with blood. [So] I took a referral letter and went to the [private] Nazareth English Hospital. And all the time, he cries that it hurts, and the blood comes out of his leg.

Ja’far shared another story of humiliation about his father:

I remember my father, may his soul rest in peace, had lung cancer and was in [a big government-owned public hospital] ... At the end of his life, they put him in a disgusting, filthy place. He no longer had a chance. The doctors told us there was no chance – just to wait ... If he was a private [patient] this hospital would have treated him differently ... He would have received all the conditions that a person deserves. [He was] someone who had passed so many years and contributed [to society] ... You know, he also worked in the National Transportation Agency, [in the] government.

Ja’far’s painful story does not mock the public system. He seeks private services because he was pushed out (in his eyes), feeling humiliated and even betrayed. The fact his father, part of the Arab minority, worked for the Israeli government, probably amplifies the narrative of betrayal.

Warda, a relatively successful, upwardly mobile Arab woman who moved from the north to the south canceled her supplementary insurance when she realized that it did not offer services in her region for the Bedouin communities. Hence, her story ends with a direct payment:

You call to book an appointment. Your condition is difficult, and you need a diagnosis because you have recurrent infections and a swollen face, and you’re not functioning. Then you’re told that the appointment will be in six months ... We will send you a letter to the post office with your appointment [time] and it will be about six more months. [But] the postal service is lousy in the village. We don’t get mail. So, there’s no way to receive an appointment over the phone ... And they say, go back to your office at your [local] clinic, but it’s lousy at the clinic. In the end, I had to take money out of my pocket and go to a private doctor. I reached him through an acquaintance, a doctor [I] studied with at Hebrew University. He said: “He is a senior specialist in this mouth surgery, and he has a private clinic in Nazareth. Go and [end] your suffering. You have money [or] you don’t have money. Just go.” I went and I paid 500 shekels. I had surgery and that’s it. The pain was gone.

**Theme 2: Supplementary and Public Insurance – Utter Confusion**

Supplementary insurance is a commodity as it is bought and sold in a so-called free market. However, it is sold by the public HMOs, its price is regulated, and patients cannot be denied coverage based on pre-existing conditions. It is a semi-commercialized insurance. Most of the lower-middle-class strata buy it and, as noted, it is their only private insurance. How, then, do lower ethno-classes experience it?

Nora, an elderly Mizrahi Jew from the southern periphery felt no need for supplementary insurance or privatized medicine, paying no attention to it when her husband. After his death, her children demanded that she buy the insurance, which she eventually did. She related her troubling experience:

I was at an ophthalmologist 18 months ago. He told me to do a cataract [operation] urgently [and] gave me a reference letter. I brought it to our [public HMO] clinic. They told me: “Well, we’re [faxing] it to [the regional HMO hospital].They’;; send you an appointment time.” … I’ve been already waiting for a year. [After more than a year]… I received a letter in which they tell me, “you’re in the waiting line. When an appointment is available [we’ll call you].” So I rang [a private clinic and] ... they made it perfect ... [It was] a different treatment ... patience, [people] talking nice to you.

Further inquiry revealed that Nora’s children played a major role in her decision to buy supplementary insurance and assisted in covering the required copayment for the surgery (NIS 7,000 NIS or ~$2,000). Her children, relatively upwardly mobile, third-generation Mizrahi Jews., had to reach out and pull their mother up to what they consider now a taken-for-granted standard of health.

**Theme 3. Local (Arab) Community Capital**

Jaber, a middle-aged plumber from an Arab town in the periphery, bluntly declared that, “I like to go to private medicine.” Yet, a closer look reveals a world of difference between what Jaber calls private and what might be imagined based on the neoliberal consumerist discourse (Harley et al., 2011). Jaber does not describe a linear route which starts from the public and goes to the private with the power of money. His route starts with the local family doctor who is also a distant relative:

Normally, I like to go to private [medicine]: the private [doctor] shows interest ... not that others don’t (God forbid) but they don’t relate too much. He [the private doctor] wants to work to get good results for him . That’s it.

So [my] doctor tells me, “We have a doctor in our [HMO] … first of all, you go to him.” Like, he wants to save my money… So we go to him. If it doesn’t help ... then go to more specialist doctors.

What Jaber casually narrates is the fact that a rather complicated network operates which is “ours” – meaning an Arab-Israeli communal network. It might start with “our” doctor receiving in a local public clinic or a regional public hospital. The doctor refers to another doctor that “we have,” but the referral is not done through standard medical public routes. At this point, if the possibility of seeing a specialist is raised, it will be done privately – not through insurance but through the network and paying a direct fee to the doctor.

This practice was mentioned by other respondents. Belal, a successful NGO manager, lives in a nice home but in a poor Arab village. He is undoubtedly among the local elite, serving as an information source and cultural interpreter. Belal talks about the “Arab ways” – distinctive routes to get proper or better health care that cross the borders of public and private but do not use commercial insurance. The whole network, he says, is based on a network of personal connections among Arabs. “Our doctor,” explained Belal, might ask for payment. If so:

I pay. Absolutely, like everyone else. Even more sometimes if [the doctor] asks. I have no problem. If you reach a critical point and you want to heal someone, you … don’t haggle over prices here.

For Belal, this practice is simply a survival strategy deployed by an Arab minority that suffers discrimination and sometimes humiliation in the public system. For Belal, the following account justifies this strategy in his eyes:

I hear about many cases of people who are dependent, very shaky. … [M]y uncle, for example. He went to [a public hospital]. After three months of waiting, he got there, and it turned out that the referral letter is missing … I told him, “Calm down, one second, what?” So he said: “ [The doctor] didn’t accept me. I have to go back [home]”… I said to him, “Why are you coming back? We’ve been waiting for three months! Let’s pick up the phone, take a look, [let’s do it]!”

Eventually Belal intervened, but his uncle was too tired and went home.

A socially mobile Arab young woman who migrated to the Bedouin Negev related a story about the need for communal networks of personal acquaintances:

My daughter suffered from stomach pains and constipation and our [HMO] has no pediatric gastroenterologist in the Negev. So, the first time I had to consult a gastroenterologist, … I had to go to the French hospital in Nazareth in the north … simply because [the HMO] could not give me a close enough [appointment] date. [Here] there is no doctor who belongs to [my] HMO. There are no upcoming appointments. The closest appointment was in Tel Aviv in something like two months, and the girl was suffering … I went to the French hospital because I knew people who were treated there. I knew someone who works there. He told me, “There’s a children’s gastroenterologist there; you can make an appointment with him.”

Warda, continued, relating some peculiarities in the communal network among the Arab Bedouin communities in the Negev, which are the poorest in Israel. According to Warda, the HMO chooses a person who is quite well-known in the local community, whose mission is to bring in people and even entire families to enroll in the HMO. From the patients’ perspective, this person will serve as their representative, smoothing their daily contacts with the HMO.

**Discussion**

Like many western countries in which a universal public system existed until around the 1990s, Israel has gradually experienced a well-documented process of health care privatization and commercialization (Filc & Davidovitch, 2020). And, as in other countries, these processes have created a private-public “maze” (Collyer et al., 2017). Although disputes exist around the impact/value of privatization and commercialization, most policy makers adhere to the axiom that "people want choice" (Filc, ibid; Yam-Hamelach 2012, 13). Yet, from a subjective-cultural perspective many questions remain about the impact of these processes, particularly on the social group and its ethno-class position.

Respondents were asked to tell stories about their experiences in the health system. It is worth noting that the interviewers did not prompt the respondents in any way to criticize the public system. Instead, respondents were ’asked to tell their personal stories about their healthcare experiences. Without prompting, their stories, almost without exception, were critical of the public system and reflected a binary favoring the private system. Certain repeated narrative patterns rise to the level of “key plots” of culture, attesting to the existence of values, interpretation, and even the basic categories of perceiving and acting in reality (habitus).

Begin with a general assumption about the external cultural context which was not a part of the analyzed material: the patient-subject as an agent, happily making choices is a fundamental part of a discourse activated mainly by marketing entities – commercial insurance companies, HMOs selling supplementary insurance – and by policy makers. This discourse, in Israel and other modern societies, tells a victorious story of choice, freedom, self-assurance, healthcare quality, and other values that can be characterized as neoliberal. Our initial contention was that this context, together with Israel’s exceptionally high levels of supplementary insurance coverage, would be mirrored in the subjective-cultural sphere by an appearance of the neoliberal self or neoliberal habitus in all social strata, reshaping both patterns of behavior (e.g., purchasing and using private health) and meaning (stories, values).

Our findings, however, indicate that this cultural assumption is not entirely valid – so much so that the variations we describe may even partially refute it. Indeed, undoubtedly, there is a widespread commodification and commercialization of health revealed in the subjective narratives among interviewees in all the echelons that we explored, reflected in the public=negative, private=positive binary mentioned above. Yet we also found important variations on an ethno-class basis which tell a surprising story.

The “ideal” model of a neoliberal self – narrative, values, interpretation of reality – appears quite clearly only among upper-middle-class respondents or among the lower-middle-class that resides in communities characterized as upper-middle class (such as the kibbutz). Consequently, in these social spaces, a subjective model or even habitus (that shapes perceived reality) prevails. Repeated narratives from this stratum depict a hero-quest story of a self-assured patient with high CHC. While the hero-quest plot is not always explicit, its values and interpretation of reality were prevalent in each and every narrative – contempt, even rage and a picture of a degrading public system.[[10]](#footnote-13)

Descending the SES ladder to lower ethno-class communities, the narratives change, the feeling is different, and unfamiliar practices emerge. The hero-quest story was essentially absent, even if the story of zigzagging to the private was a successful one. It seems that a different model is needed if we are to understand the texts of lower ethno-class groups. Along with the binary of PN-PP – citing a lack of services, long queues, provider indifference, and even blatant humiliation – the respondents expressed totally different feelings. To the contrary, the feeling in these narratives was not one of contempt for the public system, nor of individualized celebrations of the choice made possible by private insurance. Rather, emerging between the lines were feelings more akin to despair, fear, perhaps even nostalgia for the forgotten, once dominant, “logic of care.”

Two hypotheses can be postulated about the varied forms of commercialization operating among the two dominant ethno-class groups – the lower-class Mizrahim and Arabs of the working classes. The first hypothesis concerns Mizrahim in the middle-lower-class, and possibly also Russians in the same class position. Some common narrative elements can be identified. Right at the beginning of the story, the narrator tells of an event reflecting disappointment with an experience in the public system, but with a feeling of sorrow and even regret regarding the public system, strongly implying that things could have been, or were in the past, different.

It should be emphasized that all the Mizrahi lower-middle-class respondents had supplementary insurance but only part of them obtained commercial insurance – conforming to published statistics. Furthermore, the HMOs that sell supplementary insurance tend to blur the difference between this insurance and its function in improving access to publicly-provided care. Hence, the study narratives adopt this blurring and still see the HMO as the “one in charge.” If the HMO fails to provide proper care in its public function, the patients – at least for now – still regard the HMO as “worthy of disappointment.” In so doing, they maintain some contact with the “logic of care.” Yet, as the pattern of the story unfolds, the patient is driven to seek assistance individually, thereby adopting and adapting to the “logic of choice.”

Referral to the privatized or commercialized route does enable the Mizrahi lower-middle-class patient to experience personal treatment and care, but at least some conveyed feeling that are related to the heavy burden of choice and the anxiety of being lost in the public-private maze. These negative feelings were much more apparent in the lower-class narratives. Again, let us stress that this is a subjective analysis. It might be interesting to explore empirically what actually happened to the narrating patient and what was the result in medical terms. Future studies, qualitative and quantitative, would prove valuable on this subject.

The second hypothesis refers to a pattern that appears unique to the Arab community. The Arab respondents were located mainly in the working class and even lower or were higher-class cultural intermediaries living in communities that are mainly poor. Here, too, there is no evidence of the “neoliberal self” narrative pattern as it appeared in the stories of the upper (Jewish, mainly Ashkenazi) echelon. As with the Mizrahi lower-middle-class experience, the Arab narratives rarely express contempt for the public system. The respondents do not tell a success story of juggling between the public and the private while skillfully using financial and social resources and cultural health capital. Instead, disappointment and very often even humiliation are prevalent, together with the same air of lamentation.

The interviews with Arab respondents also reveal the surprising existence of a bypass route that does not rely on commercial or supplementary insurance, nor on economic or cultural-health capital. Instead, it relies on community networks that are based on the extended family or several extended families with a local community anchor. At the center of the network are doctors who often work in the public system and sometimes even in the village’s HMO clinic. Patients can reach these doctors through the public system, but the solution to a problematic health event often ends outside the public system. The narratives describe the weakness of the public system – from long wait times, indifferent attitudes, humiliation, and ethnic-class discrimination The doctors to whom the community then turns are reached through this network; they might charge a fee, but this is not a financialized route, as far as we could find. Its level of financialization (effectively commodification) could be the focus of future research.

This thick description of the habitus among the lower ethno-classes appears to create a gap between our research findings and other recent findings. For example, using survey methods, Niv-Yagoda (2020) found that Israelis in the lower classes who do not have commercial insurance (Arabs, for example) express more trust in the public system, thereby implying (in our terms) that their self is less commercialized. This seeming contradiction can be the result of our different methods. When people are asked for their positions, they act in accordance with their self-presentation and might return to their professed set of values, and even express the “logic of care” which we too found to exist in some form. This does not necessarily contradict their daily life, actions, and interpretations, as described in narratives reflecting ambivalence towards the public system and its logic of care.

The overall dynamic is indeed complicated. The upper middle-class seems to adopt and celebrate a variation of the neoliberal self, at least in its outspoken statements, even though it certainly carries its own risks and even repressive aspects. This adopted self can be interpreted as a variation of what Skeggs (2004) called the reflexive self, based on exchange value and modeled in the measures of the white Euro-American middle-class male. In contrast, the lower classes in our research do not evidence the prognosis of linear penetration of this neoliberal self. Nor do they evidence a (perhaps naïve) expectation that they continue to trust the troubled over-burdened public system. Instead, they share a critical view of the public system and participate in what seems to be a cultural corpus of complaints while developing their own attitudes and interpretation of reality, to the point of a genuine habitus.

The Mizrahi lower-middle-class and the Arab working-class present narratives that imply a new habitus that experiences the lack of services, long wait times, and, in short, humiliation in the struggle for good health. It does adopt commercialized values to some point (PN-PP) and seeks individual solutions in conditions of scarcity with limited financial resources and CHC. The Jews of the lower-middle-class seem to seek personal solutions through supplementary insurance together with family assistance. Working- and lower-class Arabs tend to participate in a community network located alongside and within the public system.

**Conclusions**

What emerges from this study is a mixture of class determinacy (conditioned by the position in the fields) and group agency. From a neo-Marxist point of view, a certain “voice” or agency may be found in the experience of relatively oppressed groups facing powerful forces. Theirs is neither the victory of class oppression nor of neoliberal false consciousness. Likewise, it is not the celebration of the freedom promised by neo-liberalism. Rather it is a picture of agency exercised in conditions of objective scarcity and subjective-cultural pressure exerted by the neoliberal model and by marketized and policy forces. Future research, perhaps using mixed methods, might confirm these insights and widen the scope to other relatively low SES groups, such as the Haredi communities. ​

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Figure 1:



**Table 1: Respondents**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Name (pseudonym) | Gender | Age | Profession  | Education  | Residence  | Ethnicity  | Class profile  |
| 2 | Ronny  | M | 77 | Insurance agent | academic | City  | AJ (Ashkenazi Jewish) | UMC\* |
| 3 | Ada | F | 70 | Cosmetician  | ? | Kibbutz[[11]](#footnote-14)  | AJ | LMC\*\* |
| 4 | Mor | F | 41 | Kindergarten teacher  | Academic  | Kibbutz | ~AJ (probably AJ) | LMC |
| 5 | Reli  | F | 62 | Lawyer  | Academic  | City | ~AJ | UMC |
| 6 | Ami | M | 66 | Teacher-Lecturer  | Academic  | Kibbutz  | AJ | UMC |
| 7 | Michael  | M | 30 | Student  | High school  | City | ~AJ | LMC |
| 8 | Kobi | M | 53 | Scholar  | Academic  | City | ~AJ | UMC |
| 9 | Ari | M | 30 | IT | Academic  | City | ~AJ | UMC |
| 10 | Rivi | F | 65 | Retired textile worker  | High school | Peripheral town  | MJ (Mizrahi Jewish) | WC\*\*\*\*\*\* |
| 11 | Mona  | F | 52 | House maid  | High school  | City (poor community) | AI (Arab-Israeli) | WC - MWC |
| 12 | Ira | F | 70 | Retired accountant  | Profession-al diploma  | City  | RJ (Russian Jewish immigrant 1990s) | LMC |
| 13 | Fani  | F | 71 | Retired worker (~secretary) | High school  | City (poor community) | RJI | WC |
| 14 | Mimi | F | 72 | Retired worker (cashier) | High school  | City (poor community) | MJ | WC |
| 15 | Belal | M | 51 | NGO manager | Academic  | Peripheral Arab village  | AI | UMC |
| 16 | Jaber | M | 55 | Plumber | ~Elementary  | Peripheral Arab town  | AI | WC |
| 17 | Nora | F | 64 | Retired factory worker | Elementary  | Peripheral Mizrahi village  | MJ | WC |
| 18 | Ja’far  | M | 56 | Painter (worker) | ~Elemen-tary  | Peripheral mixed (Arab and Jewish) town  |  | WC |
| 19 | Warda | F | 34 | Driving instructor  | Academic  | Peripheral Arab town | AI | LMC  |
| 20 | Yossi  | M | 70 | Locksmith  | High school  | Peripheral Jewish town | MJ | WC |

\* UMC = Upper Middle Class

\*\* LMC = Low Middle-Class

\*\*\* WC = Working Class

\*\*\*\* MWC = Marginal Working Class

1. The research on which this paper is based was funded by the Israeli National Institute for Health Policy Research. [↑](#footnote-ref-1)
2. The authors would like to extend special thanks to Dr. Efrat Leibovich who conducted a large part of the interviews during the field work. [↑](#footnote-ref-2)
3. The popular classes are subordinated to capital, sometimes directly through debt (Lazzarato), but mostly through their subordination to the new service class. [↑](#footnote-ref-4)
4. In the English literature, there is a resistance to using this term. Even when translating research specifically focused on the popular classes, such as Masclet’s research group, the selected term is “working classes” (Masclet et al. 2022). [↑](#footnote-ref-5)
5. We understand subalternity in the Gramscian way, in which the subaltern groups have agency and voice. [↑](#footnote-ref-6)
6. Arab-Palestinians are residents of Israel and not the occupied territories. The text will relate to them simply as “Arabs.” [↑](#footnote-ref-7)
7. While the public system allows for choosing doctors for ambulatory services and hospitals, it does not allow for choosing specific doctors within the hospital system. [↑](#footnote-ref-8)
8. Another useful theoretical account, close to Mol’s in principle, is Fotaki’s which differentiates the citizen’s and the consumer’s discourse (Fotaki, 2011). [↑](#footnote-ref-9)
9. “Protektzia” is a popular slang meaning using all kinds of social connections with influential people, including bending rules, in order to get something, e.g., construction permit or medical treatment. [↑](#footnote-ref-12)
10. This does not mean the objective reality per se corresponds totally with the subjective. Indeed, we cannot measure the exact outcomes of any “free” choice. Ronny’s “hero quest” story, for example, relates a successful back surgery obtained quickly with a private doctor, while the relevant medical professional community is quite weary of quick decisions on back surgeries. נדב תוכל להוסיף הפניה [↑](#footnote-ref-13)
11. A kibbutz is an Israeli-Jewish originally cooperative small community village, once an important part of the Zionist Labor movement. Today most are associated with the Jewish-Ashkenazi middle class, but the reality is more diverse, as they provide geographic mobility the Mizrahi middle class as well. [↑](#footnote-ref-14)