Main Insights and Recommended Measures for Israel

a. Insights on public health

Background

The global SARS-CoV-2 (novel-coronavirus) pandemic has created a public-health emergency in Israel and worldwide. It revealed the need for a strong public-health system that can respond to a broad range of public-health challenges in emergencies and in normal times. This epidemic, like any crisis, presents an opportunity for reform in Israel’s public-health system so that it will emerge strengthened and better prepared to protect the public-s health. The same happened in various countries after the SARS epidemic in 2003; indeed, these countries, e.g., Canada, China, and Singapore, were better prepared for the coronavirus pandemic. Already today, with the “corona era” in Israel and abroad still under way, it is obvious that apart from the virus itself, the response to it poses a threat to public health for reasons including impairment of the public’s trust in the healthcare system generally the segment tasked with public health specifically; burnout of healthcare staff and exhaustion of healthcare-system resources; and direct impairment of health due to lockdown damage such as weight gain, dearth of physical activity, increase in smoking rates, loneliness, depression, and degradation of social capital, among many others. Conversely, the event presents an unprecedented opportunity to bolster the status of public health and fund it properly, given its importance as a frontline player in national preparedness for emergencies that threaten the population’s health. This document presents a literature review, initial from a systemic perspective and in its specific topics, of public-health challenges and opportunities in Israel during and after the coronavirus era.

Strategies and precipitants of improvement in public health

The coronavirus pandemic, as stated, creates a learning moment and an opportunity for thinking and deriving lessons from the coping efforts made at the present time and after the epidemic blows over. Various countries published conclusions in regard to public health after the SARS and MERS epidemics; they are the ones that have seen greater success in coping with the current pandemic. Israel’s public-health system, as noted, needs reforms and revisions in a range of fields. Most lessons learned by public-health systems abroad can be applied in Israel and additional specific fields may be developed, allowing Israel’s public-health system to deliver more successful and efficient treatment and to cope more effectively in ordinary and emergency times.

Public-health organization and human resources

Personnel planning in the healthcare professions is a topic that has much occupied healthcare systems abroad and, in particular, in Israel. Many countries (Australia, UK, Canada, France, Ireland, and Belgium) have entities that deal with human-resource planning only. The planning entities are differentiated in the sense that in some, such as Israel’s, the state owns some of the hospitals; therefore, it is the state that runs and funds them. Even countries that do not have state-owned hospitals, such as the UK and the United States, have a large sector of NPO public hospitals (Nirel, Schatz, and Tarov[], 2010). Human-resource planning in the medical professions is strongly associated with setting quotas on admission to medical schools and even in certification.

Israel’s healthcare system suffers from a shortage of personnel slots for doctors and nurses. In 2018, for example, the country had 3.1 doctors per 1,000 of population, as against 3.5 on average in the OECD countries, and had 5.1 nurses as against 9.2, respectively. Furthermore, the share of doctors aged 55+ in Israel is high and has been rising over the years (OECD, 2019). In the past year, only 3,411 personnel slots were allocated for the entire public-health. These data underscore the need to create more staff and personnel slots for the public-health system in particular, including doctors, healthcare and environment professionials, epidemiologists, laboratory staff, and others. The robustness of medical teams and their ability to treat the ill are definitive in the effort to keep the system healthy and stable. Thus, given the acute risk that accompanies these teams, it is important for staff to conduct drills and organize hospital care when an infectious disease erupts (Occupational Safety and Health, 2009; Peeri et al., 2020). Notably, the reinforcement of public-health infrastructures such as laboratories, computer equipment, and standards, among other things, may be useful in the current pandemic and may also be advantageous in additional crises. In emergencies, unlike non-emergency situations, the public-health system makes gains in public relations and publicity. It is important to amplify this identity and create camaraderie and pride among public-health workers all year long and foremost in emergencies, in order to improve their work and to attract more people to these occupations in the future.

Public-health legislation

When an emergency strikes, rapid legislation and centralization of powers are needed in order to shorten the time between making a decision and implementing it, to preempt and forestall an outbreak of illness or an upturn in morbidity, and to keep the population of the ill in line with the condition of the healthcare system. It is also necessary to legislate the state’s obligations to its citizens’ health in lieu of the Public Health Ordinance, which spells out the duties and powers of the various organizations and offices. Also needed are legislation and a program put forward by public-health experts to thwart situatons of contagion (Shaw, 2006). The legal framework that regulates such issues also needs attention in the contexts of workers’ rights, protection of privacy, private health monitoring and information, and existing legal tools pertaining to detection of cases of illness, sharing of data (e.g., procedures for reporting new cases and rules for the protection of privacy) and dissemination of information (responsibility for communicating various kinds of content). It is much like the 2014 Government resolution that mandates a Regulatory Impact Assessment (RIA) for all primary and secondary legislation, which pertains mainly to manufacturing and the business sector. Such assessments may be extended to the domain of public health, which is strongly influenced by government decisions in routine times and, in particular, during health-environment emergencies. This again demonstrates the need for an operative entity and for legislation that would create one authoritative body, such as a national crisis authority, that would coordinate all offices, experts, and processes (for gathering, analysis, and processing data, etc.) and, as a consequence, make decisions in a way that would respect the various population gropus and give epidemiology and public health professional emphasis.

Data

In states of emergency, as in those of normality, diverse data on various health-related matters are generated that allow decisions to be made and conclusions drawn. In many East Asian countries, the importance of this factor for successful coping is acknowledged, ensuring cooperation among national and international institutions (Frost, Li, Moolenaar, Mao, & Xie, 2019; MoH, 2014). This demonstrates the need to connect diverse systems and entities and to centralize data at the Ministry of Health in order to expedite data analysis, response time, and reaching of conclusions. This would create an opportunity to strengthen infrastructures, including the overhaul of computer systems and the addition of personnel slots, in a way that may help to improve public health in ordinary times as well. Even so, while most East Asian countries bolstered their rosters of epidemiologists and experts on contagious diseases, Israel’s Ministry of Health relied on unprofessional outside players in these fields and appears to have failed to gather data (morbidity and mortality from COVID-19 and other illnesses, the effect of measures relating to health indicators, etc.), to make data accessible, and to analyze and process data from the standpoint of epidemiology, in a way that would allow more balanced and thoughtful decisions to be made.

Reinforcement and training in public-health occupations

The coronavirus pandemic underscores the need for a stable and strong public-health system that would include advanced study and research, epidemiological analyses, construction of continuing models and strategies, and devoted and effective care for citizens. To allow the system to function in all respects and discharge all of its duties, young human resources are needed that can evolve within the public-health ecosystem and acquire a comprehensive systemic perspective. Apart from the obvious need for more personnel slots, young people should be encouraged to study medicine and doctors [] before they choose a specialization in order to improve and bolster the ability to operate and provide service. This reinforcement may be effectuated by co-opting schools of public health into medical associations’ discussions, meetings, and activities, setting up a joint course among the four public-health schools, adding applied studies to the public-health curriculum, and offering and advertising a range of incentives and economic and occupational benefits (wage increases, funding of specialization, scholarships, downscaled work hours, and easier admission to studies for graduates of MPH programs). Another tier in this effort xxxis creating new employee posts that will allow, apart from employment in research, applied employment. This requirement embodies the need for specific standard-setting for public health and creation of additional jobs for public health physicians, occupational physicians, subdistrict deputy physicains, e.g., a veterinarian who heads out to specialize in public health receives funding from the Ministry of Health, whereas specialized training of a dentist in public health is not funded. Public health is a multisystemic field ni which the parts interact. Thus, the response of service should be amplified so that it can provide medical care and advice in an integrated range of domains. Mother-and-child cetners, for example, can become multiprofessional centers that accommodate different specializations that can give the public a brace of services and respond to it in many ways (occupational therapy, physiotherapy, clinical communication therapy, nutrition, etc.). The current crisis also brings to the surface additional important issues in public health such as climate events and illness tracing to animals and the food industry, which entail allocation of budgets and large-scale recruitment of professionals in the fields of epidemiology, environmental health, and veterinary medicine.

Sources of funding for public health

Mnay countries, paticulary those in Eastern Asia, understood the immense need to rstrenthn their healthcare systems after previous epidemics that serve them as wake-up calls. The public health domain and the medical system in Israel have been in an ongoing state of crisis since the “aughts,” and fore more than a decade what exists is a far cry from shat should (Hillel and Haklai, 2020). The public health serives budget is in even graver condition and has long been contracting. Ini 2019, the Ministsry of Health budget was only NIS 37,984,845,000, and that specifically for public health was NIS 1,487,585,000—3.8 percent of the Ministry’s budget (the smallest in the past decade).[[1]](#footnote-1)

This sum, of course, is gross and does not reflect exceptions such as inoculations, the price of which has been rising in recent years. t\he state of inpatient care and care in the public services is dire, as the State Comptroller recently pointed out, reporting a shortage of protective equipment, medicines, inoculations, and inpatient beds (State Comptroller, 2020). At the end of 2019, for example, there were 16,299 standard general inpatient beds (16,148 in general hospitals and 151 in geriatric hospitals). The rate of inpatient beds to population has been in continual decline, 1.780 per 1,000, 3 percent down from 1.830 in 2015. The share of psychiatric and geriatric inpatient beds per 1,000 of population is also slumping (Hillel and Haklai, 2020). The failure to treat this problem has created, among other things, a personnel shortage (3,411 personnel slots in public health) and ongoing disparities in health indicators between center and periphery. Furthermore, the steady erosion of the healthcare budget has impaired availability and accessibility of medical equipment and care (Hillel and Haklai, 2019). This is manifested in by lengthening queues for doctors and medical services, shorter vitis to doctors, and erosion of the system’s infrastructures. The lengthy queueing in the public system is one of harshest problmes that the Israeli public suffers from (State Comptroller, 2020). Thus, when these failures well up, it is necessary to take resposiblity and draw conclusions, e.g., bringing the budget for public health services up to date and reinfording public health outside the healthcare system.

b. Economic insights

1. **A comparison of the SARS epidemic with the COVID-19 pandemic** shows that the economic measurs taken pursuant to the first-mentioned crisis were not enough to recommend economic measure as part of the relief package for the economy today. However, one can learn from the measures that East Asian governments are invoking at the present time. The scale and intensity of the damage we are experiencing today far exceed those underwent by East Asian coutnreis in the SARS crisis. Consequently, the economic response to SARS focused on minimal compensation for affected industries. The tools currently being applied are much broader; they embrace the entire economy and all areas of life—support for those affected, mitigation of unemployment and encouragement of re-employment, short- and medium-term relief for businesses and the self-employed, and massive support for the most affected industries. In addition, there is a perceptible difference in the restsrictions imposed on the economy. East Asian economies remained continually operative during the SARS crisis and did not have to weigh how and when to return to normality, whereas today the way of reopening is one of the most important economic issues.

2. **Comparison of Israel’s relief package with that of East Asian countries**—Israel in the past few months has invoked an extensive package of economic relief divided into many characteristics, with the relief packages deployed in East European countreisand the world at large. Comparison of the Israeli package with counterparts widely invoked elsewhere shows that one of the main characterisics of the East Asian packages that Israel lacks is support for job retention. Due to mass unpaid furloughs and terminations, Israel’s unemployment compensation outlays are rather large. In the East Asian relief packages, one sees that the preference is support existing employer payrolls instead of paying unemployment compensation. Apparently a similar measure in Israel, reducing job loss, might reduce unemployment compensation outlays on the one hand and would rpeserve the macroeconomic employment structure during the period of restrictions. Retaining the structure of employment may have the additional advantage of because job security might encourage households to spend and thus allow activity to rebound more quickly.

In addition, there appears to be a gap between Israel and the countries surveyed in the quality of implementation of the economic packages. Although we did not examine this matter in depth, the relief measures seem to have been applied more quickly in Eastern Asia than in Israel. Given the need to stimulate demand and check unemployment, rapid implementation of the budgeted measures is important even at the price of errors in distribution and loss of funds. Namely, bureaucracy in distributing the benefits should be reduced.

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3. Preparedness for Wave 2 or the next visur

3.1 Economic insights should be obtained from the measures invoked in Israel. Each step should be analyzed in terms of its extent of harm to the economy and its contribution to accommodating the virus. For example, and much like the remarks of the adminsitration’s team, it may not worth imposing restrictions on the economy’s most productive industries (e.g., high-tech) except in very extreme situations. The use of tees commensurate with the harm to the economy / accommodation of the disease would bringus closer to an optimal response. According to reportage in the world media, studies on issues such as these are expected to appear within a few weeks.

3.2 An early extreme response has proven economic advantages. As the Taiwanese model shows, total and early lockdown of the country and very tough enforcement of public health instructions may allow economic activity to continue. A radical response such as this comes with a price that may prove excessive in the event of a “false alarm” but may head off a major economic downturn. In future repoertage on a second wave or a new virus, thought should be given to adopting this as part of the attempt to minimize harm to the economy.

3.3Two kinds of support of the economy are important: compensation (personal, based on criteria) and recovery and rebound. In the medium term, there should be a transition from giving compensation to stimulating employment (for a Wave 2, it is preferable payments to employers in preferred industries, allowing full employment instead of National Insurance benefits for unpaid furlough, and to support training of workers who leave the labor market for crucial occupations. More resources should be addressed to badly affected industries.

c. Social and welfare insights

Given the nearly total dearth of studies on social-work activity after the SARS crisis, we base our insights on implications of the few existing studies and a small number of interviews with people in the “Israeli mosaic”—*haredi* (“ultra-Orthodox”) society, Arab society, people living in poverty, the elderly, and social workers. The main insights are the following:

1. Everything possible should be done to avoid adding people to the cycle of poverty. To assure this:

1.1 The imiplications of the pandemic for the situation of people living in poverty should be examined (and, more specifically, considering the possiblity of adjusting the level of benefits), to estimate the number of “newly p oor,” and to formljate policies and practices of reaching out to the newly poor who are afraid of the stigma of turning to welfare services and/or do not know how to do so.

1.2 Policies and practices for rapid extrication of the “newly poor” from poverty before they tumble into “chronic poverty” should be formulated.

1.3 A policy and cooperation sould be worked out with economic players [] to create a welfare policy that will alow economic recovery of disempowered poplation groups that were further disempowered by the ravages of the epidemic.

1.4 disempowered population groups already in the cycle of poverty should be helped to take up their entitlements (due to far of stigma or access difficulties).

2. It is important to counter the exclusion of population groups on the basis of age, gender, and special needs.

3. The Ministry of Social Services and the community of social workers played an important if not vital role in Wave 1 of the coronavirus crisis in assuring the most essencial needs: warm meals, foodstuffs, and medicines for the elderly population, Holocaust survivors, persons with disabilities, people living in poverty, and others. Concurrently, it seems important to add another layer of group and community work with the vearious groups and communiteis. Active involvement of social workers is immensely important and some of them should be declared essential workers.

4. Community work under conditions of physical distance—digital responses should be developed, telephonic, and others, that may both allow community work to take place at times of full or partial lockdown and ot help narrow digital gapsamogn disempowered population groups.

5. Support of NGOs that help needy population groups or the population at large is recommended.

1. <https://next.obudget.org/i/budget/0024/2019?li=2> [↑](#footnote-ref-1)