**Titles and Keywords**

Titles

הסחרת הבריאות בקרב קבוצות חברתיות מודרות במעמד נמוך בישראל – דפוסי פרשנות ופעולה

Commercialization of Healthcare among Marginalized and low SES groups in Israel – Patterns of Interpretation and Action

Fields of research:

Sociology, Ethnography, Healthcare policy

Class, Ethnicity, Low SES, Health, Healthcare Privatization, Healthcare Commercialization, Choice, Narrative, Habitus, Field, Arab, Haredi

**Scientific abstract (up to 250 KB)**

The Israeli healthcare system was built upon a robust public universal base. Yet, over the past two to three decades, privatization and commercialization, together with neoliberal policy and culture, have changed its structure and daily practice.

The proposed research focuses on how individuals experience, interpret, and navigate the resulting public-private healthcare “maze.” This mixed method research will conduct (180 semi-structured qualitative interviews and 900 quantitative surveys) to study the experience of people residing in communities of lower socioeconomic status (SES) levels, which in Israel are associated with three marginalized ethno-class groups: Arabs, Haredi Jews (ultra-Orthodox), and non-Haredi Jewish residents of underprivileged peripheral towns (mainly Mizrahi and Russian Jews). This study significantly expands an earlier study led by the proposing PIs, extending its scope from an initial 20 interviewees and adding Haredi communities to its focus.

Nine Israeli communities of low SES will be chosen, drawn from three geographical areas (north, center, and south), one for each ethno-class community. In the first phase, we will conduct and analyze 90 qualitative, semi-structured interviews among each group (10 in each of the 9 communities). The findings will inform a quantitative survey to be conducted in the same communities but on a much larger scale (100 for every community; 900 in total). In the third and final phase, we will conduct an additional 90 interviews to elicit additional nuance and verify survey findings.

The study’s main hypotheses relate to the practice patterns (meaning and action) of the commercialization experience among the three target, lower ethno-class Israeli communities. We expect their experiences to differ from those of upper-middle class patients, to markedly reflect distress and feelings of risk, and to be affected by demographic characteristics, ethno-class identity, and communal networks. Also expected are specific communal practices (social networks) that enable people in conditions of scarcity to avoid using private insurance and yet acquire healthcare services so as to better cope with the over-burdened public system.

The research proposed here has significance for policy makers and students of Israel’s deep cultural-class processes. It aims to explore a perspective missing in several areas; the ongoing debate on and examination of the regulation of the supplementary insurance products; discussions about the interrelationships and required boundaries between private and public in the healthcare system; and discussions on how healthcare services may be adjusted to meet the real needs and perceptions of peripheral populations, who are seldom at the forefront of public discourse. Further, it addresses a gap in the empirical literature on the subjective aspects of healthcare commercialization among patients in the lower SES.

**Research Program (PDF up to 16MB):**

1. **Scientific Background**

The Israeli healthcare system was built upon a robust public universal base. Yet, over the past two to three decades privatization and commercialization have changed its structure and operation. Research on the objective, institutional aspects of these processes is quite extensive. Less is known about its subjective and cultural aspects, such as how people or patients experience, interpret, or navigate the resulting public-private healthcare “maze.” Even less is known about the specific experience of members of lower-SES groups, who in Israel are associated with marginalized social (ethno-class) groups – Arabs, Haredi (ultra-Orthodox) Jews, and non-Haredi Jewish residents of underprivileged towns in Israel’s periphery (mainly Mizrahi and Russian Jews).

The proposed research continues and expands on an earlier, smaller-scaled study led by the proposing PIs, which included some patients from low-SES levels (mainly Arabs and Jews from underprivileged communities) but did not include Haredi communities. This study seeks to explore the hidden dynamics of everyday life within the lower-SES levels in Israeli society in spaces where patients from marginalized communities interact, share concerns and needs, and seek medical assistance in the public, commercial, and semi-commodified healthcare services.

The study is based on three key social-historical factors: 1. The stratified and ethno-class structure of Israeli society, which places three ethno-class groups in the lower-SES echelons – Arabs, Haredi Jews, and non-Haredi Jewish residents of the poorer development towns in Israel’s periphery; 2. The objective processes of commodification and commercialization, which changed the structure and daily course of Israel’s public healthcare system; and 3. The subjective aspects of the “neoliberal era,” that is, the deep cultural and psycho-social changes that are related to the late-modern culture beginning in the mid-1980s (Harvey, 2005).

**Research on Patients’ Experience of Semi-Commercialized Healthcare**

The combination of private and public healthcare insurance is quite common in developed countries, including countries that constructed robust public universal healthcare systems. Modes of private/public integration range from outsourcing certain services through incorporating private stakeholders in infrastructure development (UK) and private options at different levels in public services provision (Spain, Portugal), to privatization with strong regulation (Netherlands) (Acerete et al. 2011; Barlow et al. 2013; McDonald et al. 2011; Rosenau and Lako 2008; Sanchez et al. 2013).

Since the 1990s, several studies have been published in Great Britain on the patterns of use of healthcare services, including the inequality in healthcare services between the center and the social and geographic periphery that make extensive use of qualitative and integrated research methods, including cultural research tools (e.g., Williams, 2003). Popay and colleagues (2003) began to focus on the local community framework, and within it, on the actions initiated by the individual as part of community action patterns under conditions of inequality. They made use of a typology of relationships between place and healthcare (following Curtis & Rees Jones, YEAR) drawn from various sources of critical sociology and class culture research, especially the typology that focuses on geographic-human space.

Other scholars used cultural-class tools and phenomenological concepts, focusing on the practice of “choice” in the cultural context of neoliberalism (Gabe, Harley & Calnan, 2015). Generally, critical scholars, especially in Western welfare countries, noticed the growing expansion of what Mol (2008) termed as “the logic of choice.” This “logic” gained dominance over the “the logic of care,” which was the founding principle of mid-20th-century public healthcare systems (Mol, 2008).

Based on ethnographic observations of patients with diabetes in the Dutch public-private system, Mol (2008) provided a phenomenological analysis of “choice” as the main symbolic axis of a consumerist discourse in which healthcare is a marketized commodity and patients become an aggregate of individuals (rather than a social group), their actions conceptualized as the actions of a rational individual.[[1]](#footnote-1)

Importantly, Mol observed that this discourse expects patients to take on the heavy load of personal responsibility for their choices. That is, adopting (or adapting to) the logic of choice may be considered an act of freedom and empowerment, as the discourse of insurance marketing and policy makers’ neoliberalism often present it. However, this freedom could be experienced in different ways, depending on the individual/group’s SES position, with lower-SES patients possibly experiencing the “burden of choice” as intensifying insecurity, anxiety, and perhaps even suffering actual physical damage as a result of bad decisions.

In Shim’s terminology, an individual from the upper-class social level would possess relatively high “cultural health capital” (CHC) – a Bordieusian term Shim adjusted to fit the healthcare field (Shim, 2010). In fact, even such privileged individuals may suffer from the darker aspects of “the logic of choice,” if only because they lack sufficient medical knowledge to make fully rational decisions. Choice may be even more limited if the patient/user is situated in society’s lower echelons, and therefore likely faces higher risks associated with the choosing process.

By definition, lower-SES patients have poorer financial means and more limited social contacts and educational resources (such as digital and English fluency) than do their higher-SES counterparts. In Israel, they would probably belong to marginalized groups with less access to privatized medicine, financial resources, or professional elites. In short, such patients possess lower CHC (Shim, 2010) and can get lost in the public-private healthcare “maze,” pressured by the discourse of choice to take on too heavy a load of individual responsibility (Collyer, Willis & Lewis, 2017).

This critique paved the way for empirical studies aiming to transcend the limits of the existing market-based or neoliberal discourses on choice and healthcare commercialization and to delve into everyday reality. Such research is especially important in welfare societies (Israel being a marginal one) with healthcare systems built on a robust universal basis but which underwent neoliberal changes in the 1980s and 1990s. The resulting public-private healthcare “maze” tends to obscure the reality experienced by the lower-SES levels, as most marketing and policy attention is focused on upper-middle class users.

Shim’s and Mol’s analyses are illuminating and ostensibly reflect Israeli reality. However, sharper class lenses are needed to penetrate the binary debate of “celebration or lamentation” (with or against commercialization) in order to capture the real healthcare experiences of lower-SES patients. Fully understanding commercialization processes requires focusing on the intersection of the objective and the subjective, that is the (objective) accessibility to private insurance. This is determined by the layering of private insurance along class lines, and the (subjective) experience of specific social ethno-class groups under unique social conditions.

Some Australian scholars provide impressive examples that meet this theoretical and empirical challenge. Resembling Israel more than the often-cited British system, Australia’s former universal healthcare coverage is today layered horizontally, with some 30–40% residents (the upper-middle-class levels) insured by private insurance, while the lower levels rely on universal insurance (Harley et al., 2011). The resulting system reflects a 2- or perhaps 3-tier stratified social hierarchy in terms of access to commercialized health.

Collyer and colleagues (2015) suggested a Weberian-inspired class analysis, mostly adapting Bourdieu’s terms of Field, Habitus and Forms of Capital. They hypothesize that a choosing patient’s *habitus* involves both subjective agency and an individuality (or self) that was objectively determined under class (or other social hierarchical) conditions. That is, seemingly individual, isolated free actions are in fact rooted in a *field*, or the social structure in which different types of *capital* are recreated and interact. Analyzing a field means identifying the specific power relations between the social groups that are already structured in hierarchies. In healthcare, the field can be characterized by “contests between the dominant ‘position-takings’ … those of the corporations of capitalism … the capitalist state … and those of subordinate actors” (Collyer et al, 2015, p. 690).

*Field*, then, as applied by Collyer, is an objective structure that helps shape the seemingly isolated individual actions of commercialized medicine. The routes of *capital*(s) can be tracked to see how they reproduce and how they evolve from one form to another – from social ties to financial means, cultural resources, and mastering (CHC, in Shim’s terms), and vice versa. The result is a class-cultural analysis of “agency in action” placed in structure.

Collyer, Willis, and Lewis (2017), for example, interviewed 78 Australian residents to analyze their experiences of commercialized choice. Some had been persuaded by insurance and government appeals and had bought private healthcare insurance (PHI) and some had not. The findings show how deep the “choice” discourse penetrated to the public, even to the core of the patients’ habitus. This process was clearly demonstrated among people who bought PHI, but it also had a dramatic effect on others who were possibly less affluent. Moreover, the study reported the dangers observed earlier by Mol: pressure to purchase PHI and private healthcare extends also to people in financially disadvantaged positions. These perspectives reveal how dominant values of patient choice and responsibility are interlinked and embraced as well as the dangers of shifting responsibility from professionals and systems onto patients, which may, in turn, undermine healthcare quality, especially for those least able to successfully navigate the healthcare system.

These themes – the “burden of choice” among lower-SES patients who belong to marginalized ethno-class groups, their manners of coping with limited resources and possibly the desire for better services, and the levels and forms of commercialization of patient habitus in lower-SES positions – which might reshape the interpretation of reality in conditions of illness, have rarely been touched upon in Israeli scholarly literature. Direct investigations of subjective-cultural aspects are especially lacking. Our proposed study aims to fill this gap.

**The Israeli Semi-Commodified Healthcare System**

The Israeli healthcare system is complex and relatively fragmented. The Ministry of Health, in charge of service planning and supervision of four non-profit health maintenance organizations (HMOs), also runs hospitals and is in charge of public healthcare services. The HMOs are tasked with providing a legally mandated “healthcare basket” to their members. Each HMO administers and provides primary and secondary care, and finances and sometimes provides hospitalization services. Alongside the public system, and intermingled with it, is a growing private sector.

While the 1994 National Health Insurance Law created a single-payer universal system providing broad coverage, during the last two to three decades Israel has undergone a process of privatization of financing and ownership of healthcare. Increasing costs due to demographic changes and rising healthcare prices were not matched by increases in public financing, causing a cumulative deficit of about 26%, representing a shortfall of about NIS 20 billion in the healthcare funds’ budgets (Levi & Davidovitch, 2022). In order to compensate for the shrinking public budget (among the lowest for OECD countries), the government introduced significant increases in co-payments for medications and specialist care. In addition, the healthcare funds were allowed to sell private insurance policies, creating a bypass for introducing services not included in the healthcare basket as well as a mechanism for avoiding wait times.

The decrease in governmental financing has been reflected in the growing share of household spending devoted to healthcare services and in the growing number of people among the poorer 20% of the population who forgo treatments. In 1997, healthcare expenditures represented 3.8% of total household expenditures, reaching closer to 6% by 2021. The rise in private healthcare expenditures has also affected equality in access to services, with expenditures on healthcare significantly higher among the more affluent 20% of the population than among the poorer 20% of the population. In 1997, upper-quintile households spent 2.9 times as much as the poorer 20%, this figure increasing to 3.5 in 2001 and 4 in 2021. While the percentage of those forgoing needed healthcare services among the general population rose from 6% to 12% between 1999 to 2021, it increased from 11% to 19% among those in the lower-SES quintile.[[2]](#footnote-2)

In Israel, private insurance – also termed voluntary insurance – covers services excluded from or only partially covered by Israel’s public benefits. It generally comes in two types – commercial insurance sold by private for-profit companies or supplementary insurance sold by the HMOs and heavily regulated by law. While the bulk of private expenditure is in the form of out-of-pocket payments, most of the increase in private expenditure is due to the cost of purchasing private healthcare insurance (combining its two types). Between 2000 and 2021, the revenues of private insurance funds more than quadrupled, from NIS 700 million to NIS 3.1 billion. Israel now has one of the highest rates of private healthcare insurance ownership in the world (Levi & Davidovitch, 2022).

Of the two private insurance types, supplementary insurance is critical for this study’s purposes as it is generally much more accessible and relevant to the lower-SES levels. Such insurance covers services not included within the public “healthcare basket,” including certain diagnostic procedures and prescriptions. It also covers alternative and cosmetic medicine. However, people are drawn to buying this kind of insurance policy mainly because it permits them to choose surgeons, and thus avoid the public system’s wait times.[[3]](#footnote-3) Indeed, the private share of Israel’s healthcare expenditures has grown mainly due to the expansion of supplementary insurance, with 49% of the population purchasing it in 1999, and more than 80% in 2021.

From the societal point of view, Israel’s present situation is quite dramatic, with 86% of the entire population holding some sort of voluntary insurance. Yet, this aggregate masks class differences; within the lowest quintile, 33% have no private insurance at all. Among the Arab population – which despite internal diversity, represents the lowest socioeconomic ethnic group within Israeli – about half (some 54%) purchased voluntary insurance, mostly supplementary, while the other half have only the public insurance. Perhaps surprisingly, among the Haredi, the second lowest socioeconomic group, 84% have such private insurance, albeit mostly supplementary.

A very high percentage (90%) of the other parts of the Jewish population, presumably situated in the lower-, middle- and upper-middle classes, hold voluntary insurance. Moreover, more than half (56%) of the entire Israeli population have both commercial and supplementary insurance. The data indicate that these doubly-insured are mostly non-Haredi Jews, mostly in the middle-higher levels of the middle classes (Ash Committee, 2022). Indeed, other government statistics show that middle- and upper- income households purchase commercial insurance five times more than do lower-income households (Davidovitch & Filc, 2022).

Overall, Israel is a 3-tiered society regarding insurance coverage: the lowest SES levels hold only the basic public coverage. Above them are those with supplementary in addition to public coverage. Finally, the middle- and upper-middle classes purchase both supplementary and commercial insurance in addition to the public mandatory universal insurance.

This situation heavily influences access to healthcare, as the manner of privatization and expansion yield different forms of a public/private mix that are characterized by the blurring of boundaries between the public and the private sectors. The fact that some HMOs own private hospitals and medical imaging and laboratory facilities is a good example of this process. Moreover, since the 2000s, budget constraints have pushed hospitals and HMOs to find alternative, market-related sources of income. In addition to being permitted to sell supplementary insurance, hospitals have developed an array of private initiatives to offset funding shortfalls (Filc, Rasooly & Davidovitch, 2020).

A formal government committee admitted that patients receiving care through the public system are relatively deprioritized in terms of access, wait times, and seniority of the attending specialist 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), thereby increasing existing inequalities in service provision between the center and the socio-geographic periphery (Ash, 2022).

Israeli society’s overall neoliberalization and the healthcare system’s gradual privatization resulted in healthcare’s commodification (Filc, 2010). This takes two main forms. First, an institutional-structural one, consisting of, as reviewed here, the privatization of services. The second form is subjective, expressed in how users of healthcare services adopt a consumerist approach, 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 the latter as customers who must use market instruments (i.e., private insurance, informal payments) and market strategies to navigate the system (Filc, Rasooly & Davidovitch, 2020; Michael, Filc & Davidovitch, 2022; Niv-Yagoda, 2020).

The subjective-cultural aspects of commercialized healthcare in the lower-SES levels have great potential for elucidating the impact of neoliberal forces on the Israeli healthcare system. However, the scholarly attention given to remains astonishingly limited. This is a gap that the proposed research aims to fill.

**2. Research Objectives and Expected Significance**

The proposed research is an expansion of an earlier project, led by the proposing PIs, that aimed to assess healthcare commercialization, both objectively and subjectively, among patients and physicians. The initial project also approached the subjective aspects of healthcare commercialization among Israeli lower classes (mainly Arabs of the working classes and Mizrahim [Jews of North African and Mideastern ancestry] of the lower-middle class, but its scope was quite limited (N=20) and it included no Haredi patients. However, it yielded some preliminary hypotheses that we propose to examine on a much wider scale (see below).

The research proposed here is vital for policy makers as well as for any student of the Israeli deep cultural-class processes. It explicitly aims to explore a perspective missing rarely at the forefront of public discourse, including: the continuing debate on and examination of the regulation of the supplementary insurance products (Ash, 2022; Yam-Hamelah, 2012); discussions about the interrelationships and required boundaries between private and public in the healthcare system; and examinations of how to adjust healthcare services to meet the real needs and perceptions of peripheral populations.

Further, the existing (scant) empirical studies on the subjective aspects of healthcare commercialization in the lower-SES levels appear to be limited mostly to quantitative methods; it fails to tap some deeper, subjective-cultural aspects (see also: Michael, Filc and Davidovitch, 2022; Niv-Yagoda, 2020; Rasooly et al., 2020). The earlier research upon which the current project builds even alluded to some communal practices in the everyday life of Haredi and Arab populations that remained completely hidden from scholarly eyes. These merit thorough examination.

**3: Detailed Description of the Proposed Research**

The study, which will take place in three phases, encompasses both 180 qualitative, semi-structured interviews – 90 at each of two separate times – and 900 telephone surveys with respondents who live in one of nine communities characterized by low SES (in the bottom four quintiles), located in the north, center, and south of Israel.

The first phase of the research, anticipated to take a year, will consist of collection and analyses of 90 qualitative semi-structured interviews with 10 members of the three groups from each of nine low SES communities in the north, south and center of Israel. Following specific training in this interview method, students who are members of each ethnic community (but not necessarily from the locale) will conduct the interviews. One of them (a PhD or MA student) will be the general coordinator.

In the second phase, we will use the preliminary findings from the qualitative interviews to generate a survey questionnaire to be administered via telephone to 900 respondents, 100 in each of the nine communities. The surveys will be adapted to each community in terms of language, culture, and identity of the interviewer. The interviews will be conducted by a qualified company (see attached proposal).

In the third and final phase, we will conduct an additional 90 qualitative interviews to investigate questions and check conclusions emerging from the initial 90 qualitative interviews and the survey. Hence, our analyses will move first from qualitative to quantitative, and then back from the quantitative to the qualitative.

Using this mixed-methods strategy, qualitative semi-structured interviews, performed in two waves, complement the strengths and weaknesses of a quantitative survey (Huston, Duncan, Yoshikawa, 2016; Sieber, 1973; Safdar, Abbo, Knoblach, et al., 2016; Sofaer, 1999). Survey research offers the opportunity to make quantitative inferences using large, even national populations, to examine empirically the patterned distribution of – and correlations between – various attributes, behaviors, and attitudes, and to formally test specific hypotheses.

It is not always clear, however, particularly when asking new research questions, or asking questions of never-before-studied or under-studied populations, which questions to include in a survey, or even which issues are salient or what they mean from the perspectives of the social actors themselves. For this reason, preliminary qualitative interviews, offering depth and access to the “lived experience” of social actors, can contribute to the selection of relevant, salient questions and phenomena for closer examination using quantitative surveys. Information from the interviews can also provide important insights for designing and refining the sampling frame. Potential contributions apply not only to study design, but also to data interpretation. Specifically, the proposed study uses the survey to assess how widespread the meaning and action practices are among the respective communities, and whether and to what degree these practices are influenced by parameters such as age, income, gender, and educational level, which can be assumed to vary among each ethno-class community.

The second set of 90 qualitative semi-structured interviews will be conducted after completion of the quantitative survey and will focus on clarifying and deepening our understanding of issues arising from the survey data, capturing “[c]omplexities and nuances” (Safdar, et al., pg. 1276) that are inaccessible from the survey data alone.

In general, the analysis of the semi-structured interviews (Phases 1 and 3) will employ a grounded theory approach, in which questions and insights emerging from data collection, analysis, and theorizing drive one another, with conclusions emerging from this iterative process. Yet, as mentioned above, this research continues and expands on a former study. In the proposed research (as in the former) we intend to use narrative analysis which aims, in this case, to expose the “key cultural plots,” or frames of stories, about healthcare, public and commercialized. These can be hypothesized to characterize ethno-class communities, becoming a symbolic axis in the specific community (Bruner, 1991,2004; Spector-Mersel, 2011). We assume that each cultural item that we find is rooted in the specific field, that is, the objective social conditions of each community.

Two examples illustrate the tone of the qualitative vs. the quantitative methods. An example of a question in the semi-structured interview could be: *Please tell us about a good/bad experience of a healthcare situation which you personally had. Please elaborate on the function of public or private healthcare service provider.* A preliminary example of a survey question could be: *In case you used privatized healthcare service, who directed you to it?: 1. Myself. 2. Friends or relatives. 3. Local/traditional leader (such as the Rabbi). 4. A public physician.*

**Working Hypotheses**

Qualitative research neither begins with nor tests clearly defined hypotheses. However, it can generate them. Yet the present situation is slightly different because this study is an expansion of a former qualitative project which generated some initial hypotheses. We expect that the Phase 1 interviews will not only produce the same hypotheses but generate new ones as well. In addition, we expect to test the relevance of the former study’s hypotheses to Haredi Jews. Hence, in the proposed research, we expect to find that:

1. Patterns of commercialized action and meaning (habitus, repertoire) are prevalent among all the three main lower-ethno-class Israeli communities – Arab, Haredi, and Peripheral Jewish (SES clusters 1–4).
2. Practice patterns among the three study populations are quite different than the ones that were found to characterize the upper-middle-class (in public discourse and in the earlier study). They do not reflect full adoption of a neoliberal self–values, interpretation of reality, or habitus, but instead attest to heightened distress and risk.
3. Gender, income, education, and age all have a discernible impact on these practice patterns. However, their impact is secondary relative to the effect of the ethno-class identity, e.g., to the fact that one is a member in the community.
4. The local ethno-class identity (e.g., village or extended family) is highly important. However, the ethno-class identity has a stronger impact than that of the specific locality.
5. Arabs and Haredi Jews possess (different) communal nets that allow them to seek services in a “semi-commercialized” fashion, bypassing both public routes and fully commercialized-commodified insurance.
6. Other Jews, mostly Mizrahi and Russian from the lower-middle classes, are more apt to use fully commercialized services individually.

 **Research Design and Methods**

Phase 1, Year 1: Interviewing 90 individuals residing in 9 localities in 3 geographical areas – north, center and south – which rank 1–4 in the socioeconomic and periphery scale. In each region we will choose participants from among three communities: Arab, Haredi, and a non-Haredi Jewish town in the periphery. Preliminary analysis of some of these interviews will be conducted toward the end of Phase 1 to inform the development of the quantitative questionnaire which will be revised in the summer.

Phase 2, Year 2: Conducting 900 telephone surveys in the same communities in which the 90 semi-structured interviews took place, but on a wider scale (N=100 in each community). After conducting the surveys, we expect to start the statistical analysis that will inform the final qualitative step of the study.

Phase 3, Year 3: Conducting the second half of the qualitative interviews (N = 90) in the 9 chosen communities. During this year, we will combine the survey findings with the qualitative findings and generate the final conclusions.

**Potential Pitfalls**

The pitfall of the research might be rooted in its use of a snowball method in the first qualitative phase. Underprivileged communities tend to create a certain bias by leading researchers to social circles that are relatively affluent in the community – that is, a local elite. Hence, the method may miss the lower-SES segments of the local community. Our awareness of this pitfall and the ability to start new snowballs might prevent a more severe bias.

**Bibliography**

1. Acerete, B., Stafford, A. and Stapleton, P. (2011). Spanish health care public private partnerships: The ‘Alzira model.’ *Critical Perspectives on Accounting* 22 (2011) 533-549.
2. Barlow, J., Roehrich, J., and Wright, S. (2013). Europe sees mixed results from public-private partnerships for building and managing healthcare facilities and services. *Health Affairs* 32, pp. 146–154.
3. Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry* 18, no. 1, pp. 1–21.
4. Bruner, J. (2004). Life as narrative. *Social Research* 71, no. 3, pp. 691–710.
5. Collyer, F.C., and Willis, K., (2020). *Navigating Private and Public Healthcare Experiences of Patients, Doctors and Policy-Makers*. Singapore: Palgrave Macmillan.
6. Collyer, F. M., Willis, K. F., Franklin, M., Harley, K., & Short, S. D. (2015). Healthcare choice: Bourdieu’s capital, habitus and field. *Current Sociology*, *63*(5), 685–699.‏
7. Collyer, F. M., Willis, K. F., & Lewis, S. (2017). Gatekeepers in the healthcare sector: Knowledge and Bourdieu’s concept of field. *Social Science & Medicine*, 186, 96–103.
8. Davidovitch, N. & Filc, D., (2022). This is how the Supplementary Insurances Damaged the Public Health System (in Hebrew). In, The Health Basket of Services, *Medic* 10, pp. 60-64.
9. Filc, D. (2010). Circles of exclusion: Obstacles in access to health care services in Israel. *International Journal of Health Services*, *40*(4), 699–717.‏
10. Filc, D., Rasooly, A. & Davidovitch, N., (2020). From public vs. private to public/private mix in healthcare: Lessons from the Israeli and the Spanish cases. *Isr J Health Policy Res* 9, 31.
11. Fotaki, M. (2011). Towards developing new partnerships in public services: Users as consumers, citizens and/or co‐producers in health and social care in England and Sweden. *Public Administration*, *89*(3), 933–955.‏
12. Glaser, B.G. & Strauss, A.L. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine Pub.
13. Gabe, J., Harley, K., & Calnan, M. (2015). Healthcare choice: Discourses, perceptions, experiences and practices. *Current Sociology*, *63*(5), 623–635.
14. Harvey, D. (2005). *A Brief History of Neoliberalism*.‏ Oxford: Oxford University Press.
15. Harley, K., Willis, K., Gabe, J., Short, S. D., Collyer, F., Natalier, K., & Calnan, M. (2011). Constructing health consumers: Private health insurance discourses in Australia and the United Kingdom. *Health Sociology Review*, *20*(3), 306–320.‏
16. Huston, A.C., Duncan, G.J., & Yoshikawa, H. (2016). Mixed methods in the science of understanding antipoverty policies for families with children: Four case studies. Pp. 329–352. In, Hay, M.C. (ed.). *Methods that Matter: Integrating Mixed Methods for More Effective Social Science Research*. Chicago: University of Chicago Press.
17. Levi, B., and Davidovitch, N. (2022). *The Healthcare System in Israel: An Overview*.‏ Jerusalem: Taub Center.
18. McDonald, J., Powell Davies, G., Jayasuriya, R., & Fort Harris, M. (2011). Collaboration across private and public sector primary health care services: benefits, costs and policy implications. *Journal of Interprofessional Care*, *25*(4), 258–264.
19. Michael, T., Filc, D., & Davidovitch, N. (2022). What motivates physicians to propose private services in a mixed private-public healthcare system? A mixed methods study. *BMC Health Services Research*, *22*, 1–11.‏
20. Mol, A. (2008). *The Logic of Care: Health and the Problem of Patient Choice*. London: Routledge.
21. Niv-Yagoda, A. (2020). Association between trust in the public healthcare system and selecting a surgeon in public hospitals in Israel: A cross-sectional population study. *Israel Journal of Health Policy Research*, *9*(1), 1–11.‏
22. Popay, J., Thomas, C., Williams, G., Bennett, S., Gatrell, A., & Bostock, L. (2003). A proper place to live: Health inequalities, agency and the normative dimensions of space. *Social Science & Medicine*, *57*(1), 55–69.
23. Rasooly, A., Davidovitch, N., & Filc, D. (2020). The physician as a neoliberal subject–A qualitative study within a private-public mix setting. *Social Science & Medicine*, *259*, 113152.‏
24. Rosenau, P. V., & Lako, C. J. (2008). An experiment with regulated competition and individual mandates for universal health care: The new Dutch health insurance system. *Journal of Health Politics, Policy and Law*, *33*(6), 1031–1055.
25. Safdar, N., Abbo, L. M., Knobloch, M. J., & Seo, S. K. (2016). Research methods in healthcare epidemiology: Survey and qualitative research. *Infection Control & Hospital Epidemiology* 37(11):1272–1277.
26. Sanchez F., Abellan J. and Oliva J. (2013). Gestión pública y gestion privada de servicios sanitarios públicos: Más allá del ruido y la furia, una comparación internacional, Documento de Trabajo 4/2013 Real Instituto Elcano Madrid.
27. Shim, J. K. (2010) Cultural health capital: A theoretical approach to understanding healthcare interactions and the dynamics of unequal treatment. *Journal of Health and Social Behavior* 51(1): 1–15.
28. Sieber, S.D. (1973). The integration of fieldwork and survey methods. *American Journal of Sociology* 78(6):1335–1359.Sofaer, S. (1999). Qualitative methods: What are they and why use them? *Health Services Research*, 34(5 Pt 2):1101–1118.

**Publications in Hebrew**

1. Ash Committee (2022). The Committee for Strengthening of Health Services in Israel and the Regulation of the Public and Private System (in Hebrew). Israeli Ministry of Health.
2. Davidovitch, N., & Filc, D., (2022). This is how the Supplementary Insurances Damaged the Public Health System (in Hebrew). In, The Health Basket of Services, *Medic* 10, pp. 60–64.
3. Spector-Mersel, Gabriela. Narrative Research as an Interpretive Research Paradigm. *Shvilei mehkar* 17 (2011): 63–72.
4. Yam-Hamelah Conference (2012). *Health Insurances in Israel: Developments, Interrelationships, Problems and Designs for Solutions* (in Hebrew). The Israel National Institute for Health Policy Research.

**Time Schedule and Work Plan**

|  |  |  |
| --- | --- | --- |
| **Objective**  | **Beginning**  | **End**  |
| Three years  | October 2024 | September 2027 |
| First year: training interviewers (students native to the ethno-class communities) to perform semi-structured interviews conducting half of the interviews in the respective communities – South, Center, North (N= 90)  | October 2024 | September 2025 |
| preliminary analysis of the interviews; using the analysis to design the survey questionnaire | Summer 2025  |  |
| Second Year: conducting the survey (N=900); statistical analysis of the survey; preliminary conclusions | October 2025 | September 2026 |
| Second summer: using the survey's findings to elaborate the interviews | Summer 2026 |  |
| Third Year: conducting the last half of the interviews in the same communities (N=90); full transcriptions; thematic analysis; integration of quantitative and qualitative findings  | October 2026 | September 2027 |
| 3rd summer: final report and publication | Summer 2027 |  |

**Explanatory Notes:**

The interviewers will be conducted by students who originate in the participants’ ethno-class groups, but who do not necessarily live in the local communities. Entering the field and creating the desired confidence and a snowball effect might take time, especially with marginalized communities. Year 1’s interviews will comprise half of the required number of interviews. Their preliminary analysis in the summer will enable us to adjust the survey’s questionnaire to suit the three different communities. The survey will then be conducted using specific adjusted tools and interviewers from the Geocartographia company (see attached proposal). During the summer of Year 2, after initial analysis of the survey, the mixed methods will be switched, and the questionnaire findings will inform the semi-structured qualitative interviews. The remaining qualitative work will be carried out during Year 3, and the findings will be integrated so as to produce conclusions.

**Budget Details**

**Personnel**

|  |  |  |  |
| --- | --- | --- | --- |
| Name (last, first) | Role in project  | % time devoted | Salaries (in NIS) |
| 1st year  | 2nd year | 3rd year |
| Davidovich, Nadav | PI | 50 | 0 | 0 | 0 |
| Filc, Dani | PI | 25 | 0 | 0 | 0 |
| Rier, David | PI  | 25 | 0 | 0 | 0 |
| Adut, Rami | PI | 25 | 0 | 0 | 0 |
| To be recruited  | Project coordinator + Interviewer in the South – development towns (N=20) | 25 (3 years) | 2,000 \* 12 months + 200 \* 12 (traveling) = 26,400  | 26,400 | 26,400 |
| Interviewer 2South – Arabs (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Interviewer 3South – Haredi Jews (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Interviewer 4Center – development Towns (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Interviewer 5Center – Arabs (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Interviewer 6Center – Haredi Jews (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Interviewer 7North – development Towns (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Interviewer 8North – Arabs (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Interviewer 9North – Haredi Jews (N=20) | 25 (6 months) | 5,700  | 0 | 5,700  |
| Traveling  |  |  | 6,000  |  | 6,000  |

**Justification of Personnel Expenses:**

The project coordinator will be a PhD student working with one of the PIs. Each interview requires field work creating a snowball effect. The required working time is estimated to be 3 hours for each interview and the total for each interviewer will be 60 hours, equaling 6 months of work, with 10 hours per working week. This period is divided in two: half in Year 1 and the other half Year 3. Employer costs for each research assistant are estimated at NIS 7,600 monthly for a full-time position and NIS 5,700 for quarter-time position during 3 months of each working year. The estimated sum for traveling is based on a monthly student ticket at NIS 200 (total, NIS 1,200).

**Services**

|  |  |
| --- | --- |
| Item  | Requested Sum (in NIS) |
| Year 1  | Year 2 | Year 3 |
| Transcription of interviews (AI) and corrections (students) | 2000  |   | 2000  |
| Translation of interviews from Arabic to Hebrew (N= 60) + corrections  | 10,000 |  | 10,000  |
| Survey (N=900)  | 0 | 48,200 \*1.17 = 56,394 (attached) | 0 |

**Explanatory note**

The transcription estimate is based on the annual payment to an AI company (Transkriptor) for automatic transcription and an additional sum for the necessary check and corrections which will be performed by the project coordinator and/or students. The translation from Arabic will also be based on AI technology, with corrections by the interviewers. This method was tested in another research project which two of the PIs are currently conducting. A semi-structured interview is estimated to last about 40 minutes. The estimate of the survey’s expenses is based on an inquiry with Geocartographia and receipt of a detailed proposal (attached).

**Other Expenses**

|  |  |
| --- | --- |
| Item  | Requested Sum (in NIS) |
| Year 1  | Year 2 | Year 3 |
| No items | 0 | 0 | 0 |

Justification of requested “Other Expenses”: not applicable to the present project.

**Equipment**

|  |  |
| --- | --- |
| Item  | Requested Sum (in NIS) |
| Year 1  | Year 2 | Year 3 |
| No items | 0 | 0 | 0 |

Justification of requested “Other Equipment”: not applicable to the present project.

**Supplies and Materials**

|  |  |
| --- | --- |
| Item  | Requested Sum (in NIS) |
| Year 1  | Year 2 | Year 3 |
| N/A | 0 | 0 | 0 |
| Total supplies and materials  |  |  |  |

Justification for requested “Supplies and Materials”: not applicable to the present project.

**Miscellaneous**

|  |  |
| --- | --- |
| Item  | Requested Sum (in NIS) |
| Year 1  | Year 2 | Year 3 |
| Publication charges in scientific journals, including editing and translation  |  |  | 20,000  |

**Budget Summary**

|  |  |
| --- | --- |
| Item  | Requested Sum (in NIS) |
| Year 1  | Year 2 | Year 3 |
| Coordinator  | 26,400 | 26,400 | 26,400 |
| Interviews (personnel = 8)  | 45,600 |  | 45,600 |
| Travel  | 6,000 |  | 6,000 |
| Equipment  | 0 | 0 | 0 |
| Services (survey) | 0 | 56,394 |  |
| Services (transcription + translation)  | 12,000 |  | 12,000 |
| Miscellaneous  | 0 | 0 |  20,000 |
| Total  | 90,000 | 82,794 | 110,000 |
| Overhead (17%) | 15,300 | 14,075 |  18,700 |
| Total Budget  | 105,300 | 96,869 | 128,700 |
|  Total 330,689 |
| Annual Average  |  110,290 |

1. Another useful theoretical account, quite close to Mol’s in principle, is that of Fotaki (2011), which differentiates the citizen’s discourse from the consumer’s discourse. [↑](#footnote-ref-1)
2. As will be described, the proposed research will concentrate attention on the two lower quintiles, using the community SES scale rather than individual income. [↑](#footnote-ref-2)
3. While the public system allows users to choose doctors for ambulatory services and to choose hospitals, it does not allow them to choose specific doctors within the hospital system. [↑](#footnote-ref-3)