**National Health Insurance Law (1994) in Israel and the nursing Profession: A historical overview**

**Abstract**

**Background** The initiative to legislate a National Health Insurance Law in Israel was first documented in 1925 when Clalit Health Fund, The Biggest Hmo In Israel, suffered its first severe economic crisis. The crisis was caused by the socialist approach which formed the basis of Histadrut policy at the time—payment according to ability and treatment according to need. Thereafter, the topic was alternatively raised and removed from the agenda. The economic crisis that again threatened Clalit in the 1990s, the determination to separate between the regulator (Ministry of Health) and the body that supplies health services as well as dissatisfaction with the manner of suppling services—prepared the ground for the legislation of the National Health Insurance Law in 1994.

**Objectives** To examine the impact of the enactment of the National Health Insurance Law in Israel on Nursing Profession in Israel

**Methods** The study was carried out using a historical method and was based mainly on historical documents and studies carried out on the subject in Israel. Data collection was based on nurses’ documentations, and reports.

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

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

**Introduction:**

הסיעוד כמקצוע הגדול והדינמי בכל מערכת בריאות בעולם, חיוני ומשפיע על מערכת הבריאות וקביעת המדיניות. מחקרים בוחנים עד כמה מגמה זו נובעת ממדיניות מכוונת. סקירה שיטתית של מאמרים בסוגה זו אינה מספקת עדות מספקת למעורבות הסיעוד בחקיקה וביישום חוקי בריאות. קידום מדיניות הוא מרכיב יסודי במנדט החברתי של הסיעוד. אף על פי שהיא הפכה לתפקיד ליבה של ארגוני סיעוד ברחבי העולם, השיח התמקד בעיקר בפעילות של אחיות בודדות, עם תשומת לב מועטה לעשייה בתחום קידום המדיניות של ארגוני הסיעוד. כדי לחזק פונקציה קריטית זו, נדרשת הבנה של הספרות הקיימת כדי לזהות תחומים הדורשים מחקר נוסף. סקירה מקיפה שנעשתה כדי לבחון את האופי, ההיקף והטווח של העבודה המחקרית שהתמקדה בארגוני סיעוד ובקידום מדיניות, בשישה מאגרי מידע הניבה 4,731 מאמרים ומתוכם-68 נכללו לצורך ניתוח וסינתזה. הממצאים מצביעים על כך שהספרות הולכת וגדלה עם השנים, אינה אמפירית ברובה.[[1]](#footnote-1) ישראל חוקקה את חוק בריאות ממלכתי כבר בשנת 1994 ובכל זאת גם מספר מאמרים שפורסמו בישראל רובם על ידי מינהל הסיעוד אינם מזכירים את הרפורמה והחוק כמניע למדיניות הסיעוד.[[2]](#footnote-2) בודד בתחום זה הוא מחקר שהייתי מעורבות בו הדן באחיות הקהילה.[[3]](#footnote-3) מטרת המאמר הנוכחי תהיה להביא את הסיפור של הסיעוד בישראל, שהייתה כאמור מהחלוצות בעולם בחקיקה למען ביטוח בריאות לכל התושבים. השאיפה לביטוח בריאות חינם בישראל החלה שנים רבות לפני קום המדינה ולכן הדרך שבה בחרתי היא המחקר ההיסטורי

.Israel's healthcare system is unique because of the way it was established and because of the ideological concepts that shaped it from the beginning. The State of Israel is considered a young country of only 75 years, and the current pluralistic nature of its healthcare system was largely shaped even before it was established. זהו הרקע למאבק המתמשך לחקיקת חוק בריאות ממלכתי עוד לפני שישראל הוכרזה כמדינה. בהינתן שערכים כשיווין סולידריות ואחריות הדדית בתחום הבריאות ליוו את המאמצים הללו, נכון לנו כאחיות לשאול איפה היו האחיות וכיצד השפיעו הערכים והחקיקה על המקצוע מיום שחוקק חוק בריאות ממלכתי. While the story of Israel's healthcare services is unique to the State of Israel, health reforms characterized many other countries during those years and their impact on nursing was documented in many studies during this period. Analyzing such trends – as suggested below - may help the nursing profession in planning its ways and highlights for the future. מטרת המאמר תהיה לאפיין בשיטה מחקר היסטורית את התהליכים ההיסטוריים מחד ומנגד לבחון מהן המגמות והכיוונים שאליהם על הסיעוד לנווט את פעילותו בישראל.

**Background**

**התפתחות מערכת הבריאות כפי שהיא היום בישראל התחילה להתאפיין עם תחילת המנדט הבריטי שרבים מנהליו ושיטותיו קיימים עד היום. הסיעוד לעומת מערכת הבריאות התבסס על החינוך האמריקאי ושאף לאקדמיזציה מראשיתו בזכות ארגון הדסה שהיה אמריקאי:**

Until Britain's occupation of The Land of Israel (1917), responsibility for health services was in the hands of charities and religious institutions. In 1918, delegations of welfare organizations and medical professionals from the United States, including the Hadassah Women's Organization[[4]](#footnote-4), which also established the first nursing school in Jerusalem, arrived in Israel. A few years earlier, labor organizations established Health Medical Organizations (HMOs), the main of which is Kupat Holim Clalit[[5]](#footnote-5) (Clalit Health Fund), which was established in 1911, soon founded a few hospitals, and also affiliated nursing schools in each hospital.After the establishment of the State of Israel, the Ministry of Health had also founded nursing schools all state-owned hospitals.

This complex infrastructure has affected the entire Israeli healthcare system for many years and to this day[[6]](#footnote-6).

By the time the country was established, it already had infrastructure created by the British Mandate government and an established system of services by the various organizations. From the very beginning, there were disagreements about the nature of the healthcare system. Israel's first Prime Minister, David Ben-Gurion, who believed that national health services should be established, encountered resistance from political parties, especially the Workers' Federation (the Histadrut) that supported the continued use of existed services, Including the HMOs, thus preserving the bodies that existed before the establishment of the state to this day. Two bodies that operated out of the same socialist ideology, were responsible for the development of the healthcare services: Hadassah and the Workers' Federation (the Histadrut). The Histadrut, joined by the Clalit Sick Fund, had an affinity with the ruling party[[7]](#footnote-7) at that times. However, legal regulation of the provision of services was delayed late until 1994 for political reasons and lack of resources. This situation changed as detailed in this article only when Clalit, the country's largest Sick fund, was in financial crisis.

**טבלת התפתחות מערכת הבריאות**

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| **הערות** | **אירוע** | **שנה** |
| **קופות החולים קמות כאגונים לעזרה הדדית רפואית ביטוח וולנטרי** | **הקמת קופת חולים של הפועלים** | **1911** |
| **Vvהארגון מציב את הנרייטה סאלד בראשו** | **הקמת ארגון נשות הדסה בניו יורק** | **1912** |
| **האחיות עוזבות לאחר שמתחילה המלחמה העולם הראשונה** | **משלחת ראשונה של אחיות הדסה מגיעה לארץ ישראל** | **1913** |
| **סיום התקופה העותמנית** | **תחילת הממשל הצבאי הבריטי בארץ ישראל** | **1917** |
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|  | **הקמת בית הספר הראשון לאחיות על ידי ארגון הדסה** | **1918** |
|  | **הצטרפות קופת חולים להסתדרות הכללית** | **1920** |
| **הממשל הבריטי מסתיים בבמאי 1948 לקראת הקמת המדינה.** | **ממשלת המנדט בריטי** | **1923** |
| **הרוח החיה הוא יצחק קנייבסקי** | **קופת חולים הכללית פונה לממשל הבריטי להחלת ביטוח בריאות ורווחה** | **1925** |
| **משרד הבריאות מאמץ חוקים ונהלים מהממשל הבריטי** | **הקמת המדינה , הממשלה ומשרד הבריאות** | **1948** |
|  | **חקיקת חוק בריאות ממלכתי בישראל** | **1994** |
|  |  |  |

The initial desire and efforts to pass a mandatory health insurance law in Israel was first documented in 1925, when the Clalit Sick Fund experienced its first serious economic crisis. The crisis stemmed from policy of Israel’s The the Histadrut at that time, based on the socialist approach of “from each according to his ability, to each according to his needs”.[[8]](#footnote-8) By that time, insurance policies had already been instituted by the Histadrut in pre-state Israel for sickness and health, as well as for work-related injuries, obligating employers to pay compensation to their employees. The Histadrut also asked to participate in discussions on the issue with the British government, but their request was rejected.[[9]](#footnote-9)

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

These factors prepared the ground for the enactment of the National Health Insurance Law in 1994. As a result of the enactment of the National Health Insurance Law, the health funds became more competitive, their approach became more economics based, and services provided to patients improved.[[10]](#footnote-10) All this provided an ample basis for changing and developing new roles in the healthcare system.

An in-depth examination of these trends raises the question: to what extent was nursing, as a central health profession, aware of and an initiator in the process? Or was nursing profession merely drawn into the process due to global social, economic and political circumstances?

**Nursing and the National Insurance Law**

Studies describe nursing as an independent profession with a centuries-long tradition of helping and caring for the weak. This has always given the profession a broad basis for its activities. The nursing leadership promoted the development of professional nursing and focused on the needs of the individual, and how he is perceived in the community. “Human being” and “Caring” comprised the basis nursing.[[11]](#footnote-11)

In the 1990s, when healthcare systems worldwide entered an era of reform and change based on cost-benefit and limited health resources, nursing was not yet ready for changes in the structure of their work. For the first time, nurses were exposed to a field that was not only new to them – in some cases it even contradicted the professional education they had acquired. This created inherent conflicts and ethical dilemmas.[[12]](#footnote-12)

גולנדר ושפיצר במאמרן מתבססות על מחקרים קודמים ומביאות את השלבים שהמקצוע עבר בהתייחס לרפורמות. הן מציינות ש

nursing has gone through three main stages as a result of the changes in the healthcare system:

1. “Awakening” – Nurses became increasingly aware of the impact of the reform on their profession.

2. Sectorial introspection and organization – Changes occurred in the way nurses perceived their profession. The redefinition of nursing demanded increased professionalization and training in clinical and academic programs.[[13]](#footnote-13)

3. New initiatives – New treatment methods emerged within evidence-based practice and use of professional guidelines and treatment charts. The medical world moved away from treatment based on personal experience toward controlled and established management processes. Reports could be prepared and presented giving economic justification of the chosen directions of treatment. Specialized nurses were suited to implementing care management and disease management. In fact, they adapted to the new work environment.[[14]](#footnote-14)

מחקרים בסיעוד מהשנים האחרונות דנים בהקשר של מנהיגות ניהול טיפול ע"י אחיות ותוצאות של מטופלים . מחקרי מטה אנליזה מצאו שהסיעוד על בסיס הישגים מקצועיים ולא על בסיס היררכיות ותפקידים היסטוריים של כוח ומגמה המתחזקת על ידי התפתחות הטיפול הממוקד במטופל הדורש גמישות רבה יותר בשיטות העבודה ובארגון השירות. אחיות בהחלט מוכיחות את עצמן כיעילות במגוון תפקידים לאורך תוחלת החיים ומסלול המחלה. בעוד שאנחנו יכולים להיות בטוחים בזהירות כי הטיפול שלהם הוא יעיל כמו רופאים בתחומים שבהם לאחיות יתרון הטיפול עשוי להיות יעיל יותר מטיפול רפואי בקידום דבקות והענות לטיפול הדבר בא לידי ביטוי בשביעות רצון המטופלים ובדבקות בטיפול. למעשה, נראה כי אחיות מוסיפות ערך מוסף במונחים של שביעות רצון המטופלים ומסוגלות ליצור קשרים טיפוליים עם מטופלים אשר עשויים לקדם את הבנתם ואת המוטיבציה שלהם לנהל את מחלתם.[[15]](#footnote-15)

חוקרים אחרים גם כן במטה אנליזה מתארים את החשיבות של ארגוני סיעוד בקידום מדיניות ומעורבות הסיעוד

Policy advocacy is often accepted without question as a key function of many nursing organizations. As a result, it has not been subject to much critical examination or empirical investigation. This review has provided an overview of the nature, extent, and range of scholarly work focused on examining policy advocacy undertaken by nursing organizations. The findings lay the groundwork for future areas of inquiry and suggest that a more focused and critically reflective body of knowledge is required to help challenge current approaches, identify areas for improvement, and offer new insights into how these institutions can best meet the needs of nurses, the public, and health systems. To continue to strengthen the policy influence of nursing globally for the betterment of our societies and healthcare systems, our focus must extend beyond the advocacy undertaken by individual nurses to ensure we effectively mobilize the capacity of nursing organizations to have optimal impact on policy, practice, and society.[[16]](#footnote-16)

שמאיין ואלן מתייחסות לכך שהתשומה, כלומר הטיפול הסיעודי המתאים, חיונית להשגת תוצאות חיוביות ברמת המטופל והמערכת, ו שכדי שהקלט יצליח, צריכות להיות כמה אבני בניין חיוניות שיתמכו באחיות בעבודה שהן מבצעות. מספר האחיות, היחס וההשכלה, יחד עם גורמי התהליך כמו במודל המגנט הם השילוב האופטימלי, לדעתה אם התשומות המבניות או גורמי התהליך קיימים, יש לסיעוד יתרון . זהו מסר מהותי, שכן מנהלים/מנהיגים לא צריכים להניח שאם המשאבים אינם זמינים או קיימים באופן חלקי אין למנהיגים מה לקדם וטוענת שבכל מקרה יש למנהיגים תפקיד בכדי לקדם את התוצאות.[[17]](#footnote-17)

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

Shamian, while she was head of the World Nurses Association Organization, found that despite global changes in the economy, in the status of women and in other areas, there is insufficient awareness of the ability of nursing to contribute to scientific and professional policy-making for global change. This is in contrast to the recognition of the contribution of the profession to patient care, where the nurses’ main impact is in hospitals and the expectations of them are related to their daily activities. In the meantime, nurses are making a significant contribution in terms of clinical medicine. Shamian cites US research that shows a decrease of mortality in surgical wards where the rate of college-educated nurses was high.[[18]](#footnote-18)

These findings indicated that nurses played a key role as team members and as leaders of the patient-centered approach. Nurses have significantly increased economic effectiveness, without any lessening of concern, compassion, respect, representation and social justice in their medical contribution. Not only can nurses take more responsibility that will lead to further increases in flexibility and effectiveness, but they can also directly influence the social benefit to the community. Not only can nurses take on more responsibilities that will lead to greater flexibility and efficiency, but they also have the ability to directly influence social gain. The authors are of the opinion that nurses should also be more involved in setting policy. The authors believe that nurses should also be more involved in policy-making.[[19]](#footnote-19)

Another important study conducted in eight European countries found a significant connection between nursing staff and care outcomes such as mortality and satisfaction. Aiken and her associates found that increasing nursing staff reduced mortality by 7% within 30 days of admission to hospital. In 2011, the Institute of Medicine published their findings after examining the role of nurses as part of the reform.[[20]](#footnote-20) Linda Aiken, a leading scholar of nursing, discusses the relationship between manpower and care outcomes. She notes that the cost of hospitalization in the US was $59 billion in 2004-2005; and the public’s awareness of the safety and risk management issues point to the need for a change in the attitude to nursing. In an economic budget-oriented marketplace, nursing is precisely the field that can provide a scientific basis for nursing practice and bring about improvements in the staffing levels and nursing work force.[[21]](#footnote-21)

In recent years, studies show that the efficacy of nurses is comparable with that of physicians in the community.[[22]](#footnote-22) Other studies examine quality indicators in hospitals where registered nurses are employed versus unskilled auxiliary personnel. They relate to the development of expertise in nursing to higher levels of specialization. Clinical Specialist Nurse in Hospitals and the Advanced Nurse Practitioner in the Community.[[23]](#footnote-23)

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

The National Health Law, enacted in 1995, was based on the recommendations of a state committee established by the government. The Committee was established on June 14, 1988 to examine the functioning and efficacy of Israel's health system, whose recommendations formed the basis for the National Health Insurance Law, heard testimonies from nurses in its deliberations, but nurses were not represented among the members of the Commission. In its recommendations the Commission discussed the composition of human resources in nursing, and recommended reducing the proportion of registered nurses. This move necessitated the addition of unskilled auxiliary staff. The committee then determined that the development of high-tech services, the transition to community care and the emphasis on preventive medicine and health education would require the addition of extensively trained nursing staff. The committee recommended strengthening the independence of the nursing workforce and giving it more powers, which could attract more staff to the profession.[[24]](#footnote-24)

Surveys of manpower in the years following the adoption of the law showed contradictory trends: the demand to reduce professional manpower created a need to develop new positions.[[25]](#footnote-25)

In her historical analysis of nursing in Israel (1960-1995), Shahaf also includes technological change within the professional debate on changes in the nursing profession. This encompasses changes and advances in information and medical technology, specialization and academization of nursing, and the introduction of measurement methods and indices. The increasing professionalism and specialization in nursing has not changed the position of nurses in Israeli society.[[26]](#footnote-26)

Of particular note by virtue of its uniqueness in Israel is a pioneering study by some nurses led by Spitzer and Golander, under the auspices of the National Institute for Health Services and Health Policy Research.[[27]](#footnote-27) In 1998-1999 groups of nurses were questioned on their knowledge, attitudes and experience with regard to the National Health Insurance Law and the healthcare reforms. The study of Spitzer and Golander focuses on four aspects: changes in workplace and work environment; changes in the profession; changes in the nature of the clients; and changes in the self-perception of the nurse as an individual, against the backdrop of parallel processes in the US and Europe.

Spitzer and Golander examined the knowledge and attitudes of nurses in the various sectors in Israel regarding the law and the reform in health services. In this pioneering study, hospital, community, public health nurses and nurses in education were questioned about their knowledge, attitudes and familiarity with the content of the law and the recommendations of the Netanyahu Commission. Their knowledge was low to medium. Later on, follow-up studies were conducted among nurses in geriatric hospitals, community and mental health nurses, as well as those working with elderly invalids.[[28]](#footnote-28) Spitzer and Gollander found that nurses in Israel have little knowledge of the reform and the law.

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

1. Clients and nurse-client relationship.

2. The nursing profession.

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

4. Nurses as an individual and their work environment.

1. *Clients and nurse-client relationship*

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

From the 1980s the social terminology change – “sick men” became “patients” or “clients”. The public campaign against medical paternalism has turned HMO (Health Maintenance Organization) members into “clients” with rights and expectations for quality and accessible service. The HMOs are required to bring in new clients on the one hand, and to deal with budget on the other. As a result, the HMOs began to develop programs to promote health and prevention focusing on a healthy life style, even though this field is not included in the “Basket of Health”. For the first time, indices of medical quality are determined in the HMOs and published. The information is accessible and available, sent to clients by post or email. The right to receive a second opinion and the obligation of medical staff to cooperate in such cases have made the healthcare field transparent and competitive as never before. The language of healthcare services now includes terminology such as “client experience”, “patient-centered”, and even “client-centered quality indices”.

Krulik noted that healthcare services consumption is influenced by a kaleidoscope-like reality, reflecting demographic changes characterized by an increase in age and longevity and an increase in the number of chronic patients.[[29]](#footnote-29) A second aspect is the change in the nature of morbidity: infectious diseases that had been eradicated have returned in more virulent forms, while experts believe, on the other hand, that the main causes of disability in the future will be heart disease, road accidents and depression. The World Health Organization predicts an increase of 400% in the rate of invalids by 2020. Technological changes will have an impact on health. Imaging and diagnostics, as well as genetics and bio-technology developments, will affect healthcare professions and lead to an increase in healthcare expenditure.

Alongside these predictions, trends are emerging indicating decreasing resources and increasing social needs during this era of migration, loss of social cohesion and deterioration in social support systems and the structure of the nuclear family.[[30]](#footnote-30) One should add to these characteristics the constant rise in client participation in the financing of healthcare services and in the ever-increasing payments that citizens are forced to make from their pockets. Policy-makers and pathfinders in nursing will be needed to handle these changes, together with changing nurse-client relationships. In many cases, these changes have reduced the accessibility of the benefits of the law for specific groups, and their ability to gain from the objectives of the law as determined in its enactment.

2. *The nursing profession*

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

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

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

More attention can be given to more informed use of healthcare and to ensure the quality of care. A managed environment has benefited nurses, both personally and organizationally.[[31]](#footnote-31) Nissenholz and her colleagues investigated the changes in the role of the nurse in the community.[[32]](#footnote-32) They found that the nursing leadership, together with the great majority of nurses (85%), felt the nature of their work changed significantly during the relevant years. The main changes included a transition from responsive to more proactive work processes, more specialization, transfer of tasks from hospitals to the community, and greater autonomy. Their main areas of activity today include treating chronic patients, promoting health, and ongoing care. Four out of five nurses were satisfied with their work to a great or very great extent, and three out of four felt that they had independence in their work to a large or very large extent.

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

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

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

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

Shulamit (Shuli) Mualem-Rafaeli, a member of Knesset until 2019 and a nurse by profession, also promotes a professional agenda such as the appointment of nurses to the hospital ethics committees. In recent years she has been noted for her sponsorship of Nurses Day in the Knesset, during which debates on the subject of nurses and nursing are held in the various Knesset committees. This trend shows an increase in clear-headedness and readiness to “play” the accepted rules of the political game.[[33]](#footnote-33)

In 1995, legislation of a National Health Insurance Law not only assured medical coverage for all Israeli residents. The reform led to fundamental changes in the structure of the health system as a whole, including nursing. nurses were given roles that they had not conducted prior—care management, disease management and case management. It was in these realms that nurses found full expression and utilization. Nurses excelled in the advances and efficiency they brought to health management in terms of cost-benefit and achievement of optimalclinical outcomes. The change most prominent was in the role of nurses in the community. While health costs continued to rise and where care for the chronically ill constitutes 70-80 percent of all expenditures, optimal utilization of resources is indispensable. A managed care provides advantages in the organizational, clinical, and economic domains, alike. Most programs where nurses were appointed to manage patient/clientcare were successful. It was found that nurses with suitable training bring improvement in clinical measurements and lower costs.[[34]](#footnote-34)

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

Another area is the research that, with academization, has expanded and is reflected in publications in prestigious journals and its increase in the number of researchers with PhDs and professorships. All this thanks to prominent academic leadership and the struggle for academization that began before the establishment of the state. Prominent nurses in the field are Hava Golander, Tamar Krulik and Freda DeKeyser Ganz, Chaya Greenberger, Miriam Hirschfeld, and others who are conducting nursing research in Israel and serve in academia. An exceptional example is Prof. Rebecca Bergman, who won the most prestigious prize in Israel for her doing in nursing and the establishment of the first Academic nursing department in Israel – the Israel Prize.

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

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

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

As a bridge to full academization, BA/BSN has been made a prerequisite for admission to all 20 post-basic certification programs. An additional incentive to pursuing nursing, specifically on an academic level, are the scholarships currently awarded to BA/BSN students committing to 2 years’ service in a public health facility. These scholarships are available (as of 2010), thanks to successful lobbying of the Finance Ministry by the ND.[[35]](#footnote-35)

The European Nurse Directors Association (ENDA), which convened during this period (in 1996), set three main goals: a. To strengthen the contribution of nurses to policy-making and healthcare management; b. To develop knowledge and skills in nursing leadership and management; c. To establish formal links between Nurse Directors and Nurse Leaders across Europe to support a communication network of experts.[[36]](#footnote-36)

However, excessively rapid changes also risk destabilizing the profession unless the necessary resources are available. Following the reform in the British National Health System, nurses in the United Kingdom were given an important role in the planned change. Nursing leadership in the UK warns against rash, accelerated development without the necessary resources.[[37]](#footnote-37)

,ארגון האחיות האמריקאי כארגון המייצג את האינטרסים של 4 מיליון האחיות המוסמכות מכריז ומאמין שתפקידו להשפיע על מדיניות הבריאותומפנה את מאמציו כארגון כלפי קובעי המדיניות והגופים שהחלטותיהם ישפיעו על המטופלים ועל אלה המטפלים בהם. הארגון מאמין שזו חובתו להבטיח שקולו של הסיעוד יישמע בכל הרמות שבהן החלטות אלה מתקבלות.[[38]](#footnote-38) אבל האם היה שותף בוועדות ובפורומים שתכננו את הרפורמה בארה"ב. לא מצאנו מאמר או מחקר המתאר מעורבות כזו.

According to Kighali, even today, nursing leaders must identify the environment in which they operate. They must build on research studies and identify the areas in which they can be of influence, to establish research groups, and encourage loci of excellence and recognition in research and academic.[[39]](#footnote-39)

4. *Nurses as an individual and their work environment*

The changes in the healthcare system have affected both the immediate and the broader sphere of nursing. Healthcare managers assume that the emerging scarcity of nursing manpower in the Western world and the reasons more and more nurses in the Western world today are leaving nursing fall into two main categories: elements affecting the sphere closest to the nurse, such as demanding and changing technological requirements, risk management processes and the increased ease of litigation; and social trends in the broader sphere of the nurses’ environment increasing the nurse’s exposure, such as public media debate and transparency.

By contrast, other studies show that the loyalty of nurses to their workplace is linked to the level of clinical interest and professional fulfillment in their work. These findings, on the one hand, show the importance of challenging and interesting nursing work, and on the other hand depict a work environment that is becoming increasingly complex and demanding from day to day. Leadership and vision make the difference between coping and avoidance. Good leadership creates an atmosphere and a work environment that enable growth and involvement in policy-making.[[40]](#footnote-40)

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

Missri’s study,[[41]](#footnote-41) ten years after the enactment of the law, returns to the pioneering collection of studies by Spitzer and Golander that examines the attitude of nurses in various clinical fields to the reform as mentioned above. In the absence of further studies on the subject of nurses and health reform, we will present Missri’s main findings.

The Missri’s encouraging finding is that while the knowledge about the achievements of the law is low, knowledge of the law’s significance for the profession is high (about 80%) in all sectors. The study’s recommendations are that action should be undertaken in the field of research and in the involvement of nurses in policy matters. In my position as the Head Nurse at Clalit during the years 2008-2018, we promoted the Magnet model in Clalit hospitals.

In the community, Nissenholz et al.[[42]](#footnote-42) found that the general picture emerging from the 2017 survey was that nurses felt their work had expanded, that they have autonomy, and that for the most part they were satisfied with their work. Nurses said that they believed in the future and in the further development of their profession, while indicating significant difficulties and barriers, such as the opposition of family physicians’ organizations to nursing expertise discussed in 2018. Acron et al. also see decentralization as the effective solution to raising satisfaction, professional autonomy and organizational commitment.[[43]](#footnote-43)

Nursing profession, is now the largest sector of the healthcare system. As nurses serve on the front line, they can be significant in the rapid changes occurring in the system. The barriers preventing them from responding effectively must be removed to assure that nurses are positioned to spearhead the changes to be implemented in the healthcare system following the legislation and reforms. Nurses work in many care environments including hospitals, schools, long-term clinics, private homes, the military, the community and health centers. They have differing levels of education, from the registered nurse working with direct care to the research nurse who studies and evaluates more effective ways of providing nursing care and promoting health.[[44]](#footnote-44)

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

The World Health Organization announced the year 2020 as the year of the nurses and midwives. Professor Sheila Tlau, the co-chair of the Nursing Now Global Campaign and Global HIV Prevention Coalition of the WHO. The Global Campaign aims to raise the status and profile of nursing for Universal Health Coverage. Tlau has stated that “with health services under severe strain everywhere, there is a growing consensus that we need to move from a ‘bio-medical’ focus on treating disease to a more people-centered approach, collaborating with the patient to focus on disease prevention and healthy living. Nurses are already leading this paradigm”.[[45]](#footnote-45) Recognizing the value of nursing’s contribution to the law will improve both the profession’s positioning and its ability to implement the principles of the Reform.:

**Conclusions**

המאמר שנכתב בשיטה ההיסטורית התחיל וסקירת ההתפתחות בישראל ממנה ניתן ללמוד לסיעוד היה תפקיד מרכזי בהשגת רמת רפואה ובריאות ציבור טובים במדינה, עם זאת המסקנה הנובעת מהמאמר מעידה כי הסיעוד היה מי שקידם וביצע מדיניות ואף הביא לתוצאות אך לא היה שותף לקביעתה . כמו כן בניתוח מחקרים על מדיניות הסיעוד בישראל לא נמצאו קשרים לחקיקה אלא למדיניות מינהל הסיעוד ועומדים בראשו.

מול העדר השפעה מלמעלה כלפי מטה בהקשר של החוק, המאמר מתאר תהליכים שהחלו מלמטה כלפי מעלה. כך למשל האחיות בקהילה שקיבלו לאחר החוק תפקידים חדשים של ניהול הטיפול ובזאת הצליחו להביא לשינוי מדיניות חלוקת תפקידים והיקף כוח האדם כולל מיצוב הסיעוד במערכת הבריאות ( למשל הכשרת אחיות מומחיות קליניות).

מחקריהן של שפיצר וגולנדר וממשיכותיהן מעידים שהשינוי לא נבע ממודעות בתוך המקצוע וכי האחיות בשדה שמחו להצטרף לרפורמה ולקדם את המקצוע אך לא נערכו לחקיקה מראש. המאמר אימץ לשם ניתוח את ארבעת ההיבטים שהובאו לעיל.

Clients and nurse-client relationship, the nursing profession, Promoting the interests of nursing through leadership, research and academic education, Nurses as an individual. בארבעתם השינוי לא היה מוכוון ומנוהל במסגרת הערכות לקראת החוק

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

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   Nurses station had to closed down (1915) due to official pressure. In 1918, Hadassah

   established six hospitals in Palestine and founded a nursing school to train local personnel

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