**The Impact of Israel’s National Health Insurance Law (1995) and Health Reforms on the Nursing Profession**

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**Abstract**

This article examines the trends and directions of travel of the nursing profession and healthcare practices in the country in Israel following enactment the National Insurance Health Law (1995), which entitled every Israeli citizen to healthcare services shifts in. Since the law’s enactment, Israel’s health funds became more competitive and services to patients improved. Nurses in Israel have taken on new roles in the healthcare system, including joint activity with professional colleagues to develop efficient teamwork that serves the needs of patients. These changes reflected global trends in the nursing profession and demand new thinking about the role of nurses, including how nursing can best serve patients and the wider healthcare system.

**Introduction**

Nursing, as a dynamic, progressive, and changing profession strives to influence and involve itself in decision-making and policy-making with regard to health and healthcare reforms (Cummings et al., 2021). To date, studies examining this goal have uncovered scant evidence of the involvement of nurses in creating and implementing healthcare legislation. While Israel, enacted its National Insurance Health Law in January 1995, there has been little scholarly discussion of healthcare reform in general or this legislation as a motive for nurses’ involvement of in policymaking or reforming existing healthcare policy (Missri, 2011). The single study in this field focused on community nursing (Nissenholtz-Ganot, 2017).

The purpose of this article is to examines the trends and directions of nursing in Israel following enactment the National Health Insurance Law (1995),

Israel is a small country in The middle east, located at the juncture of three continents (Africa, Asia and Europe). Its population is just over 9 million, and the population density is very high. In comparison with other developed countries, Israel’s fertility rate is relatively high and its age mix is relatively young. Israel has a modern market-based economy with a substantial high-technology sector. Income inequality in Israel is among the highest in Organization for Economic Co-operation and Development (OECD) countries. Immigration has played a critical role in the demography of Israel. When the State of Israel was declared in 1948, its population was 873 000. (Rosen, Waitzberg, Merkur.2015) In 2021, the National Expenditure on Health was 8.1% of GDP, compared to an average of 9.5% in OECD countries. (Central Bureau of Statistics 2022). Israel’s healthcare system is unique because of how it was established and because of the ideological concepts that shaped it from the beginning of its development. At just 75 years old, Israel is considered a young country, and the pluralistic nature of its healthcare system was shaped largely Israel’s establishment in 1948, with the quest for free health insurance beginning many years before the establishment of the State. The legislation of 1995 can therefore been seen as the fruits of a decades-long struggle for free health insurance that started during the period of British Mandatory Palestine. Given that values such as solidarity and mutual responsibility in healthcare were central to these efforts, it valuable to examine what part nurses played in these important healthcare reforms, and how social values and legislation have affected the nursing profession in Israel to date. (Rosen, Waitzberg, Merkur.2015)

 In order to answer the research question, the historical research method was chosen.

 לקראת כתיבת המאמר בוצעו ראיונות עם פרופ' שני שהיה הרוח החיה בועדת נתניהו שעל פי המלצותיה חוקק חוק בריאות ממלכתי וכן עם פרופ' יצחק ברלוביץ ממובילי הרפוארמה וסגנו של פרו' שני באותה תקופה משני הראיונות עולה כי נושא הסיעוד היה שולי בדיוני הועדה ועיקרה עסק ברפורמה כלכלית וביטוחית ופחות בנושאי כוח אדם והכשרה.מסיבה זו גם לא רואיינו האחיות שהעידו בפני הועדה מתוך ארבע שתיים נפטרו מאז..the intention of this study is toThe study חיפוש במקורות המקובלים כמו CINHAL and CAMPUS ,PUB MED, לא העלו מאמרים נוספים על אלו שצוטטו במאמר. על פי סקירה של Mundet מאותם שנים , selected review of books published during height of the health reform debate (1993 and 1994). A total of 35 books written by authors from 13 different disciplinary perspectives were reviewed to determine how the nursing profession was represented in discussions of health system reform. The books were categorized according to title, author affiliation, purpose of the book, and the number and category of references to nursing. Seven categories of reference to nursing emerged from the analysis. Approximately one half of the books contained no references to nursing, 39 per cent had less than 10 references to nursing, and only four books had more than 10 references to nursing. The books with the greatest number of references were further analyzed and compared regarding thematic presentation of reform issues. (Mundt ,1997).

**Historical Background**

The development of Israel’s healthcare system began at the start of British rule in Palestine in 1917. Many of the systems and methods created in the first decades of the 20th century still exist today. In 1918, delegations of Jewish welfare organizations and medical professionals from the United States, including the Hadassah Women’s Organization,which would later establish the first nursing school in Jerusalem, visited British Mandatory Palestine. In the same decade, Jewish labor organizations within the Jewish settlement in Palestine had founded Health Maintenance Organizations (health funds), the largest of which was Kupat Holim Clalit(Clalit Sick Fund, later known as Clalit), formed in 1911. The Clalit Sick Fund founded several hospitals, with affiliated nursing school. After the establishment of the State of Israel in 1948, the newly-created Israeli Ministry of Health also founded nursing schools in all state-owned hospitals.

 This complex infrastructure has affected the entire Israeli healthcare system until the present day (Bin Nun, 2005). By the time Israel declared its independence in 1948, there existed a healthcare infrastructure created by the British Mandatory government as well as an established system of services created by various Jewish organizations. From the outset of Israeli statehood, there were disagreements about the nature of its healthcare system. Israel’s first Prime Minister, David Ben-Gurion, believed that national health services should be established, but encountered resistance from political parties, especially the powerful Workers’ Federation trade union (the Histadrut), which supported the continued use of existing services, including the health funds. The success of this opposition ensured the preservation of the bodies that had existed before Israel’s declaration of independence to this day. Two bodies with the same socialist ideology were responsible for the development of healthcare services—Hadassah and the Workers’ Federation trade union (the Histadrut). The Histadrut, under whose auspices the Clalit Sick Fund operated, had an affinity with the ruling political party of the time (Shvartz, 2003). However, legal regulation of the provision of healthcare services was delayed until January 1995 for political reasons and because of a lack of resources.

Table 1 shows key dates in the development of the healthcare system in Israel).

The initial desire and efforts to pass a compulsory health insurance law in Israel was first documented in 1925, when the Clalit Sick Fund experienced its first serious economic crisis. By that time, health insurance policies had already been instituted by the Histadrut for the Jewish settlement in British Mandatory Palestine, including for work-related injuries, obligating employers to pay compensation to their employees.

In the decades following World War II, most western countries underwent a similar process of health care reform. From 1945 until the 1980s, a socialist approach prevailed in healthcare systems worldwide. Prior to the implementation of the Law in 1995, about 95% of Israel’s population were covered by one of its four health funds.

These factors prepared the ground for the enactment of the National Health Insurance Law in 1995. Following the law’s implementation, Israel’s health funds became more competitive, their approach became more economics-based, and services to patients improved (Bin Nun, 2005). This provided an ample basis for changing and developing new roles in the healthcare system, including in the nursing profession.

An in-depth examination of these developments raises the question of the extent to which nursing in Israel, as a central healthcare profession, was aware of, and an initiator in, this process of reform, or whether the nursing profession was merely drawn into the process as a result of global social, economic, and political circumstances.

**Discussion**

Studies have described 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 has promoted the development of professional nursing and focused on the needs of the individual patients, and how they are perceived in the community. The concepts of the “human being” and “caring” comprised the basis of nursing (e.g., Bradshaw & Bradshaw, 1995; Hendel, 1997; Odem, 2002).

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

According to Spitzer and Golander (2001), nursing in Israel went through three main stages as a result of the changes in the country’s healthcare system in the wake of the National Health Insurance Law:

1. “Awakening”—Nurses in Israel became increasingly aware of the impact of the 1995 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.

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 a chosen direction of treatment. Specialized nurses were suited to implementing care management and disease management. In fact, they adapted to the new work environment (Spitzer and Golander, 2001)

In recent years, studies in nursing have dealt with the relationship between leadership and management to ascertain treatment results and patient satisfaction. Nurses have proven themselves to be effective in a variety of roles during the lives of patients and at different levels of morbidity. In some areas, their treatment is as effective as that of physicians and in other areas nurses may be more effective than physicians in terms of promoting treatment adherence. This is reflected in patient satisfaction and compliance with treatment. In fact, nurses appear to add value in terms of patient satisfaction and are able to build therapeutic relationships with patients that may promote their understanding and motivation to manage their disease (Coster et al., 2018). Other researchers have described the importance of nursing organizations in policy promotion and policy involvement (Chiu et al., 2021).

Policy advocacy is often accepted without question as a key function of many nursing organizations. As a result, it has not been subjected to a great deal of critical examination or empirical investigation. This review provides 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 healthcare systems. To continue to strengthen the policy influence of nursing globally for the betterment of 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.

Judith Shamian, who served as president of the International Council of Nurses (ICN) from 2013–2017, has shown that after an adjustment period, nursing changed globaly drastically (Shamian, 2014). Healthcare managers understood the importance of training highly-skilled professional nurses, and the contribution such nurses could make to economic efficiency and improvements in the quality of medical processes. The decisions that nurses, as caregivers, make each day can make a significant difference to the efficiency and effectiveness of the entire system. In light of this, Shamian called for the “nursing voice” to be developed and promoted within organizations, countries, and globally to enable all nurses to be confident advocates, analysts, partners, and caregiver leaders (Shamian, 2016).

However, during her term as ICN president, Shamian found that despite global changes in the economy, in the status of women, and in other areas, there was still insufficient awareness of the ability of nursing to contribute to scientific and professional policy-making for global change. This was in contrast to the recognition of the contribution of nursing to patient care, where nurses’ main impact is in hospitals, and expectations regarding nurses are related to their daily activities. In the meantime, nurses are making a significant contribution in terms of clinical medicine. Research from the United States, for example, has shown a decrease in mortality in surgical wards with a high number of college-educated nurses (Shamian & Ellen, 2016).

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

Another important study by Aiken et al. (2014), conducted in eight European countries, found a significant connection between nursing staff and care outcomes such as mortality and satisfaction. A 1% increase in a nurse’s workload increased the likelihood of an inpatient dying within 30 days of admission by 7%, while every 10% increase in the number of nurses with BA degrees was associated with a decrease in this likelihood of 7%. Noting that the cost of hospitalization in United States was $59 billion in 2004–2005, the authors argued that public awareness of safety and risk management issues pointed to the need for a change in attitudes toward nursing. In an economic budget-oriented marketplace, nursing is precisely the field that can provide a scientific basis for nursing practice and help improve staffing levels and nursing workforce.

Other research has shown that the efficacy of nurses is comparable with that of doctors in the community (e.g., Horrocks et al., 2002). Other studies have examined quality indicators in hospitals where registered nurses are employed versus unskilled auxiliary personnel, relating the development of expertise in nursing to higher levels of specialization, such as clinical specialist nurses in hospitals and advanced nurse practitioners in the community. (Dunn, 1997, Aiken, et. el. 2018).

While these present a clear picture of the processes in nursing in various countries that have been impacted by healthcare reform, in Israel, only a handful of studies have examined the impact of the National Health Insurance Law and other reforms on Israeli healthcare professions, including nursing. The National Health Insurance Law, which came into force in January 1995, was based on the recommendations of a government-appointed committee established on June 14, 1988, to examine the functioning and efficacy of Israel’ health system. Although the committee heard testimonies from nurses, there were no nurses among its members. In its recommendations, the committee focused on the composition of human resources in nursing, and recommended reducing the proportion of Academic registered nurses. The committee also determined that the development of high-tech services, the transition to community care, and the emphasis on preventive medicine and health education would require the addition of nursing staff. It recommended strengthening the independence of the nursing workforce and giving it more powers, which could attract more people to the profession (State Comptroller’s Report, 2008). Surveys of human resources following the implementation of the law showed contradictory trends, as the demand to reduce professional human resources created a need to develop new positions (Nirel & Paryente, 1999).

In her historical analysis of nursing in Israel from 1960–1995, Shahaf (2014) also included technological change within the professional debate on shifts in the nursing profession. This encompasses changes and advances in information and medical technology, specialization and academization of nursing, and the introduction of new measurement methods and indices. However, despite the increasing professionalization and specialization in nursing, the position of nurses in Israeli society has not changed.

Particular notable is the unique pioneering study in Israel nurses led by Spitzer and Golander (2001), under the auspices of the National Institute for Health Services and Health Policy Research. In 1998–1999 groups of hospital, community, and public health nurses and nurses in education in Israel were questioned about their knowledge, attitudes, and familiarity with the content of the National Health Insurance Law and the recommendations of the government committee. The study focuses on four elements: changes in workplace and work environment, changes in the profession, changes in the nature of patients-nurse relationship; and changes in the self-perception of the nurse as an individual, against the backdrop of parallel processes in the United States and Europe. The authors found that nurses’ knowledge of these issues was low to medium. Later, follow-up studies were conducted among geriatric, community, and mental health nurses (Levy, 2002; Manor, 2000; Odem, 2002; Re’em 2002; Teitler, 2000). Spitzer and Golander found that nurses in Israel had little knowledge of the reforms or the law.

Based on these findings and the other studies cited, I have chosen to discuss the following in an Israeli context in relation to the Law.

: patients and the nurse-patient relationship; impact on the nursing profession; promoting the interests of nursing through leadership, research, and academic education; and nurses as individuals and their work environment.

1. *Patients and the nurse-patient relationship*

The practitioner-patient relationship in Israel is anchored in the National Health Insurance Law (1995) and the Patient’s Rights Law (1996). The last decades, following the entry into force of these laws, have seen increased consumer awareness regarding healthcare services among the public in Israel and the emergence of various layers of health insurance to complement the “health basket” services established in law. For most of the Western world, especially after World War II and until the late 1980s, the provision of health services was a social obligation. The health of the individual was perceived to be beyond any debate and cost. From the 1980s, there has been a conceptual and semantic shift, whereby “sick people” became “patients” or “clients.” In Israel, a public campaign against medical paternalism transformed health fund members into “clients” with rights and expectations for quality and accessible healthcare services. The health funds were now required to recruit new clients and be cost-effective. As a result, they began to develop programs to promote health and prevention, often focusing on healthy lifestyles, even though this area is not officially part of the “health basket.” For the first time, indices of medical quality were determined by the health funds. This information is publicly accessible and available, and 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 Israel’s healthcare field more and more transparent and competitive. The language of healthcare services now includes terminology such as “client experience,” “patient-centered,” and even “client-centered quality indices.”

According to Krulik (2003), healthcare services consumption in Israel reflects a diverse population and demographic changes characterized by an aging population and increased life expectancy, and an increase in the number of chronically ill patients. A second aspect is changes in the nature of morbidity: some infectious diseases that had been eradicated have returned in more virulent forms. To date, researchers note that by 2060, an estimated 48 million people (47% of all deaths globally) will die with serious health-related suffering, which represents an 87% increase from 26 million people in 2016. Globally, serious health-related suffering will increase most rapidly among people aged 70 years or older (183% increase between 2016 and 2060). In absolute terms, it will be driven by rises in cancer, dementia and low-income. The immediate global action to integrate palliative care into health systems is an ethical and economic imperative The authors note that immediate global action is required. (Sleeman et el ,2019)

During 2018 the Israeli ministry of health carried out a process to unify and update the strategy in light of the significant changes expected to shape the future of medicine, such as, the aging population, increase in chronic ailment and the emergence of technologies such as BIG DATA etc. In light of this and in a long-term perspective, the administration has decided to make a future plan concerning the time period of up to 2030 and out of that to derive a strategic plan for the coming years. (The Ministry of Health,2022).

Alongside these global predictions, trends are emerging indicating decreasing resources and increasing social needs during this era of migration, loss of social cohesion, deterioration in social support systems, and in structure of the nuclear family (Krulik, 2003). To these can be added the constant rise in patient participation in the financing of healthcare services. Policymakers and pathfinders in nursing will be needed to address these changes, as well as changing nurse-patient relationships. .

2. *The nursing profession*

The studies noted above use a range of definitions when describing nursing—a profession that is learned, service-oriented, and autonomous. Scholars describe a professional environment characterized by ambiguity and change.

Nursing in Israel as a profession is undergoing transition, including planned and initiated changes, and changes stemming from global social and political trends. A number of steps have been taken by Israel’s nursing leadership since the Law’s enactment. Faced with unfamiliar ethical dilemmas and issues, the nursing profession established a Bureau of Ethics (2002) within the National Association of Nurses.The ethical code of nurses in Israel refers to nurses’ behavior in their encounter with individuals, society, and the community, as well as to issues of quality and safety The Code was updated in 2017.( Asman, & Tabak,2017).

 In 2004 the Chief Nursing Officer of Israel, Dr. Shoshana Riba, organized a conference of senior nursing leaders to discuss these issues. Efforts to legislate a Nurses’ Law (yet to be enacted) were accelerated, and led to the establishment of a Nursing Council, with representation from different levels of nursing in Israel.

As noted, various scholars have found that the nursing profession is currently undergoing a process of professionalization, technological development, and specialization. The consensus among professionals and office-holders regarding the need to develop additional fields of nursing 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. Greater attention should be given to more informed use of healthcare and to ensure quality of care. A managed environment has benefited nurses, both personally and organizationally (Joel, 2002). In an investigation of the changes in the role of the nurse in the community, Nissenholz et al. (2017) found that the nursing leadership, together with the great majority of nurses in Israel (85%), felt the nature of their work had changed significantly during the relevant years (1995-2017). The main changes included a transition from responsive to more proactive work processes, more specialization, the transfer of tasks from hospitals to the community, and greater autonomy. Nurses’ main areas of activity included treating chronically ill patients, promoting health, and undertaking 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 continued advancement in the role of nurses included the conservative attitudes of some doctors and nurses, the scarcity of specialized nursing positions, and insufficiently attractive salary levels.

Nurses in Israel have clearly and consistently worked to promote their professional status. Various researchers have recommended the continued academization of nurses, based on the factual findings of their studies. (Shatzman, et. el, 1981, Ehrenfeld, et. el. 1993). In my position as the Head Nurse at Clalit Health Services (2008-2018), we held workshops for hospital and community nurses in which they identified accepted work practices and examined whether these were optimal within an evidence-based research model.

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

The nursing profession, which strives to influence the advancement of its professional perception and vision, must act on several levels to promote its views. However, several questions remain unanswered. For example, does nursing in Israel have the necessary means to do this? Has this profession learned to promote its standing and cooperation among policy-makers to achieve these goals? And is the nursing leadership in Israel partnering in the macro processes currently influencing health policy?

In 2003, a nurse was elected to Knesset (Israel’s parliament) for the first time. Ilana Cohen, member of the 16th Knesset, chaired the National Association of Nurses, and has spearheaded many struggles in the past. Nurses who belong to professional organizations, such as the Association of Public Health Nurses in Israel, are involved in advancing the interests of nursing in Knesset including via professional lobbyists. Their professional struggle has found political expression in the deliberations of various Knesset committees. Meanwhile, Shulamit Mualem-Rafaeli, a member of Knesset until 2019 and a nurse by profession, also promotes a professional nursing agenda, such as the appointment of nurses to hospital ethics committees. In recent years, Mualem-Rafaeli has been noted for her sponsorship of Nurses Day in Knesset, during which debates on nurses and nursing in Israel are held in various Knesset committees. This trend shows an increase in their understanding of and willingness to play the accepted rules of the political game (Antrobus, 2004).

The enactment of the National Health Insurance Law not only assured medical coverage for all Israeli residents, but led to fundamental changes in the structure of Israel’s healthcare system as a whole, including nursing. Nurses were given new roles, among them care, disease, and case management. It was in these areas that nurses found full expression and utilization of their many skills. Nurses excelled in terms of the advances and efficiency they brought to health management in terms of cost-benefit and achievement of optimalclinical outcomes. However, the most prominent change has been the role of nurses in the community. While health costs continued to rise and with care for the chronically ill constituting 70–80 percent of all health expenditures, optimal use of resources is essential. Managed care provides organizational, clinical, and economic advantages. Most programs where nurses were appointed to manage patientcare have been successful. Nurses with suitable training have successfully brought improvement in clinical measurements and lower costs (Magnezi et al., 2010).

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 undertook several schemes to bring about the full academization of nursing, including opening nursing programs at regional colleges. Between 1995 and 2010, eight study programs in nursing were opened in colleges as well as schemes to retrain university graduates for careers in nursingwith study grants and shortened study programs

Alongside the academization of nursing in Israel, nursing research has expanded and is reflected in publications by Israeli nurses in prestigious journals and the increase in the number of Israeli nursing researchers with PhDs and professorships. This is a continuation of the prominent academic leadership and the struggle for the academization of nursing that began prior to Israeli statehood. Prominent nurses in the field in Israel include Hava Golander, Tami Krulik, Freda DeKeyser Ganz, Chaya Greenberger, and Yafa Haron, who are all involved in nursing research in Israel and work in academia. An exceptional example is Prof. Rebecca Bergman (1919–2015), who was the first and only nurse to win the Israel Prize (the country’s highest honor) for her lifelong work in nursing. Her many achievements included the establishment of the first academic nursing department in Israel (Weiss & Golander, 2022).

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 of these roles has a different scope of practice. RNs have either a diploma or degree, while nurse practitioners must have a master’s degree at a minimum and also complete a specialty residence ([Nursing Division Circular, 2013](https://journals.sagepub.com/reader/content/16e304424e7/10.1177/1527154414538101/format/epub/EPUB/xhtml/index.xhtml%22%20%5Cl%20%22bibr28-1527154414538101)).

A decade ago, despite the nursing shortage, the Ministry of Health’s Nursing Division took the bold step of phasing out educational programs for LPNs. Today, LPNs comprise 19% of the workforce, and their numbers are steadily declining as these nurses retire. ([Ministry of Health, Health and Computer Services and Department of Health Information, 2010](https://journals.sagepub.com/reader/content/16e304424e7/10.1177/1527154414538101/format/epub/EPUB/xhtml/index.xhtml%22%20%5Cl%20%22bibr20-1527154414538101)). Currently, there is little demand for LPNs as most nurse managers will actually only hire nurses with a Bachelor of Science in Nursing (BSN) (Nirel et al., 2010).

As a bridge to full academization, a BSN has been made a prerequisite for admission to all 20 of Israel’s post-basic certification programs ([Nursing Division Annual Report, 2004](https://journals.sagepub.com/reader/content/16e304424e7/10.1177/1527154414538101/format/epub/EPUB/xhtml/index.xhtml%22%20%5Cl%20%22bibr23-1527154414538101)). An additional incentive to pursuing nursing, specifically on an academic level, are the scholarships awarded to BSN students. These scholarships are available since 2010, thanks to successful lobbying of the Finance Ministry by the Nursing Division (Greenberger et al., 2014). It is hoped that these will keep the nursing shortage at bay, although it is important to note that Israel currently has 5.7 nurses per 100,000 residents—fewer than in most OECD countries ([Ministry of Health, 2010](https://journals.sagepub.com/reader/content/16e304424e7/10.1177/1527154414538101/format/epub/EPUB/xhtml/index.xhtml%22%20%5Cl%20%22bibr19-1527154414538101)).

4. *Nurses as individuals and their work environment*

The changes in Israel’s healthcare system have affected both the immediate and the broader sphere of nursing. Healthcare managers assume that the emerging scarcity of nurses in the developed world and the reasons more and more nurses in the developed world, including Israel, are leaving the profession fall into two main categories: factors affecting the sphere closest to nurses, such as demanding and changing technological requirements, risk management processes, and the increased ease of litigation; and social trends in the broader sphere of nurses’ environments that increases their exposure, such as public media debate and transparency. Patterns identified across 91 studies consistently show that adverse job characteristics are associated with burnout in nursing. (Dall'Ora et el,2020)

Other studies show that the loyalty of nurses to their workplace is linked to their levels of clinical interest and professional fulfillment in their work. Thirty‐four studies identified that nurses stay if they have job satisfaction and/or if they are committed to their organizations. The factors permeating these constructs weigh differently through generations and while not an infallible explanation, demonstrate stark differences in workplace needs by age, which influence the intention to stay, job satisfaction, organizational commitment and ultimately nurse turnover. (Pressley, et el ,2023).

These findings show the importance of challenging and interesting nursing work, but also 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 (Goldberg & Benor, 2004).

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 a greater impact on loyalty. A correlation has been found between quality of care and the satisfaction of the nurse who provided the care. (Aiken, 2012).The Magnet Hospital Recognition Program was launched in the United States in 1990 along the same lines. The 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. (Kelly et el, 2012).

 The Missri’s study (2011), undertaken ten years after the entry into force of the National Health Insurance Law, returns to the pioneering work by Spitzer and Golander (2001) examining the attitude of nurses in various clinical fields to the Law. The most encouraging finding is that knowledge of the Law’s significance for the nursing profession was high (about 80%) in all sectors. The study recommended that action be undertaken in the field of research and in the involvement of nurses in policy matters. Nissenholz-Ganot et al. (2017) found that nurses in Israel 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. Acorn et al. (1997) twenty years earlier also saw decentralization as the effective solution to raising satisfaction, professional

As nurses serve on the front lines of healthcare, they can be significant in the rapid changes occurring in the system. The barriers preventing nurses in Israel from responding effectively must be removed to ensure that they are positioned to spearhead the changes required in the healthcare system in the wake of the Law and other reforms.

The Ministry of Health’s Nursing Division has led a process of licensing Nurse Specialists in key clinical fields. Expert nurses in the field of nursing policy and management are fully familiar with the Law, and teach and act to advance its principles and implementation., The findings of the study indicate that this is the way forward to open a much-needed discourse to lead the profession on the frontline of healthcare.

The WHO declared 2020 as the year of the nurse and the midwife. The Nursing Now campaign, which began in 2018, aims to raise the status and profile of nursing for Universal Health Coverage. (Thorne, 2019). In Israel, recognizing the value of nursing’s contribution to the implementation of health reforms will improve both the profession’s positioning within the healthcare system and society more generally, and improve its ability to implement the reforms.

**Conclusions**

Nursing has always played a central role in achieving a good level of healthcare and public health in Israel, and thus played a part in the development and enactment of the National Insurance Health Law in 1995. However, nurses were excluded from active involvement in planning these reforms. They were not invited to participate in the government-appointed committee on whose findings the reforms and Law were based. Despite this, to a large extent, nurses in Israel were responsible for implementing the new policies that emerged as a result of the Law, and were an essential factor in their success. Nurses were heavily involved in processes that started from the bottom up, including through the new roles that nurses adopted in care management, and helped bring about a policy change among nursing leaders and in the positioning of nursing in the Israeli healthcare system.

Spitzer and Golander (2001), and those that followed them indicate that Israeli nurses undertaking frontline care were happy to participate in implementing the reforms and promote the profession, but their exclusion from the planning stages meant they had not been prepared for these changes in advance and were not able to contribute to their development as fully as possible. The article adopts their approach and analyses the effects in four different aspects— changes in workplace and work environment, changes in the profession, changes in the nature of patients-nurse relationship; and changes in the self-perception of the nurse as an individual,

ליתר בהירות מובאים הממצאים בטבלה המצורפת:

|  |  |
| --- | --- |
| הממצאים | התחום |
| התחום שעבר שינוי מהותי יותר מאחרים היה הקשר בין האחות למטופל וזאת בעקבות הרפורמה שהיבאה את הסיעוד לפתח תחומים של ניהול טיפול ומומחיות קלינית דבר שהביא את הקליינטים לראות באחות כתובת מקצועית ולמרות שוועדת החקירה המליצה דווקא לצמצם את ההכשרה בסיעוד ץ | 1. Clients and nurse-client relationship; |
| הרפורמה השפיעה מעט על הפרופסיה בסיעוד . חוק סיעוד לא נחקק ומעמדן הפורמלי של האחיות במערכת הבריאות לא השתנה למרות השינוי בתפקידים שהן לקחו על עצמן וההכרה בתרומתן. | 2. The nursing profession |
| התחום השני שבו חלו שינויים משמעותיים היה החינוך, האקדמיזציה והמחקר. בניגוד להמלצת הועדה דווקא ועדות מאוחרות יותר המליצו על מעבר לאקדמיה וכיום כל המוסדות ההכשרה בסיעוד הם אקדמאיים ואחיות עוסקות במחקר. בתחום המנהיגות ומעורבות בקבלת החלטות ובין קובעי המדיניות היו אחיות ששנים הראשונות שחוללו מהפכות במערכת הבריאות אך ממרחק הזמן ניתן לחשוב שהישגים משהוצגו במאמר היו פרסונליים והשינויים הקיימים אמנם מעידים על התקדמות אך האחיות עצמן רואות כברת דרך שעדיין יש לעבור להשגת מטרה זו.  | 3. Promoting the interests of nursing through leadership, research and academic; education |
| האחות כפרט וסביבת העבודה השתנתה במעט בעקבות הרפורמה והשינוי בקשר מטפל מטופל שבא בעקבותיה. מצד אחד נושא המטופל במרכז מביא ליותר שיתוף פעולה ועבודת צוות שבה האחות היא חלק מצוות רב מקצועי אך מצד שני אין שינוי מהותי במעורבות אחיות בקביעת מדיניות וקבלת החלטות בהשוואה לעבר וזהו תחום שהמחקרים שצוטטו ממליצים לקדם. | 4. Nurse as an individual and her work environment." |

From the above review of studies and discussions of data in Israel, it would appear that the healthcare reforms implemented from the mid-1990s have presented new challenges (adopting to new roles, responsibilities, and technologies) and opportunities for nurses. The opportunities afforded by these new ways of working are helping to pave the way for the nursing profession in Israel to take on new roles in the healthcare system, and encourage joint activity with peer professions to develop efficient teamwork that ultimately serves the needs of patients. Nursing leaders in Israel today who are leading a rethinking of the role of nurses, including how nursing can best impact patients and the broader healthcare system, need to be aware of the processes the profession has undergone. No less important, innovative thinking is needed for the nursing profession in Israel to plan ahead and prepare for the future. This requires familiarity with the past and an analysis of the processes that have furthered or hindered the development of nursing in the wake of the National Health Insurance Law and other healthcare reforms

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**Table 1: Key dates in the development of Israel’s healthcare system**

|  |  |
| --- | --- |
| **Year** | **Event** |
| 1911 | The Workers Health Insurance Fund established for mutual medical assistance and voluntary insurance. |
| 1912 | Hadassah Women’s Organization established in New York, with Henrietta Szold as its leader. |
| 1913 | First delegation of Hadassah nurses arrives in Ottoman Palestine, departing after the start of the First World War. |
| 1917 | The British Army occupies Jerusalem. |
| 1918  | Hadassah Nursing School established. |
| 1920 | The Clalit sick Fund is joined to the Histadrut. |
| 1923 | British Mandate over Palestine officially comes into force. |
| 1925 | The Clalit Sick Fund applies to the British Mandatory government for the application of health and welfare insurance. |
| 1948 | Israel declares independence, establishes a government and a Ministry of Health, which adopts laws and procedures from the British Mandatory government. |
| 1995 | The State Health Law enters into force in Israel following a state commission of enquiry into the functioning of Israel’s healthcare system. |