**Commercialization of Health in Israel – An Ethno-Class Perspective**

**A class-cultural inquiry of patients' narratives[[1]](#footnote-1)**

**Abstract**

The present paper discusses the subjective-cultural aspects of the commercialization of health care from an ethno-class perspective. The paper analyzes 20 patient stories in order to reconstruct the patterns of action and interpretation which can be attributed to their ethno-class segment. The respondents' ethno-class identities vary from upper-middle (mainly Ashkenazi Jews), low-middle (mainly Mizrahi jews) and working-class (mainly Arab) positions.

Using narrative analysis which aims to extract "key plots" and Bordieusian concepts like field and habitus, the paper checks if and to what extent a "neo-liberal" self has penetrated the different echelons of Israel society. The findings point on a complicated picture. Wide and deep commodification of health is evident in all narratives, along with negative impressions of the public system - long queues, low quality and bad attitude. Yet there are important variations.

The "ideal" neoliberal self appears quite clearly among upper (mostly Ashkenazi Jewish) middle-class respondents who typically hold both private and supplementary insurance in addition to the universal public coverage. Some of their narratives show a hero-quest story of a self-assured patient celebrating choice. All these narratives express deep dissatisfaction with the public system to the point of contempt, rage and degrading descriptions.

The Mizrahi low-middle class and the Arab working-class present a different narrative, perhaps even a different habitus. Although they too tend to describe the public system negatively, they do not despise it and they do not tend to celebrate the use of private insurance. They seem to express sorrow and some nostalgy to the public system of the past.

Mizrahi low-middle class patients tend to seek personal solution by using the supplementary and family assistance. Arabs (of which half have only public coverage) tend to use a communal network which bypasses the public routes, not with financial but with social contacts. This research offers insights which a further and wider mixed-methods research should check thoroughly.

**Text**

The present paper discusses ways in which different ethno-class groups in Israel navigate a semi-commodified health care system in the neo-liberal age.[[2]](#footnote-2) The paper discusses the complex ways in which subjectivities are expressed using qualitative method of narrative analysis (Harvey, 2005; Mol, 2008; Sweet, 2018; Rasooly et al., 2020) using Israel as a case study and concentrating on middle and low echelons of society (Adut et al., forthcoming).

We begin by defining the ethno-classes discussed, and briefly present Israel’s class structure. In the second section we depict the Israeli health care system(s) and the complex interrelationship between the public and the private sectors. The third section will present in broad lines the scholarly literature on the subjective-cultural aspects of health commercialization in developed countries.

The following section will present the themes from the analysis of the 20 interviews that we conducted.[[3]](#footnote-3) Finally, in the concluding discussion, we explore the theoretical possible impacts of our research, and its relation to the growing literature on the commercialization processes in health among popular classes.

**Class and the popular classes**

We understand class as a social group or a web of social groups sharing a common material ground (the relationship to capital and its practices), linked into power relationships with other classes. Class is also defined by shared practices: shared spatial spaces, practices of consumption, partially shared culture, forms of individuation, and sometimes, common political worldviews and/or practices. All coalesce in the way a certain social group defines the boundaries between itself and other social classes (Lamont & Molnar, 2002).

We define the popular classes as the subaltern classes, in its original Gramscian sense (Galastri, 2018). For Gramsci the subaltern classes possess agency and voice, and a certain degree of autonomy, in spite of their subordination to capital[[4]](#footnote-4) (Thomas, 2018). The subalterns have consciousness about their condition, they are able to organize themselves and even challenge the hegemonic model or promote their interests as a peripheral part of the hegemonic historical bloc (Liguori, 2015).

As a collective and as individuals, they are constituted in a constant tension between their subordination to capital and their autonomous agency. We use this concept in plural, because, following the literature on the topic (Schwartz, 2011 ;Pizzorno, 2018; Beroud et al., 2016; Bernard et al., 2019 ;Pasquier, 2018; Cayouette-Rembliere, 2015), we consider that it better reflects the changes in class composition that took place in the late 20th and the 21st centuries, and the heterogeneity and internal differences that characterize the subaltern social groups[[5]](#footnote-5).

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

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

Among the occupations included within this sub-class we find agricultural workers, ancillary workers, and low-skilled service occupations (Byiniamin, 2006). In Israel this class is divided also according to citizenship status (Israeli citizens/migrant workers and asylum seekers), and according to ethno-national lines (Jewish/Palestinian citizens; and within Jewish citizens immigrants from the former USSR, Mizrahim and immigrants from Ethiopia). In the present paper we will focus on Israeli citizens or formal residents - Israeli Jewish and Israeli Arabs[[7]](#footnote-7), since being a legal resident is the condition for full access to the public health care system. Our analysis of the popular classes will cover mainly the popular middle classes and the working class which - mostly composed of Israeli residents.

**The Israeli Health Care System**

The Israeli health care system is a complex and relatively fragmented one. Its base is a universal basket of services which every resident is entitled to. Two mandatory taxes - health and income – are its main financial sources. Yet, in fact, it is a mixture of privatized insurance(s) and commercialized medicine of different sorts. If there was a "commercialization index" Israeli would have been graded high, probably higher than the UK (see below).

The Ministry of Health (MOH) is in charge of planning and supervision, but also runs hospitals and is in charge of public health services. The health funds are non-profit health maintenance organizations (HMOs) responsible for the provision of the "health care basket" as defined by law to their members. The health funds administer and provide primary and secondary care, and finance (and sometimes provide) hospitalization services. Along the public system, and intermingled with it, there is a growing private sector.

While the 1994 National Health Insurance Law (NHIL) created a single payer universal system providing broad coverage, during the last 25 years Israel underwent a gradual but steady process of privatization of financing and ownership of health care. There has been a cumulative erosion of the healthcare services’ basket, during the almost three decades following the implementation of the law. 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%, which represents a shortfall of about NIS 20 billion in the budgets of the health funds) Levi & Davidovich, 2022).



In order to cover for the diminishing public budget (among the lowest in OECD countries), the government introduced significant increases in co-payments for medications and specialists’ care. In addition, the health funds were allowed to sell private insurances which are called "Supplementary" (see below). The decrease in government financing has been reflected in the growth of the share of health expenditure for households and in the growing numbers of people among the poorer 20% of the population who give up treatments. In 1997, healthcare expenditure represented 3.8% of total household expenditure and in 2021, it reached closer to 6%.

This rise is mostly attributed to purchasing of private insurance or expenses of privatized medicine (such as copayment) because during this period the proportion of mandatory taxes was quite stable. The rise in private healthcare expenditure has influenced equality in access to services. Household expenditure on health was significantly higher for the more affluent 20% of the population than for the poorer 20% of the population—by 2.9 times in 1997, increasing to 3.5 times in 2001, and 4 times in 2021. While giving up health services rose between 1999 to 2021 from 6 to 12% among the general population, it went up from 11 to 19% in the lower SES quintile.

While the bulk of private expenditure is in out-of-pocket payments, the increase in private expenditure is mostly an increase in the bulk of private insurance. Between 2000 and 2021, the revenues of private insurance grew more than fourfold, from 700 million NIS to 3.1 billion NIS. Israel has now one of the highest private health insurance ownership rates in the world, reaching close to 90% of the population, but the insurance is highly diversified and stratified.

Whereas 86% of the entire population obtained some sort of voluntary insurance, within the lowest 5th quintile 33% have only public and no private insurance. Among the Arab population 54% have some voluntary insurance (mostly supplementary) and almost half have only the public insurance. Surprisingly, among the Haredic (ultra-Orthodox) which is relatively low in SES, 84% have voluntary insurance, mostly supplementary. The other Jewish population, which can reasonably be hypothesized as mostly in the middle-classes, obtain voluntary insurance in very high figures (90%) and more than half (56%) have both the commercial more expensive and the supplementary. All indications allow us to speculate that this last group – the Non-Haredic Jews which obtain both insurances - are mostly in the higher SES middle-class layers (Ash Committee, 2022). Indeed, governmental statistics show that household with relatively medium and higher income obtain commercial insurance in 5 times more than households with lower income (Davidovitch & Filc, 2022).

The above picture shows that the ongoing reforms have created a 3-tiered system that differentiates between three types of insurance coverage and three layers by and large - those that have only public insurance, those holding the supplementary sold by the public sick funds, and those holding in addition commercial private insurance. This is the picture in gross terms, but, as the Haredic case shows, it is a nuanced one. Generally, patients receiving care through the public system are deprioritized in terms of access, waiting times, and seniority of the attending specialist in comparison to patients that own 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), increasing existing inequalities in service provision between the center and the periphery.

While private ownership of health care facilities increased, the high-way of health privatization was the expansion of different forms of public/private mix, namely, blurring of the boundaries between the public and the private sectors. The public health funds own private hospitals, medical imaging and laboratory facilities. Moreover, since the 2000s, budget constrains pushed hospitals and sick funds to find alternative, market-related, sources of income. In order to alleviate pressure on the state budget, governments allowed the public sick funds to sell private supplementary or complementary insurance while hospitals developed different arrays of private initiatives in order to replace insufficient funding (Filc and Davidovich, ibid).

The private share of Israel's health expenditures has grown mainly due to the impressive expansion of supplementary insurance sold by the public sick funds (HMOs), from 49% of the population in 1999 to more than 80% in 2021. Supplementary insurance covers services not included within the public “health basket”, such as certain diagnostic procedures and pharmaceuticals. It also covers alternative and cosmetic medicine. However, the main reason drawing people to buy this kind of insurance policy is to allow for choosing surgeons, and mainly to skip queues.[[8]](#footnote-8)

Neoliberal practices include practices that expand the logic of the market to everyday life, and the constitution of a neo-liberal subjectivity, by which we act in every social situation as “consumers” (Hall and O’Shea 2013; Torres 2013; Woodly 2015). The neo-liberalization of Israeli society as a whole, and the gradual privatization of health care resulted in the commodification of health care. This has two main expressions. The first one, an institutional-structural one, consisting, as we saw in the privatization of services. The second one is the subjective one, the ways in which users of the health care service adopt a consumerist approach, not only when purchasing private health care services, but also when using the public system.

This is a two-ways process, in which both the public health care institutions and the users of the system see the latter as costumers that must use market instruments (private insurance, informal payments) and market strategies in order to navigate the system (Filc, Rasooly & Davidovitch, ibid;Michael, Filc & Davidovitch, 2022; Niv-Yagoda, 2020).

**Cultural Research on Semi-Commercialized Health**

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

Scholars in welfare countries of the western hemisphere were quick to notice the growing expansion of what Mol, in the Netherlands, characterized as "the logic of choice". This "logic" rose in dominance over the "the logic the care" which was the founding principle of the public health systems of the mid-20th century (Mol, 2008; Gabe, Harley & Calnan, 2015). Based on ethnographic observations of diabetic patients in the Duch public-private system, Mol provided a phenomenological analysis of 'Choice' as the main symbolic axis of a consumerist discourse in which health is a marketized commodity, the patients become an aggregate of individuals (rather than a social group) and their actions are conceptualized as the actions of a rational individual.[[9]](#footnote-9)

Mol suggested that the choosing patient may suffer from the heavy load of personal responsibility for his/her choices. This might be affect patients who are upper-middle class, highly educated individuals who possess a high degree of "Cultural Health Capital" (CHC) – a Bourdieusian's cultural capital which Shim adjusted to the health field (Shim, 2010). Let alone patients from lower echelons of society, who might be lower in CHC and might get lost in the health "maze" created by the public-private mixture (Collyer, Willis & Lewis, 2017).

Shim's and Mol's analyses are illuminating fully understanding commercialization processes requires a more refined analytical tools which will enable to track the meeting point between the objective (conditioning) and the subjective (agency) aspects. This challenge was met by some Australian scholars. Australia seems to resemble Israel more than the often-cited British system. Its former universal health coverage is today layered horizontally with some 30-40% residents (the more upper middle-class layers) insured by private insurance while the universal insurance is still going on for the lower layers (Harley et a, 2011).

Collyer and her colleagues suggested a Weberian-inspired Class analysis, mostly adapting Bourdieus's terms: Field, Habitus and forms of Capital (Collyer et al, 2015). They hold that the seemingly individual isolated action (choice) is in fact rooted in a field which is the social structure in which different types of capital are (re)created and interplay. The healthcare field is in fact "contests between the dominant ‘position-takings’ … those of the corporations of capitalism … the capitalist state … and those of subordinate actors" (Collyer et al, 2015. P. 690).

Demonstrating this approach, Willis and Lewis interviewed 78 Australian residents to analyze their experience of commercialized choice. Some of them were persuaded by insurance and government appeals and bought PHI (Australian Private Health Insurance) and some did not. The finding shows that the choice discourse penetrated deeply into the diverse layers and even reached to the core of the patients' habitus, even among the poorer patients (Willis & Lewis, ibid).

 **Methodology**

This study was conducted as part of a larger mixed methods study on the public-private mix in health care. The main target in this qualitative study focuses on the patients' perspective trying to assess the influence of the "neo-liberal" discourse of commercialized health with varying class and ethno-class positions.

The paper is based on narrative analysis of 20 respondents along with several informal talks with informants. The texts were analyzed in search of common themes, patterns of narrative, common values and interpretation of reality. In interviewing and analyzing the transcripts we used several concepts which were developed in class-cultural research. In the tradition of narrative analysis, we assume that an individual account of a seemingly isolated personal happening might actually imply a grain of a "key-plot" – a collective "story" which encapsulates the experience and repertoire of the whole group (Bruner, 1991, 2004; Spector-Mersel, 2010).

Each semi-structured interview started with the respondent's occupation, education, age and their general ethnic attributes, and then moved to questions regarding personal experience, values and views on the mixed private-public health systems. The interviews were all conducted in Hebrew by two qualified researchers (one credited above and the other is one of the authors).

One social group situated in the lower echelons of Israeli society is missing – the ultra-orthodox Jews (Haredi Jews). The reason is our lack of resources at the time. Interviewing members of Haredi communities requires special arrangements such as hiring and training of Haredi personnel which was not possible for us at the time.

The following table presents the social characteristics of the respondents.

**Table of Respondents**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Name (fake) | gender | Age | Profession  | Education  | Residence  | Ethnicity  | Class profile  |
| 2 | Ronny  | M | 77 | Insurance agent | academic | City  | AJ (Ashkenazi Jewish) | UMC\* |
| 3 | Ada | F | 70 | Cosmetician  | ? | Kibbutz[[10]](#footnote-10)  | AJ | LMC\*\* |
| 4 | Mor | F | 41 | Kindergarten teacher  | Academic  | Kibbutz | ~AJ (probably AJ) | LMC |
| 5 | Reli  | F | 62 | Lawyer  | Academic  | City | ~AJ | UMC |
| 6 | Ami | M | 66 | Teacher-Lecturer  | Academic  | Kibbutz  | AJ | UMC |
| 7 | Michael  | M | 30 | Student  | High-school  | City | ~AJ | LMC |
| 8 | Kobi | M | 53 | Scholar  | Academic  | City | ~AJ | UMC |
| 9 | Ari | M | 30 | IT | Academic  | City | ~AJ | UMC |
| 10 | Rivi | F | 65 | Retired textile worker  | High school | Peripheral town  | MJ (Mizrahi Jewish) | WC\*\*\*\*\*\* |
| 11 | Mona  | F | 52 | House maid  | High school  | City (poor community) | AI (Arab Israeli) | WC - MWC |
| 12 | Ira | F | 70 | Retired accountant  | professional diploma  | City  | RJI (Russian Jewish immigrant 90s) | LMC |
| 13 | Fani  | F | 71 | Retired worker (~secretary) | High school  | City (poor community) | RJI | WC |
| 14 | Mimi | F | 72 | Retired worker (cashier) | High school  | City (poor community) | MJ | WC |
| 15 | Belal | M | 51 | NGO manager | Academic  | Peripheral Arab village  | AI | UMC |
| 16 | Jaber | M | 55 | Plumber | ~Elementary  | Peripheral Arab town  | AI | WC |
| 17 | Nora | F | 64 | Retired factory worker | Elementary  | Peripheral Mizrahi village  | MJ | WC |
| 18 | Ja'afar  | M | 56 | Painter (worker) | ~Elementary  | Peripheral mixed (Arab and Jewish) town  |  | WC |
| 19 | Warda | F | 34 | Driving instructor  | Academic  | Peripheral Arab town | AI | LMC  |
| 20 | Yossi  | M | 70 | Locksmith  | High school  | Peripheral Jewish town | MJ | WC |

\* UMC = Upper Middle-Class

\*\* LMC = Low Middle-Class

\*\*\* WC = Working-Class

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

**Themes**

**1.1 The Middle-Class Neo-Liberal Self**

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

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

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

 Other respondents which can be characterize as upper-middle middle-class subjects (in Israeli ethno-class terms) tell similar stories. Some do not tell a hero quest story, but they always express a harsh critic, even contempt to the public system and a very strong assertion of the existential need to "zigzag" to the private.

Ada is working in low middle class occupation, but she is a member of a Kibbutz which in Israel puts her culturally in an upper middle-class community in ethno-class terms. Kibbutz is a formerly a socialist-Zionist settlement. Perhaps that is why Ada feels obligated to state her values which support the public health system, yet all Ada's stories deliver a totally different message, expressing her deep mistrust and even contempt of the public system and her continuing choice to turn to the private insurance which the Kibbutz provides fully. Here is a story that Ada told about her mother:

My mother has a problem with her eyes. She didn't see well. She had a hemorrhage in her eye - blind in one eye ... And in the other eye she suddenly had some kind of hemorrhage, and she could not see. We went to doctors in X [public hospital in the periphery]. They tried and they said "there is nothing we can do", "she won't see anymore". She sat at home for three months .. no TV, no book, nothing. Four walls and that's it. … We were looking for a [private] specialist doctor [and] we found through the internet. [I told the public doctors: but] there are Avastin shots, do something. "No, she's not up to the standard, she doesn't deserve it… We went to her [private doctor], she gave her three injections … [now[ My mother sees, reads … Since then, they are erased for me. This department is deleted for me ... It was really wrong. really, really wrong.

**1.2 Low-Mid and Working Class – negative impression of the public**

Ira is a 72 year old "Russian", that is, a 90s immigrant from the former USSR, who lives in a peripheral city in the Israeli southern region. She is a retired accountant. For her, as for many "Russian" immigrants of the 1990s, poverty is a vivid memory due to immigration, deskilling and unemployment. Nowadays, she lives in her own comfortable private house. Yet, she is chronically sick, and her medical needs are many. This is how she summarizes the situation:

I think that the health system does not work for the… ordinary person. Our health system only works in favor of people who have money. If you have money, you will get really good quality treatment. If you don’t have money, well, that’s where the story starts. Queues, for example ... you can't get it easily. You can get it with "protektzia"[[11]](#footnote-11) or privately. Money. Pay money in order to undergo surgery. That was what we did.

Like Ronny and Ada, Ira too went to privatized medicine. Unlike Ronny or Ada, her story is not of the "hero quest" type and does not show any trace of contempt. Choice, so it seems, was forced upon her, from her subjective perspective. She tells of hardships and despair, and longs for the days when she could just trust the system**.**

Rivi is a Mizrahi woman, a retired factory worker from a peripheral small town. She begins with the same statement about money and health:

When it's about money, then everything is in order ["Hakol Beseder"]. But when you have to go through a professional doctor in the Clalit [HMO], then it’s a little bit problematic because the queues are long … this is very bad, and one who doesn't have the money is miserable. He falls through the cracks. I'm telling you – I went over to a Gastro [private specialist]. I hardly sat down, and he already called my name. Isn’t it surreal? It is very surreal. And [meanwhile] many people wait in line. Surreal!

Rivi's account testifies as to the deep commodification of health which is presented as a fact of nature (health=money). Yet it too does not tell a victorious narrative of privatized medicine or expresses any contempt. Just like Ira, Rivi does not celebrate this situation. Rather she seems to lament it and keeps wondering if real ("its surreal").

Nora, a Mizrahi retired factory worker from a peripheral village (Moshav) tells the first part in her story:

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

In this part, Nora suffers to the point of humiliation. She says that in public system you are treated badly: "It's like Yalla ["hurry on" in spoken Arabic. RA], like a gaggle of hens". Later on, Nora moved to the (semi-)privatized system through the supplementary insurance.

Yossi, a Mizrahi middle-aged locksmith from a peripheral relatively poor Jewish town tells another story that starts with a work injury:

I haven't worked because of my ankle for almost six months. I fell in the dining room [at work] ... So, here there are two doctors: one is blabbering, and the other listening. The first one talks to the other doctor ... Really, they are not interested in treating you, … eventually, He writes something to himself [and says to me], "Okay, take this [medicine] and leave." I didn't like it that much ...

Later on, Yossi had to be operated, but he refused:

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

Yossi too used the "Yalla" word to explain the attitude of humiliation. The Orthopedic "Treats you but not really treats **you**. Yalla, Yalla! finished? send in the next in line! … it's like a factory, a conveyor line. Again, in Yossi's story one does not notice any sign of victory, contempt or mockery of the public system. The story starts with a frustrating experience on the border of humiliation and ends with privatized medicine that carries a price tag.

Jaafar, a working-class middle-aged Arab construction professional and building team manager tells another story on work injury:

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

Another story of humiliation by Ja'afar is about his father:

I remember my father, may his soul rest in peace, he had lung cancer and was in Z [big governmental public hospital]. I will never forget the situation... at the end of his life they put him in a disgusting, filthy place. He no longer had a chance. The doctors told us there - no chance – just wait ... if he was a private [patient] this center would have treated him differently … He would have received all the conditions that a person deserves, someone who had passed so many years and contributed ... you know, he also worked in the National Transportation Agency. He was [in the] government.

Jaafar's story is painful, but it does not mock the public system. If he seeks services in the private, it is because he was pushed out (in his eyes) feeling humiliated and even betrayed. The fact the Jaafar's father worked for the Israeli government although he is of the Arab minority, probably emphasizes the narrative of betrayal.

Warda, a relatively successful mobile Arab woman who emigrated to the south from the north, canceled the supplementary insurance (sold by the HMO) when she realized that it simply did offer services in her region for the Bedouin communities. Hence, her next story ends with a direct payment:

You call to book an appointment. Your condition is difficult, and you need diagnosis because you have recurrent infections and a swollen face, and you are not functioning. Then you are told that the appointment will be in six months... We will send you a letter to the post office when is your appointment and it will be on average six more months. And here, the postal service is lousy in the village. We do not get mail. So, there is no way for you to receive an appointment over the phone ... And they say, go back to your office at your [local] clinic, but its lousy at the clinic. In the end I had to take money out of my pocket and go to a private doctor …

I reached him through an acquaintance, a doctor that studied with me at the Hebrew university. He said: "He is a senior specialist in this mouth surgery, and he has a private clinic in Nazareth. Go and finish your suffering. You have money, you don't have money. Just go." I went and I paid 500 shekels. I had surgery and that’s it. The pain was gone.

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

Supplementary insurance is a commodity. It is bought and sold in a so-called free market. And yet it is sold by the public HMOs, its price is regulated, it is not allowed to screen out patients or to deny access based on pre-existing condition. It is a semi-commercialized insurance. Most of the low-middle class segments bought it and it is their only private insurance (See above). How, then, do lower ethno-classes experience it?

Nora, an elderly Mizrahi from the southern periphery (see above) felt no need for the supplementary insurance or privatized medicine. As long as her husband was alive, she did not pay any attention to it. After his death, her children demanded that she bought the insurance, and she eventually did. Her story starts with a shocking experience:

I was at an ophthalmologist a year and a half ago. And he told me urgently to do a cataract [operation]. Now he gave me a reference letter. I brought it to our [public HMO] clinic. They told me: 'Well, we are sending it by fax to S [the regional HMO hospital]'… wait, wait, They'll invite you … I've been already waiting for a year. A year plus… I received a letter in which they tell me- 'you're in the waiting line. when its available [we'll call you]. So I rang 'bright eyes' [a private clinic] ... Now they made it perfect ... a different treatment ... patience, [people] talking nice to you."

Further inquiry revealed that Nora's children played a major role in her decision to buy supplementary insurance and assisted in the require copayment of considerable proportion (7,000 NIS or 2,000 $) through the supplementary insurance. Her children are relatively mobile of the Mizrahi 3rd generation. It is as if they reached out and pulled their mother up to what they consider now a taken-for-granted standard of health.

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

Jaber, a middle-aged plumber from an Arab peripheral town, states abruptly that "I like to go to private medicine." Yet, a closer look reveals a world of difference between what Jaber calls private and what might be imagined based on the neo-liberal consumerist discourse (Harley et al., ibid).

Jaber does not describe a linear route which starts from the public and goes to the private, sliding from one realm to the other with the power of money. Jaber's route starts with the local family doctor who is also a distant relative:

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

So [my] doctor tells me: we have a doctor in our Kupa … we have our doctor - first of all, you go to him". Like, he wants to save my money… So we go to him. If it doesn't help here and there, then go out to more specialist doctors.

What Jaber narrates in a taken for granted manner is in fact a rather complicated network which is "our", meaning that it is an Arab-Israeli communal network or net of networks. It might start with "our" doctor who sits in a local public clinic or a regional hospital, that is the public local system. The doctor refers to another doctor that "we have", but the referral is not done through the proper medical public routes. If then a possibility of a specialist is raised it will done "privately" – not by using insurance but by using the network and paying a direct sum to the doctor.

This practice was mentioned by other respondents that allowed us to clear the obscurity. Belal, a successful NGO manager lives in his home Arab village in a poor community graded 2 in the lowest fifth of Israeli socio-economic ladder. He is undoubtedly of the local elite but he serves as an informant and cultural interpreter. Belal talks about the "Arab ways". These ways are distinctive routes to get proper or better health care which cross the borders of public and private but do not use commercial insurance. The whole network, he says, is based in the final account on a net of personal connections among Arabs. "Our" doctor, says Belal, might ask for payment, and:

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

From Belal's point of view, this practice is not to be judged morally since it is a survival practice of a discriminated Arab minority that suffers sometimes humiliation in the public system. Here Belal tells a story that justifies the communal network in his eyes:

I hear about many cases of people who are dependent, very shaky. I will tell you about one case of my uncle, for example. He went to X [a public hospital in the center of the country]. After 3 months of waiting in line, he got there, and it turned out that the referral letter is missing … I told him "Calm down, one second, what?" So he said: "He [the doctor] didn't accept me. I have to go back [home]"… I said to him "Why are you coming back? We've been waiting for 3 months! Let's pick up the phone, let's take a look, come this, come that, come-come"?

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

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

My daughter suffered from stomach pains and constipation and our Kupa has no Pediatric gastroenterologist in the Negev. So, the first time I had to consult a gastroenterologist … I had to go to the French hospital in Nazareth in the North … Simply because they [the HMO] could not give me a close enough date. [here] there is no doctor who belongs to this Kupa. There are no upcoming queues. The closest appointment was in Tel Aviv in something like two months, and the girl was suffering … I went to the French hospital because I knew people who were treated there. I knew someone who works there. He told me "there is a children's gastroenterologist there, you can make an appointment with him".

Warda goes on and informs us of some peculiarities in communal network that exists among the Arab Bedouin communities in the Negev which are the poorest in Israel and inside the Arab sector. According to Warda, the Kupa (public HMO) chooses a person that must be quite well-known in the local community. His mission is to bring in people and even entire families to enlist in the Kupa. From the patients' perspective, this person will serve as their representative, smoothing-up their daily contacts with the Kupa.

**Concluding Discussion**

Privatization and commercialization of health are well-documented processes. Israel is not different to Western countries where a universal public system existed while, mainly since the 1990s, private insurance and commercialized practices evolved and took the upper hand (Filc et al., 2020). These processes created in Israel, as in other countries, a private-public "maze" (Collyer et al., 2017). Although the issue of privatization and commercialization is in dispute, most policy makers hold an axiom that "people want choice" ((Filc, ibid; Yam-Hamelach 13, 2012). Yet, from a subjective-cultural aspects many questions remain open and the answers, as far as this research suggests, are complicated depending on the social group and its ethno-class position.

In the interviews respondents were asked to tell stories about their experiences in the health system. It is worth to note that the interviewers did not lead the respondents in any way to criticize the public system. On the contrary. The two experiences researchers in the field had strong views in favor of the public system. It was the respondents' choice to tell their own stories on their health experiences which were, with almost no exception, stories that criticized the public system and reflected a binary which favors the private. Certain repeated narrative patterns, as presented above, rise in our eyes to the level of "key plots" of culture, attesting to the existence of values, interpretation and even the basic categories of perceiving and acting in reality (habitus).

Let us start with a general assumption about the external cultural context which was not a part of the analyzed material. The patient-subject as a "happy" choosing agent is an fundamental part of a discourse which is mainly activated by marketing factors - commercial insurance companies, HMOs selling supplementary – and by policy makers. This discourse, in Israel as in other modern societies, tells a victorious story of a choice, freedom and self-assurance, quality and other values that can be characterized as neo-liberal. Our initial contention was that this context together with the exceptionally high level of supplementary insurance coverage, would be mirrored in the subjective-cultural by an appearance of neo-liberal self or neo-liberal habitus in all echelons of society, reshaping both patterns of behavior (purchasing and using private health) and meaning (stories, values).

This contention is only partly true with such variations that may be considered as partly refuting it. Indeed, there can be no doubt that there is a widespread commodification and commercialization of health reflected in the subjective narratives among all the echelons that we checked, proved by the existence of the above-mentioned binary of public-negative, private-positive (PN-PP). Yet there are important variations on a ethno-class basis which tell a surprising story.

The "ideal" model of a neoliberal self – narrative, values, interpretation of reality - appears quite clearly only among upper middle-class respondents or among lower middle-class that reside communities that are characterized as upper-middle class (such as the Kibbutz) with higher levels of education and presumably higher CHC (cultural health capital). This means that in these social spaces a subjective model or even habitus (that shapes perceived reality) prevails. Repeated narratives show a hero-quest story of a self-assured patient with high CHC. While this plot appears sometimes in this pattern, its values and interpretation of reality were prevalent in each and every narrative – contempt, even rage and a degrading picture of the public.[[12]](#footnote-12)

As we descend the SES ladder to lower ethno-class communities the narratives change, the feeling is different and unknown practices emerge. We hardly found any hero-quest story even if the story of zigzagging to the private was a successful one. It seems that a different model is in need here if we are to understand the texts of lower ethno-class groups. Along with the binary of PN-PP - lack of services, long lines, indifference, even blatant humiliating – there are totally different feelings expressed and there is no trace of the hero-quest model. The whole atmosphere in most narratives of the lower echelons is not an atmosphere of contempt for the public system, nor is it an individualized celebration of the choice given through private insurance. Rather, the feelings are of despair, fear, perhaps even lamentation for the forgotten "logic of care" which seems to flicker in between the lines.

Regarding the lower echelons we can postulate two hypotheses on the varied forms of commercialization among two dominant ethno-class groups in the lower classes - Mizrahim of the low-middle and Arabs of the working classes.

The first hypothesis concerns Mizrahim in the middle-low popular class, and possibly also Russians in the same class position. Here some common narrative elements can be identified: first, right at the beginning of the story the narrator tells of an event that shows his/her disappointment with the experience in the public system, sometimes even. Yet, the feeling is of sorrow and even lamentation of public system implying strongly that thins could have different.

It is important to emphasize that all our Mizrahi low-middle class respondents had supplementary insurance but only part of them obtained commercial insurance – as is expected according to the statistics. It should be noted that the HMO which sells supplementary insurance tends to blur the difference between this insurance and its function as the public provider (See above). Hence, the narratives adopt this blurring and still see the HMO as the "one in charge". If this HMO fails to provide proper care in its public function, the patients – at least for now – still regards the HMO is "worthy of disappointment", thereby, keeping some contact with the "logic of care". Yet, as the pattern of story unfolds, the patient is driven to seek assistance individually, thereby adopting and adapting to the "logic of choice".

Referral to the privatized or commercialized route does give the (Mizrahi low-middle class) patient a taste of personal treatment and care, but at least for some, this patient might feel also the heavy burden of choice and the anxiety of being lost in the public-private maze. These negative feelings were much more apparent in the lower class narratives. Let us stress again that this is a subjective analysis. It might be interesting to check in objective terms that happened to the narrating patient actually and what was the result in medical terms. This might be the challenge for future studies, qualitative and quantitative.

The second pattern is discovered to be uniquely Arab. The Arab respondents are located mainly in the working class and even lower or they are informants living in communities that are mainly poor. Here, too, there is no evidence of the narrative pattern of the 'neoliberal self' as it appeared in the stories of the upper (Jewish, mainly Ashkenazi) echelon. Just like the Mizrahi low-middle class experience, so in the Arab pattern, there is hardly any contempt for the public system. The patient does not tell a success story of juggling between the public and the private while skillfully using financial and social resources and cultural-health capital. Instead, disappointment and very often even humiliation is prevalent together with the same air of lamentation.

Here a surprising practice was revealed, and that is the existence of a bypass route that does not rely on commercial insurance or supplementary insurance, nor on economic or cultural-health capital. This route relies on community networks that are based on the extended family or several extended families and have a local community anchor. At the center of the network are doctors who often work in the public system and sometimes even in the health insurance clinic in the village. Patients can reach these doctors through the public system, but the narrative pattern begins with a problem, a health event that simultaneously raises the level of risk and anxiety. Indeed, the public system is revealed in its weaknesses and fallbacks - long queues, indifferent attitude, even humiliation and discrimination on an ethnic-class basis. Doctors that are reached through this network might charge a fee, but this is not a financialized route, as far as we could find. Its level of financialization (effectively commodification) might be the focus of future research.

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

The overall dynamics is indeed complicated one. The upper middle-class seems to adopt a variation of the neo-liberal self and celebrate it, at least in its outspoken statements, even though it certainly carries its own risks and even repressive aspects. This adopted self can be interpreted as a variation of what Skeggs called the reflexive self, based on exchange value and modeled in the measures of the white Euro-American middle-class male (Skeggs, 2004).

Yet, the lower classes in our research do not accord with the prognosis of linear penetration of this neo-liberal self. Nor do they accord with a (perhaps naïve) expectation that they will keep a high level of trust to the troubled over-laden public system. They share a critical view on the public system and participate in what seems to be a cultural corpus of complains. Yet they develop their own attitudes and interpretation of reality to the point of a genuine habitus.

The Mizrahi low-middle class and the Arab working-class present a narrative that implies a new habitus that experiences the lack of services, the long queues, in short, the humiliation as a struggle for good health. It does adopt commercialized values to some point (PN-PP) and seeks individual a save itself in conditions of scarcity with limited financial and social capital (CHC). The Jews of the low-middle class (mainly Mizrahi and Russian) seem to seek personal solutions through the supplementary together with family assistance. Arabs of the working and poor classes tend to participate in a community network located alongside and within the public system.

What emerges is a mixture of class determinacy (conditioned by the position in the fields) and group agency. From a neo-Marxist point of view, one may hear a certain "voice" or agency that can be found in the experience of relatively oppressed groups facing powerful forces that exercise forceful practices on them on a daily basis. It is neither the victory of class oppression or of neo-liberal false consciousness nor is it the celebration of the freedom that the neo-liberalized health promises. Rather it is a picture of agency in conditions of objective scarcity and subjective-cultural pressure exerted by the neo-liberal model and by the marketized and policy forces. Future research, perhaps using mixed methods, might check these insights and widen the scope to other relatively low SES groups such as the Haredi communities. ​

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1. The research on which this paper is based was funded by the Israeli National Institute for Health Policy Research. [↑](#footnote-ref-1)
2. The authors would like to extend special thanks to Dr. Efrat Leibovich who conducted a large part of the interviews during the field work. [↑](#footnote-ref-2)
3. This paper is the fourth qualitative part of a larger research project which investigated doctors and patients using qualitative and quantitative methods. [↑](#footnote-ref-3)
4. The popular classes are subordinated to capital, sometimes directly through debt (Lazzarato), mostly through their subordination to the new service class. [↑](#footnote-ref-4)
5. In the English literature there is a resistance to use the term. Even when translating research specifically focused on the popular classes, such as Masclet’s research group, the selected term is “working classes” (Masclet et al. 2022). [↑](#footnote-ref-5)
6. We understand subalternity in the Gramscian way, in which the subaltern groups have agency and voice. [↑](#footnote-ref-6)
7. Arab-Palestinians residents of Israel and not the occupied territories. The text will relate to them simply as "Arabs". [↑](#footnote-ref-7)
8. While the public system allows for choosing doctors for ambulatory services, and also choosing hospitals, it does not allow for choosing specific doctors within the hospital system. [↑](#footnote-ref-8)
9. Another useful theoretical account, quite close to Mol's in principle, is Fotaki's which differentiates the citizen's discourse from the consumer's discourse (Fotaki, 2011). [↑](#footnote-ref-9)
10. Kibbutz is an Israeli-Jewish originally cooperative small community village which used to be an important part of the Zionist Labor movement. Today it is mostly associated with Jewish-Ashkenazi Middle-Class but the reality is more diverse being an object for geographic mobility also for Mizrahi MC. [↑](#footnote-ref-10)
11. "Protektzia" is a popular slang (probably borrowed originally from Russian) which was made popular in the early decades of the 50s and 60s. It meant using all kinds of social connections with influential people including bending regulations in order to get something, e.g., construction permit or medical treatment. [↑](#footnote-ref-11)
12. This does not mean the objective reality "per se" corresponds totally with the subjective. Indeed, we cannot measure the exact outcomes of any "free" choice. Ronny's "hero quest" story for example tells of a successful back surgery obtained quickly with a private doctor, while the relevant medical professional community is quite weary of quick decisions on back surgeries.נדב תוכל להוסיף הפניה ? [↑](#footnote-ref-12)