Privatization of health and welfare services for older adults in Israel: Gains, deficiencies and the multifaceted dilemmas.

Pnina Ron*

School of Social Work, University of Haifa, Israel

Abstract

Over the last four decades, the Western world has engaged in the process of privatizing various health and human services, such as incarceration, foster care, hospital services, and services intended for the older population, such as home-based nursing care. The rationale for undertaking this initiative was to relieve the heavy burden that the provision of such services imposes on governments and local authorities, as well as the sincere desire to improve the quality of services through free-market competition. As the process unfolded, the advantages and disadvantages of privatization became apparent, not only in theory but in practice. An especially crucial question that arose was regarding the role of the welfare state and its obligations toward the various population groups that comprise it (as well as differences in the level of commitment among various welfare states). Addressing this question raises a series of dilemmas: the political dilemma (e.g., allocating responsibility for the quality, availability, and costs of the services); the professional dilemma (e.g., the quality of care, the manner and extent of training that is required of various caregivers, the ability to monitor the extent and quality of the services rendered); the social dilemma, which deals with maintaining the principles of social justice and equity (e.g., exercising one's right to the full extent of the law; having access to services in the geographical periphery; and the ability of disadvantaged populations, such as immigrants, to meet the costs of privatized services). As regards the weaker sectors of society, such as older adults, the poor, refugees, and immigrants, there are additional difficulties to consider, as they need assistance in locating these services, meeting the costs, and finding a companion who can help take them to a clinic. Older people have even more needs, above and beyond those mentioned; hence, the impact of the privatization process is even greater in their case. This study examines the advantages and disadvantages of the privatization process in reference to this segment of the population and these dilemmas.

Keywords: Privatization of services, Elderly people, Public health, Dilemmas.

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Introduction

The term welfare state developed in the mid-twentieth century, following the economic crisis of the 1930s in the United States and in Europe and the outcomes of World War II. The goal was to ensure that all segments of the population would be able to meet their existential needs. In Israel, up until the 1970s, in most cases, the welfare state was supported publicly and politically, and there was a general consensus that it is the duty of the state to provide its citizens with essential services. Since that time, however, support for the policy that seeks to reduce the state's obligation to provide services to its citizens has been increasing constantly, with a tendency to transfer this responsibility into the hands of the private sector; hence, the privatization policy [1,2].

Finding a comprehensive definition for the term privatization is a Sisyphean effort. Generally speaking, privatization can be considered any process in which the government seeks to lessen its involvement in the production and provision of products and services for its citizens. Common categories of privatization deal with seemingly "technical" aspects, for example, whether privatization should include selling state assets to private owners or "merely" transferring the performance of these services from the public sector to the business sector. However, the more significant distinction pertains to two major issues: the degree to which the state continues to take responsibility for the services provided by the private sector and the manner in which the state manifests its responsibility to oversee and control the privatization process [3-5].

When privatization takes the form of the government's complete withdrawal, relinquishing all responsibility, the question of the manner in which responsibility is manifested becomes moot; hence, in such cases, the main issue debated is whether it is moral for the state to relinquish its responsibility for said services. By contrast, when the government remains in the picture and continues to oversee the process, the model which it uses to exercise its responsibility is the crucial issue. The type of incentive that is inherent to the privatization model calls into question whether the state's policy will be upheld, i.e., practiced in full, or at least in spirit, or whether the principles of social welfare will be impaired, diminished, or disregarded. There is a gradation between these scenarios, which gives rise to two additional important questions: if the state takes partial responsibility (how much and for what?), is that enough to

ensure that its policies are applied in full? Does the model selected for exercising partial responsibility ensure that these responsibilities will be reasonably met [6,7].

On the issue of the state's responsibility, there are likely to be disagreements based on ideological viewpoints rooted in different understandings of the "social pact" between the state and its citizens. Indeed, the privatization process developed in response to an interpretation of the welfare state, according to which the state's ability to maintain the above-mentioned social pact is limited, specifically, the government does not necessarily know what is best for its citizens or how to implement these "best" options efficiently. In financial terms, this in effect constitutes an admission that the government's failures are liable to cause greater damage to the welfare of its citizens than the shortcomings of the free-market, which (in earlier times) the state was supposed to amend. This line of reasoning led to an approach that seeks to reduce the involvement and responsibility of the state in various realms. Nonetheless, this shift in perception left a wide berth for making choices, a process which is often accompanied by valid debates of an intense nature [8,9].

Often times, the issue of responsibility is framed in terms of efficiency. In other words, reducing the government's responsibility is justified by pointing out its inefficient performance, which leads to the waste of valuable economic resources. However, questions of efficiency are related to the manner in which the responsibility is manifested rather than to the question of the degree to which the government should take responsibility. Moreover, the advocates for greater government involvement consider inefficiency “a small price to pay” for an overall better system [10,11]. In other words, this need not be an "all or nothing" state of affairs; rather, the consideration should be of cost versus benefit. Finally, an empirical study did not produce conclusive evidence that privatization did indeed lead to increased efficiency [12]. Since the privatization process was completed, the state has attempted to use many and varied models for meeting its responsibilities. In some cases, the selected model was that of regulation, i.e., setting regulations and guidelines for the delivery of services and ensuring their proper implementation. In this case, the government allows the market forces to determine the various characteristics of the services and the way they are supplied. In other cases, the government continues to finance these services either partially or fully, directly or indirectly, and the relationship between the government and the private sector bodies that perform the services is defined by means of a detailed legal contract. The privatization model is tested in terms of its ability to create incentive patterns that encourage and promote social welfare, despite the outright differences between the goals and the interests of the government and those of the private sector. With each model, a series of ethical, social, professional, economic, and political dilemmas arise [13-15]. Considerations for and against the privatization of health and welfare services

The welfare state implements the privatization policy in the realm of social services by transferring the operation of some of the services for which it is responsible to private entities, business organizations, or nonprofit organizations. This type of privatization is also referred to as outsourcing of social services. Privatizing the operations aspect through outsourcing is conducted by issuing a tender for services. However, the state remains in charge of planning and defining the scope of the services, determining who is eligible to receive the services, funding the services, and overseeing their adequate delivery. The main motivation for privatizing health and welfare services according to this model is financial, with the intent of lowering the cost and the proportion of government expenses designated for these services, while improving the quality of services, for the benefit of the eligible population.

The following were among the claims made in favor of privatization, early-on in the process.

Extreme dissatisfaction with the governments' (and local authorities') far-reaching involvement in providing these services. This state of affairs led to poor management, lack of efficiency, extravagant expenditure and the waste of resources, inflexible bureaucratic systems that focus on self-preservation, inability to adapt to change, the introduction of political factors in decision-making processes, poor employee motivation (as well as difficulty firing ineffective employees protected by professional unions), the absence of competition, and depriving citizens of the right to choose their service providers. Altogether, these factors lowered the standards of services, made them less accessible to those who needed them, and gave the government excessive control over the lives of citizens [16]. Thus, it was assumed that the waiting period for cataract or hernia surgery, which are normative procedures among the older population, would become significantly shorter, and that patients would be able to arrange for the procedure at a time convenient to them, without being subjected to unnecessary bureaucracy. Before the privatization of these services, state-funded health-management-organization (HMO) patients had faced a waiting period of anywhere between six months to two years for such routine procedures.

The advantages of the free-market economy: privatization introduces elements of the free-market into the arena of health and welfare services and enables service users to select a service provider that fits their needs and allows them to replace the provider as they deem necessary, i.e., when their needs change, or if they are dissatisfied with the service they receive [17].

Moreover, service providers' awareness that their customers have choices motivates them to offer higher quality services to attract a greater number of customers. The competition among service providers causes them to routinely act with greater flexibility and to introduce innovations in their attempt to optimize efficiency within the given financial framework. Those who favor privatization claimed that the cost of privatized services is lower than the cost when the same services are operated by the government or the local authority. Thus, for example, private organizations can provide some of their services digitally and online, whereas public health services tend to lag in the provision of digitalized services and are not able to provide immediate online responses to the

varied and numerous population groups (with the exception of pediatric services).

Privatization allows the government and local authorities to shift the focus of their activities to policymaking, coordination, supervision, and control of services. The massive involvement of nongovernmental organizations in providing public and municipal services (see also section D) is expected to reduce the government's and local authorities' occupational and financial burden, freeing them from the need to operate a wide selection of services while catering to various population groups.

As a result, they will be able to focus on issues of policymaking, coordination among the various authorities, quality control, accessibility, and cost of services. Thus, for example, the authorities will be able to take into account the need to train staff to provide much needed home-care nursing services. In Israel, these positions are most often filled by work immigrants, who have a mere week to be trained, between their arrival and the assignment to the home of an aging client [18].

(D) Another advantage mentioned is the integration of volunteer organizations in providing health and welfare services. Volunteer organizations are the backbone of civil society: the services provided by these organizations are distinct from those provided either by governmental or private or business-owned organizations, in that they are better suited to help improve the conditions of disadvantaged populations or those in need of special services.

Hence, such organizations are able to expand the range of services offered and develop special services intended to address the needs of those who are not covered by other types of organizations [19, 20]. For example, neither public nor private organizations offer accompaniment services in or around the home to individuals in need due to old age; however, this service is routinely provided by voluntary organizations. Moreover, in communities situated in the geographic periphery, only voluntary organizations are available to address social problems, information needs, utilization of legal rights, and accompaniment to health services located in larger municipal centers.

Nonetheless, the privatization of services gives rise to many unique problems and difficulties; hence, it is not surprising that in Western Europe, for example, privatization started first with factories, then with infrastructure, and only in the recent decades did they come to the privatization of community and social services [8].

Those who oppose privatization processes doubt whether it is possible to derive the benefits mentioned by its promoters and call attention to several phenomena that are likely to accompany such practices and erode the anticipated advantages, while at the same time creating ethical dilemmas of economic, social, political, and professional nature. The phenomena that privatization opposes warn about include the following.

Undesirable changes in the role and authority of governmental and municipal factors. As previously noted, some of those who promote privatization view the shift in the status of governmental organizations from service suppliers to service customers as positive because it will free these organizations to focus on policymaking, guidance, coordination, and control. However, those who criticize this approach doubt whether that goal is attainable and fear that such a shift would lead the government to gradually abandon its commitment to help disadvantaged populations. Moreover, privatization would introduce too many chefs into the kitchen, which might overburden the government's administrative functioning in terms of its ability to monitor and provide guidance to the service providers. Those who are likely to be most burdened are the social workers of the municipal welfare departments, working in the wards of non-privatized and privatized hospitals, as well as those affiliated with the publicly-funded HMOs. It will fall upon these social workers to help older individuals who, discharged from hospitals early because of upcoming weekends and holidays, are left to care for themselves in an otherwise empty home in the community. Finding themselves overburdened, will inevitably increase social workers' emphasis on administrative work and thus restrict their ability to maintain direct contact with their clients.

(B) Problems that the potential service providers are likely to encounter. A major difficulty expected to emerge with the privatization of health and welfare services is related to the limited competition among service providers, which may stem from their internal overt and covert arrangements, for example, monopolization of the market by one or a few service providers, while eliminating others. Obviously, limiting the competition limits the options available to the consumers [21].

Another difficulty is the small pool of potential service providers, especially in the geographic periphery. Providing these services requires a high level of professionalism, upheld by well-trained staff members, and costly training programs. Consequently, the number of potential service providers might be too small for free-market dynamics to develop, in which case there would be no real competition over markets, which in turn would de-incentivize providers, further limiting the quality, accessibility, and availability of their services. Furthermore, the constant reliance on services (especially among the older population) precludes the customer's ability to frequently switch from one service provider to another [22].

(C) Customers are frequently unable to exercise their right to choose among providers. Lack of knowledge among consumers (especially among older immigrants) regarding the options available to them might stem from a lack of language proficiency or the opacity of the professional terms used by service providers. In such cases, it is feasible that consumers might make decisions that do not serve their best interests and might even be detrimental to them in the long run. In addition, it appears that there is a disparity of power in the arena of health and welfare services between the consumers, who usually operate on an individual level, and the providers, who are organized, sophisticated, and able to manipulate the information presented to potential consumers. Thus, in this power-play, service providers are apt to have the upper hand,

taking advantage of consumers' gullibility at best, or leaving them disenfranchised, in the less fortunate cases [23].

(D) The question of whether privatization will indeed lead to reduced costs. To remain involved in the services provided by nongovernmental organizations requires the municipal and governmental authorities to perform a wide variety of functions, such as negotiating, formulating, and signing legal contracts, setting up monitoring, etc. Carrying out all of these functions properly is likely to create a demand for additional human resources, which in turn would lead to higher costs. Furthermore, even if we were to accept it as a given that the costs of many of the services provided through private organizations would be lower, it is often the case that this scenario is made possible by private organizations underpaying their employees and offering job conditions that are subpar. More often than not, employees in private organizations are not unionized, and often they are work immigrants [18] who are willing to earn less than the standard salary in the country, as it is substantially higher than what they could earn in their country of origin. Finally, studies indicate [24] that the turnover rate of service providers in private organizations is higher than that found in public organizations: in public organizations, employees tend to feel a stronger sense of belonging to the workplace. Moreover, studies have found that private employers are rarely willing to compensate workers for overtime, or for demonstrating devotion to their clients and customers.

(E) The problem of the quality of services available and the difficulty in monitoring them. Those who favor the privatization of health and social services claim that competition encourages efficacy and cost reduction, as well as improvements in quality. Those who oppose privatization are concerned that private service providers might find it easy to sacrifice the quality of services they provide, in an attempt to maximize profits. Unfortunately, competition among private providers is usually measured in price, rather than in quality. In the context of health and welfare services, the government and the local authorities have a strong interest in ensuring that the quality of services remains high, and to do so, they emphasize their need to monitor and oversee the quantity, quality, accessibility, and satisfaction levels of service users. To practice effective monitoring, there is a need to precisely define the "outcomes" or "products" and to formulate comprehensive service standards and service assessment measures.

(F) Lack of equity in terms of the extent and the quality of services provided is most likely to be found when comparing services provided in centrally located cities and those provided in peripheral towns. Although there are towns that have a strong social community that is able to address various social needs (e.g., the increased proportion of the old population of the town) without seeking government intervention, in the majority of cases, these towns rely precisely on such assistance. As private companies seek to maximize profits, they might engage in "cherry-picking" their customers, avoiding certain geographic areas or disadvantaged populations. While market competition typically creates services that are tailored to the various needs of potential customers, in the case of privatized health and social services, the offering of differential services might not be applicable.

(G) The point of no return. Experience demonstrates that the major reason for rejecting the idea of privatized health and welfare services (even partially) is the inability of private organizations to maintain high service standards that meet the expectations of service users. It is important to take into account that if the outcome of the privatization process is less than optimal, the authorities may find it very difficult to reverse privatization and regain control of these services [25].

It should be noted that in all types of privatization, whether partial or comprehensive, it is important to address the many aspects of the process itself, e.g., its transparency, its ability to ensure equal opportunity equity of service, and that it includes a system for supervising fees and rates, to mention but a few.

Table 1 contains a summary of the claims for and against the privatization of health and welfare services, as well as the implications of these claims in terms of local and national services.

Table 1. *Advantages and disadvantages attributed to the privatization process.*

Advantages	Disadvantages
Minimizing the flaws that are characteristic of governmental service providers: politicization, bureaucratization, and poor motivation of employees	The government and local authorities withdraw their involvement in health and welfare services
A faster rate of response to the changing needs of clients, reducing waiting periods, etc.	Too little or too much competition among the service providers
Empowering customers by offering choices	Insufficient selection options for customers
Improving the quality and efficiency of services due to competition	Increase in social inequity, affecting populations in the geographic periphery, disadvantaged areas, or customers with special needs
Reducing the cost of the services and thus reducing the expenses of the government and the local authorities	Diminished salaries, increased scope of responsibilities, and lack of professional training for employees of private organizations
Offering a more comprehensive set of services, due to market competition	Duplication or redundancy of public services offered by nonprofit organizations, as well as private organizations, resulting in unnecessary expenses and difficulties in monitoring the services

Taking advantage of the social potential inherent to communities, and volunteer organizations	Attrition in terms of the features that are unique to voluntary and business organizations
Allowing governmental organizations to focus on policymaking, coordination, and monitoring of services and frame them from the burden of providing said services	-
The availability of numerous funding organizations, and the ability to recruit additional resources through the government, customers, stock market, etc.	-

The Ethical Dilemmas Associated with the Privatization of Health and Welfare Services for the Aging Population: The Case of Israel

The political dilemmas

Changes in the health system's policies and subsidies for older adults: In 1913, Jewish workers established the first and only medical fund (henceforth: health management organization-HMO) in association with the Hadassah women's organization, which had founded several hospitals in Israel. In 1920, with the establishment of the General Workers Union, the General HMO (henceforth: Klalit HMO) became affiliated with this group and provided health care to the majority of the population through a national medical insurance policy [26,27].

Once the first Israeli government was established, the Ministry of Health was responsible for two major functions: the purchase and supply of health services through their ownership of medical facilities and the supervision and coordination of nongovernmental health-related organizations. The Ministry of Health was responsible for providing the following services: preventive health care, mental health care, and nursing and rehabilitative care for the disabled. The community medical services were owned and operated by other HMOs that were established to serve populations unaffiliated with the General Workers Union [28].

In the mid-1970s, following a "mass migration" of patients to the nonunionized HMOs, much of the middle class, which was a major source of income, had become affiliated with the alternative HMOs. The Klalit HMO was then perceived to be the poorest of the major HMOs, the one that serves the older population, and whose services were of subpar quality. In 2006, there were 373 hospitals in Israel owned by various institutions. Thus, for example, in 1984, 48% of the hospitals were under government ownership and 23% were privately owned, whereas in 2006, 28% of the hospitals were publicly funded and 33% were privately owned; this trend has continued ever since [29].

As regards dental and dietary care, the older population relied on private services [10]. In the course of the 1980s, the percentage of public funding was dramatically reduced. Thus, for example, in 1979, private households funded 20% of their health needs (in the form of medical fees, payment for medications, and equipment purchased from private businesses), whereas, by 1988, a household's share in funding its medical needs had risen to 31%.

This change was related to a higher deductible, the opening of private clinics that worked alongside the public ones, higher HMO membership fees, and the ability to directly purchase medical services in hospitals. The majority of the population, including the older people, preferred to purchase private healthcare services for a few reasons: to avoid the prolonged waiting periods associated with medical procedures and treatments that were not urgent, to be able to select their primary physician, and because the paid services were considered to be of a higher quality.

In addition to the availability of private services, there developed a practice of "black market medicine," which entailed paying the physician in the publicly-funded hospital directly out-of-pocket, in return for services that were supposed to be free. These patients were promised a shorter waiting period or that the specific physician (rather than an intern or a randomly selected physician) would be assigned to perform the particular surgical procedure in question [30].

In 1985, the National Ombudsman's study of the ophthalmology department at Beilinson hospital revealed that more than 50% of the patients were referred to the department following a paid visit to the private clinic of either the department's director or vice-director [31]. Between 1996 and 2002, private healthcare services were operating in government-funded hospitals and, despite the legal complications, it appears that the health ministers in those years not only sanctioned but encouraged the offering of private services in all of the government-funded hospitals throughout the country.

The increase in the proportion of private healthcare services meant an increase both in household expenditure and in government expenditure, with the rate of healthcare apportioned by the latter rising from 26% to 31% in the decade between 1995 and 2005.

The National Healthcare Act of 1995 made healthcare insurance payment obligatory for all citizens, in return for which they receive a set (in Hebrew: "a basket") of healthcare services, which is redefined periodically by the Israeli parliament (Knesset). On the one hand, the enactment of this law meant that the state had to uphold a broader range of responsibilities, by providing and making healthcare services available equitably to all citizens. This, in turn, increased the government's income. The monthly payment fee for obligatory healthcare insurance is determined relative to one's income, which makes it possible to provide equitable services to all. Similarly, the extent of government funding allotted to each HMO is proportionate to the number of HMO members, taking into account gender, place of residence, and age.

On the other hand, nationalizing the funding of healthcare services gave the government greater control over the expenses of the HMOs and of other medical facilities in the health care system, which in turn increased the rate of privatization [31]. In 1998, a law was passed that changed the allocation of funding and forced the HMOs to participate in the funding of the public "basket" of healthcare services. In return, the HMOs were allowed to raise the rate of members' deductible payments for the purchase of medications, to raise the quarterly HMO fees, and-most importantly-to offer additional insurance packages [12,32]. At the same time, the market portion of the business sector grew, as did the number of private, complementary health insurance policies sold by the HMOs and insurance agencies.

Between 1995 and 2003, the percentage of the population that had purchased complementary health insurance had increased from 35% to 72%. The proportion of the population in Israel that purchases complementary health insurance is among the highest in the world [27,33]. This has led to the marketization of nonprofit organizations. As a result, those among the old population who rely on a poor level of income or who have no pension fund cannot afford the complementary insurance and are effectively deprived of the level of medical and nursing care that they require, despite the fact that throughout their working life, a monthly fee was deducted from their salaries toward the provision of a national (and presumably equitable) healthcare plan. Thus, the health conditions of those who are in greatest need deteriorate at a faster pace.

A report published recently by the Bank of Israel indicates that compared to other countries, a relatively high proportion of the population in Israel is eligible for publicly-funded nursing care. This is because of the relatively low disability threshold that is used for deciding whether one is eligible to receive state-funded nursing care. Furthermore, the income criterion enables older people whose income is in the 80th and 90th percentiles to receive publicly-funded nursing services. By contrast, the public funding allotted to highly dependent older citizens who remain in the community covers only a small portion of their health-related expenses.

Other issues addressed by the same report include the following. (A) The rate of coverage provided to the Arab and Jewish ultra-Orthodox sectors is significantly lower than that provided to the rest of the population. (B) The coverage extended by the National Insurance to older citizens with a low income can be considered sufficient only in cases where the individual is hospitalized in a publically-funded nursing home and this, after having maximized the use of one's own and one's children's income and assets [34]. In other words, older people with lower incomes are encouraged to be hospitalized in a nursing home, rather than receive healthcare services within the community. (C) The accreditation level required of nursing care providers who assist older people in the community is one of the lowest among the OECD countries [35, 36]. In 2015, there were 120 companies offering nursing care services, 51 of these were NGOs, and the remainder were privately-owned companies. Approximately 40% of the employees that provide nursing care for older people in the community are work immigrants. (D) Community-based health and nursing care services are poorly supervised and there is a significant gap between the number of care hours reported, and the number actually provided. (E). While the quality of care is poorly supervised, the rates and prices are scrupulously reviewed. (F) The quality of care afforded to older people in the community and in institutions suffers due to the fact that different parts of these services are authorized and provided by different authorities, and each authority uses a different set of criteria [37,38].

The social dilemmas

The social policies in Israel toward the aging population continue to be determined according to the individual's degree of dependence, feebleness, and neediness. The older adult population in Israel is a minority group that is growing at an accelerated rate while the group's social status is increasingly weakened and marginalized. Contrary to the Jewish tenet to honor one's elders, in practice, this population is subjected to ageism, poverty, and prejudice. The poverty rate among the older population in Israel is high compared to the rates in other Western countries, and their economic status is expected to continue to worsen [39].

To assess the adequacy of both the privately and publicly-funded health and welfare services delivered to the population of older people, the following aspects should be taken into account: the availability of the service needed and the involvement of the state as compared to the involvement of family members and the community. Is the service offered as part of the older individual's basic rights? Is the service offered, available, and accessible to the entire private sector throughout the country? If this is not the case, a greater portion of the responsibility falls on the individual's family and community. Lessening the government's responsibility to provide these services could mean that certain portions of the population, most typically the weaker populations (e.g., older adults, immigrants, refugees, Holocaust survivors, and the economically disadvantaged) are effectively denied access to such services.

In general, accessibility becomes a problem not only when the service systems are privatized, but also when they are supported by public authorities or by nonprofit organizations. Typically, the systems providing the services are affiliated with a particular sector and involve political and local interests, rather than operating according to preset criteria or principles of social equity. When the selected sector includes old people who live alone in the community, it is the responsibility of the local and governmental authorities to ensure access and equitable services; however, oftentimes it is difficult to identify the individuals in need, especially if they are loners living in a big city.

Family members, mainly spouses and children, play a significant role in caring for older people's mental and financial wellbeing, as well as providing guidance and acting as direct or indirect consumers. The issue of allocating

responsibility between the state and the family is less than clear and, consequently, subject to debate. In the Scandinavian countries, for example, where the responsibility of the state is substantial and well-accepted, the provision of services is subject to changes introduced over time [40]. According to the Israeli data, approximately one-quarter of people over the age of 25 serve to some extent as caregivers to an older relative [41].

In recent years, policymakers and service planners have expressed an increased interest in finding ways to assist informal caregivers. There are several reasons for this development: (A) Increasingly, family members are called on to assist older relatives in situations that until recently were addressed solely by professionals (due to shortened hospitalization periods). (B) Family members who provide assistance perform a complex, caregiving role, which requires knowledge, understanding, and skills in several realms. (C). Compared to the past, with the increase in longevity, family members become caregivers for longer periods of time. (D) The burden of serving as caregiver over a prolonged time can lead to mental fatigue and the deterioration of the caregiver's wellbeing [35]. (E) Providing care to a family member is likely to entail covering many of the older person's expenses while affecting the caregivers' ability to remain part of the job force [42].

It should be emphasized that in Israel, family members, and especially the children of older adults are legally bound to assist their parents, and several laws have been enacted to ensure that family members are available to provide care to older family members as needed. (1) The right to remunerated sick leave due to a parent's illness (Illness Remuneration Act, 1993). (2) The right to a severance package when resigning due to impaired health (clause 6 of the Severance Remuneration Act, 1963). (3) The right to a tax reduction for funding a parent's retirement- or nursing-home residential care (clause 44 of the Tax Law, 1975). (4) The right to a guaranteed minimum income without having to meet standard employment criteria for those attending to a sick family member (clause 2.7 of the Minimum Income Act, 1980) [43] described the caregiving relative of the older adult as situated at a crossroads between the collective and the private level, between the older and the younger generation, and between familial gender roles.

The decrease in family size and in birth rates, as well as the entrance of women into the workforce, all indicate that a greater portion of the caregiving role will increasingly fall on the shoulders of fewer family members. In addition to the traditional component of caregiving, recent years have introduced an additional aspect. Often older people having difficulty adapting to emerging technologies and need assistance in using the Internet to obtain lab results, to access online consultation, etc. Even if they own the digital means, they are often incapable of using them. Hence, addressing these quality-of-life issues is another role performed by family member caregivers.

Developing a culture of service marketization: The privatization of services changes the quality of the relationship between customers and suppliers, specifically, instead of "civilians who are entitled to services" they become "customers who purchase products." The result is the development of a culture of competition and marketing, whereby considerations of loss and gain transform the relationship between the parties to a business arrangement. The supplier seeks to increase profits and the consumer's focus is likewise on getting the best price for the service and assessing the balance between price and quality. Democratic values such as equity, the right to certain services, and social responsibility are supplanted by a culture of commerce.

It is important to note that in the context of health and welfare service privatization in Israel, despite the clear demographic trend, the rights of older adults have yet to be addressed in the legal framework and, in this sense, it appears that the implications of an aging society are being ignored [44]. In general, it may be claimed that the government has yet to internalize and address the need to re-examine the effects that an aging society has on the legal rights (or the rights of family members) of consumers of privatized health and welfare services. Indeed, as regards the professional pursuit of legal knowledge and tools, the matters relating to "aging and the law" have yet to be recognized as a mandatory field of study.

The professional dilemma

In Israel, adults reaching old age are the main consumers of personal welfare services, not only in terms of their numbers and the number of caregivers but also in terms of the extent of the expenditure [45]. As a result of the criticism launched against the inadequate and partial treatment that older adult consumers of personal welfare services received, the Nursing Insurance Act was passed in 1988, which ensured that the social rights of older people must be materialized in a manner that is concretely visible, e.g., the cleanliness of the individual and his or her environment, food preparation, etc. Previously, caregivers (whether family members or hired help) would receive the needed funds, but there was no way to ensure that they were using these funds to address the rights and needs of the older adult customers.

After the law was enacted, a quasimarket of NGOs, most of them nonprofit organizations, was set up and managed by the government, in an effort to protect and deliver the full range of rights to which older persons are entitled. This solution led to several undesirable outcomes.

(a) The NGOs came between the citizen and the government, making it more difficult for those in need to express their demands or to complain about the extent and quality of the services rendered. As a result, on the one hand, the government could not fulfill its responsibilities and on the other hand, the citizens who had to cope with difficulties on a daily basis had recourse only to organizations that were not necessarily committed to helping them exercise their full rights [46].

(b) Private, nonprofit service providers would approach older individuals and offer them access to their services even before

they were legally eligible according to the government act. In many cases, the organizations would "recruit" older adults who were being discharged from a hospital (or even during the hospitalization), in the hope of gaining new customers who would soon be eligible to receive their services. In addition to the transgression that such "recruitment" entails in terms of privacy and medical confidentiality, it occasionally compromised the financial wellbeing of older individuals and their family members who were coaxed into signing a contract with the service providers [5].

(c) The private service providers competed with each other for government tenders, by attempting to reduce their fiscal costs as much as possible. The direct outcome of this was the hiring of insufficiently trained and unprofessional caregivers and/or offering them only part-time positions, effectively depriving them of job safety and benefits, while these workers had no professional union to oversee their rights. Hence, it is not surprising that the private organizations were not able to provide the appropriate level of care, nor were they able to forge the appropriate relationship with their care recipients. In Israel, the profession of caregiver to older adults is associated with a poor image and a low socioeconomic status despite it being a physically demanding job and, thus, is characterized by an exceptionally high turnover rate [24].

(d) Professionals, such as physicians, nurses, and social workers, who are required by law to be an integral part of any health and welfare service, are offered better job conditions and higher incomes by the privatized or NGO service providers in their effort to draw a strong team to their organization. Despite these enticing offers, it appears that most of these professionals are not prone to accept such positions, for several reasons: private service providers often require these professionals to carry out tasks that are not part of (or are considered beneath) their professional purview (as defined in their job contracts); the rights of professionals working in these frameworks are not protected by a professional union; there are no professional development courses or workshops that cater to professionals working in private caregiving organizations that serve the older population; and there are no options for promotion in these frameworks. In fact, the role of those professionals who do work in such organizations can become eroded to such an extent that they lose their sense of professional identity. Clearly, all of these factors have a direct effect on the quality and continuity of the services delivered, which in turn, of course, has a detrimental effect on the older people who are in need of these services.

Conclusion

The trend of privatizing health and welfare services intended for the population of older people has increased the range of services delivered by private organizations, while the relevant budgets are being reduced and the government is increasingly relinquishing its responsibility to allocate funds equitably to all of the segments of the target population. Implementing the privatization process created several significant and irreversible changes in the structure and functioning of the health and welfare services. These changes include a shift in the role of the volunteering, nonprofit organizations, and especially changes in the roles of the professionals and paraprofessionals who provide their services according to the dictates of the private organizations. These changes took place without any prior comprehensive public discussion, and without giving the various influential parties a chance to assess or oppose them. The system for providing private health and welfare services has turned into a multiorganizational arena with complex relationships among them, in which the population of older adults is virtually held captive.

It appears that a broad and systematic assessment of the outcomes of the privatization process is called for. Such an assessment must be based on several questions, among them: 1) Do the nongovernmental service providers have the capacity to meet the ever-changing needs of their customers? Will they be able to maintain this capacity over time? 2) Do private service providers manage to deliver equitable services to the population in the geographic periphery? 3) What options are available to the consumers and at what costs? To what extent will consumers be able to carry the economic burden of funding these services and for how long? 4) Is there, in fact, true competition among the nongovernmental service providers? What characterizes this competition? How does this competition affect the consumers and their family members? 5) How did the privatization process affect the income levels and job conditions of employees in these governmental and nongovernmental organizations? Has it improved or harmed their professional role and function?

Undoubtedly, there is a need to continue to investigate the implications of the privatization process, particularly by examining the satisfaction levels of the aging consumers and comparing satisfaction levels of those receiving public services versus those receiving privatized services. Furthermore, the attitudes and satisfaction levels of the professional and paraprofessional teams employed in each framework should also be assessed.

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***Correspondence to:**

Dr. Pnina Ron

School of Social Work

University of Haifa

Israel

E-mail: pnron@univ.haifa.ac.il

Tel: 972528510012