جمعيــة الجـلـيـل الجمعية العربية القطرية للبحوث والخدمات الصحية
The Galilee Society The Arab National Society For Health Research & Services

ركـــــاز بنك المعلومات حول المجتمع الفلسطيني في إسرائيل
Rikaz The Databank on the Arab Community in Israel

مـدى الكـرمل المركز العربي للدراسات الاجتماعية التطبيقية
Mada al-Carmel Arab Center for Applied Social Research

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I'lam Media Center for Arab Arabs in Israel

Health of Arab Women in Israel

Policy Paper

Dr. Mohammad Khatib

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Author:By D. Mohammad Khatib
English translation: Zvi Shulman
Design and production: Wael Wakeem

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P.O. Box 330, Shefa-Amr 20200, Israel
Phone: (972) 4 986 1171,Fax: (972) 4 986 1173 ,E-mail: admin@gal-soc.org

Preface

In recent decades, the role of the budget has come to increasingly affect economic and political disparities between different population groups and determine the limits of economic activity and the status of various population groups. Thus, the analysis of the budget and its economic particulars, political and social implications, and effects on distributive justice, has become one of the most important means in the struggle for equality and social justice, specifically the improvement of rates of women's participation in the public sphere and in the development of society at large.

This policy paper focuses analytically on the budget of the Ministry of Health through the lens of ethnicity and gender. It is part of a broader research project on "centering gender and ethnicity in the state budget", which seeks to raise awareness of the budget, increase transparency in the budgeting process, and achieve maximum public involvement in ensuring this process' equitability. The project at large focuses on understanding the political and economic system's effects on poverty among Arab women in Israel, so done through a thorough study of the state budget in three main Ministries: those of Health, Industry, and Education, respectively.

The project's primary goal is to convince decision-makers to adopt a more gender sensitive budget by encouraging them to take into account the aspects of gender and ethnicity while preparing the distribution of public resources through the budget. Such an achievement, we believe, will advance social justice and equality between men and women in general, and between Arab men and women in particular. The budgets of three government Ministries have been identified as having the most decisive impact on poverty levels among Arab women.

With great appreciation, we would like to thank the European Union for their contribution towards this project.

This research project was shared by three Arab organization: The Galilee Society – The Arab National Society for Health Research & Services, Rikaz – The Databank of the Arab Community in Israel; Mada Al-Carmel – Arab Center for Applied Social Research; and I'Lam – Media Center for Arab Palestinians in Israel.

Project team

Preface

Health, according to the accepted definition, that of the World Health Organization, is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.[1] The factors that determine a person's health are diverse: some are connected to the person himself, to his behavior, his build, and his genes. Another part is connected to his physical, social, cultural, and economic circumstances.[2] Clearly, then, the way to affect a person's health is by altering these factors. Food, nutrition, housing, drinking water, living conditions, employment, and a safe and healthy environment are crucial elements. The absence of these elements causes injury to health and violates the person's fundamental right to health.

The Right to Health

The Declaration of Alma-Ata, of 1978, which deals with primary health care, called on the whole world community to set a target for the year 2000: a level of health that will permit all the peoples of the world to lead a socially and economically productive life.[3] The signers of the Declaration held that health is a fundamental right, in accordance with the International Covenant on Economic, Social and Cultural Rights. The Declaration also made it an obligation to take action to improve environmental factors that are beyond the individual person's control and emphasized the need for cooperation in order to achieve the target goal and realize every individual's right to health.
The WHO defined the right to health as meaning the right of a person to the highest feasible level of health, without discrimination based on ethnic origin, religion, political beliefs, or economic or social status.
Human rights ensure the protection of universal values of liberty and human dignity. Human rights include civil, cultural, economic, political, and social

1 World Health Organization, *Ottawa Charter for Health Promotion* (Ontario, Canada: World Health Organization, Health and Welfare, 1986).

2 G. Dahlgren and M. Whitehead, "Policies and Strategies to Promote Equity in Health" (Copenhagen, Institute for Future Studies, 1991).

3 The declaration is available at http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf.

rights that were discussed and agreed upon by states and governments around the world and have been enshrined in binding international conventions. The Universal Declaration of Human Rights, of 1948, states, in article 25.1, that:

> Everyone has the rights to a standard of living adequate for the health and wellbeing of himself and of his family, including . . . medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability.[4]

Subsequent international conventions have given more explicit content to this right.

Human rights principles are based on these conventions and constitute a framework for interventions and procedures for change. The main principles relating to health are the following:

- The principle of equality and prevention of discrimination, based on the belief that all persons are equal and may not be denied their rights for reasons of discrimination on grounds of race, ethnic origin, skin color, age, language, religion, political opinions, social status, capabilities, or place of birth. This principle requires countries to diagnose the discrimination (intentional and non-intentional) and deal with it by means of legislative enactments, policy change, and actions, including a just and fair distribution of resources and health services. This principle is especially important with respect to gender, since the status of women, a group on the margin of society, is not only the result of sex discrimination but is also due to their being a group at risk, such as an ethnic minority or a group of persons having special needs.
- The principle of partnership, meaning that people have to make decisions jointly in matters relating to them and affecting them, such as planning, implementation, and evaluation of interventions in the field of health. This partnership must be active, open, and real.
- The principle of accountability, which requires governments and decision-makers to be transparent in their actions and to justify their decisions. This principle also requires the development of evaluation and judicial mechanisms to determine the extent to which the officials are carrying out their obligations properly.

In 1966, two major international conventions were signed. The first is the

4 The Universal Declaration of Human rights is available at http://www.un.org/en/documents/udhr/

International Covenant on Civil and Political Rights, which Israel ratified on 1992. The Covenant prohibits torture and medical experiments on persons without their consent. The other is the International Covenant on Economic, Social and Cultural Rights, also of 1966, which states, in article 12.1, that the State Parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." It also prescribes steps the states are to take to achieve the full realization of this right, which include the following:

1. Reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
2. Improvement of all aspects of environmental and industrial hygiene;
3. Prevention, treatment and control of epidemic, endemic, occupational and other diseases;
4. Creation of conditions that would assure to everyone medical service and medical attention in the event of sickness.

Subsequently, three other important conventions that touch on health were adopted. The first was the Convention on the Elimination of All Forms of Discrimination against Women, of 1979, which Israel ratified in 1991. In the Convention, the State Parties agree to take all appropriate measures to eliminate discrimination against women in the field of health care.[5] The second convention was the Convention on the Elimination of All Forms of Racial Discrimination, which took force in 1969. The third convention was the Convention on the Rights of the Child, of 1989, which Israel ratified in 1999. Article 24 of the Convention expands the right to health in the Covenant on Economic, Social and Cultural Rights, and states that the child has the right to facilities for the treatment of illness and rehabilitation of health, to ensure that no child is deprived of his or her right of access to such health care services. The Convention prescribes operative measures they must take to realize these rights. In addition, the State Parties undertook to deal with practices that prejudice the health of children, and, with regards to disabled children, to provide, inter alia, assistance and access to health services.

In sum, the right to health is a fundamental right derived from the right to life and from the principles of freedom, liberty, human dignity, and privacy. The right is enshrined in several international conventions which also prescribe the ways and means for realizing these principles. At the national level, statutes,

5 The background and text of the convention are available at http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm.

regulations, and directives enable practical application of these conventions and principles. Some of the conventions relate to specific groups, such as women and children. The convention prohibiting discrimination against women, it should be mentioned, was a turning point in the history of women's rights and women's social rights, in particular. The Convention states that, although there are statutory frameworks that ensure justice, equality, and prohibit discrimination against women, women continue to be discriminated against, in comparison with men, in realizing their rights.[6]

Women's Right to Health

The health of women is affected by diverse social and economic factors: employment, education, socioeconomic status, among others. Research studies indicate that the lower the level of education of women, the higher the birthrate, a result apparently of the traditional belief that the social function of women is to bear children. The many and frequent childbirths greatly affect their health. Also, the inequality between men and women within the family prejudices the health of the women, in nutrition, in exposure to violence, and so forth. The biological difference between men and women is a source of difference in the incidence of sickness and death; therefore, women differ from men also in the need for health services.

As mentioned above, article 12 of the Convention on the Elimination of All Forms of Discrimination against Women requires the states to take appropriate measures to eliminate discrimination against women in the field of health care services, in access to the services, including services regarding family planning, pregnancy, and giving birth. The Convention deals directly with women's health and contains provisions that ensure:

1. Equality between men and women in decision-making on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights;
2. Access to information to help to ensure the health and wellbeing of the family;
3. Safety in the work place;

6 WHO, "Human Rights and gender equality in health sector strategies: How to assess policy coherence" (2011), available at http://whqlibdoc.who.int/publications/2011/9789241564083_eng.pdf (visited on 25 February 2012).

4. Access of rural women to health services and to proper sanitation.

The Convention also prescribes obligations of states which, when carried out, directly affect the health of women, especially women belonging to minority groups. Among these obligations:

- The obligation to reduce drop-out rates in schools;
- The obligation to enact and enforce a statute establishing a minimum age for marriage;
- The obligation to deal with social practices (customs) that discriminate against women, such as female circumcision.

In 1999, the Committee on the Elimination of Discrimination against Women adopted General Recommendation No. 24, Article 12, which recognizes biological differences between men and women and the social factors that affect health, while emphasizing the importance of addressing the needs of vulnerable population groups, such as women, especially when they belong to an ethnic minority, are refugees, foreign workers, and the like. The General Recommendation states also that the lack of preventive health services for women indicates that the state is not carrying out its obligations. It also emphasizes the obligation of the state to respect, protect, and realize health rights. To meet this obligation, the state must allocate equal resources to ensure the rights of women to health care services, including the provision of free service where necessary. The state must also provide education and advice in health matters.

Two other subjects, especially relevant with respect to Israel, were raised in the Committee's General Recommendation. One is the obligation to establish its health policy on credible information regarding the causes of sickness and on scientific research regarding the health and need of women, taking into account the special features of population sub-groups, such as minority groups. The other subject involves the obligation of the state to allocate public resources for health of women and men; the state is not allowed to evade this responsibility by transferring the handling of the matter into private hands. It should also be emphasized that the state's obligation to ensure and to allocate resources for promoting women's health must take into account their special needs.

Arab Women in Israel

Demography

According to the socioeconomic survey conducted by The Galilee Society in 2010, there were 319,220 Arab women in Israel over age 20, which represents 52.6 percent of Israel's Arab female population.[7] The under-age-20 group of women therefore amounted to 47.4 percent. Women over age 60 accounted for 6.0 percent of the Arab female population (Table 1). In the south of the country, the figure for the under-20 group was 60 percent.

The Total fertility rate is 3.8 births per 1,000 women. The highest fertility is found in the 25-29 age group, which has a fertility rate of 222.2. Generally, Arab women marry at a relatively early age, 11.8 percent in the 16-17 age group. At age 25, 89.5 percent of Arab women are married.

Table 1: Arab women in Israel, by age group and area of residence

Age	North	Haifa	Center	South	Total
Under 20	44.6	34.3	47.0	60.8	47.4
20 to 60	48.7	58.7	46.9	36.6	46.6
Over 60	6.7	7.0	6.1	2.6	6.0

Arab women marry within the family in 39.5 percent of the marriages (27.6 percent with first-degree relatives). The figures differ based on geographical location: intermarriage occurs in 61.4 percent of the marriages in the South, compared with 40.4 percent in the Center, 36.9 percent in the North, and 29.8 percent in the Haifa area.

Employment

Among Arab women in Israel, 26.4 percent participate in the labor market,[8] compared with a figure of 63.6 percent for Jewish women.[9]. About 17 percent of Arab women in the workforce are married, 28 percent are divorced, and 22.5

7 Rikaz Databank, The Galilee Society, "Palestinians in Israel: Third Socioeconomic Survey, 2010."

8 Participation in the labor market means "all persons of working age (workforce) who are working, including employers and salaried employees in addition to their family members working in an employment framework for no wages."

9 Central Bureau of Statistics, *Statistical Abstract for 2011.*

percent are single. Christian women assimilate in the labor market more than Muslim and Druze women: 32.2 percent of Christian women work, compared with 19.3 percent of Druze women and only 16.7 percent of Muslim women. In addition, 46.0 percent of Arab women in the workforce have full-time positions; 21.6 percent have part-time jobs. Of the part-time workers, 11.0 percent said they did not hold full-time jobs due to their tasks and obligations as mothers of young children; 8.8 percent said they were unable to find full-time employment.

No significant differences were found regarding men from different religions, with the percentage of men holding full-time jobs being very similar (66.0 percent of Muslims, 65.7 percent of Christians, and 62.0 percent of Druze men).

The non-employed women state that the main reason they are not working is due to their obligations in running the house, raising the children, and caring for their needs. Geographic area made little difference on this point (65.3 percent in the South, 61.0 percent in the Center, 64.7 percent in Haifa, and 59.6 percent in the North). However, the survey showed that the greater the job opportunities for women, the greater their participation in the labor market. Thus, we see that Arab women's participation in the labor market is affected more by employment opportunities than by social and cultural factors.

As for the connection between education (years of schooling) and employment, the survey showed that, among the men, the more years of education following high school, the more they assimilated in the labor market. Among the women, the more years of education, the higher the unemployment rate.

As for places of employment, Arab women generally work in the area in which they live. Arab men, on the other hand, travel an average of 90 kilometers a day from their home to their jobs. For 69.5 percent of Arab women, their work place is located 0-9 kilometers from home; 15.6 percent work at a distance of up to 29 kilometers from their place of residence.

Health of Arab Women

Most surveys and studies on health in Israel show large gaps in the health indicators between the various groups, especially between Arabs and Jews. The surveys paint a harsh picture: high rates of chronic illness, cancers of

different kinds, genetic diseases, and birth defects.[10] They also indicate low life expectancy, for men and women, compared with the Jewish population, and a higher infant-mortality rate, especially among Muslims. Arab women have poorer health than all other groups. Their health condition is reflected, for example, in low life expectancy, high rates of sickness and death from chronic illness, a steady increase in incidence and death from breast cancer, and in being overweight.

Life Expectancy

In 2009, life expectancy in Israel was 79.7 years for men and 83.5 for women (Central Bureau of Statistics, 2010). Life expectancy of Jews is appreciably higher than that of Arabs, both men and women. In both populations, life expectance is rising.[11]

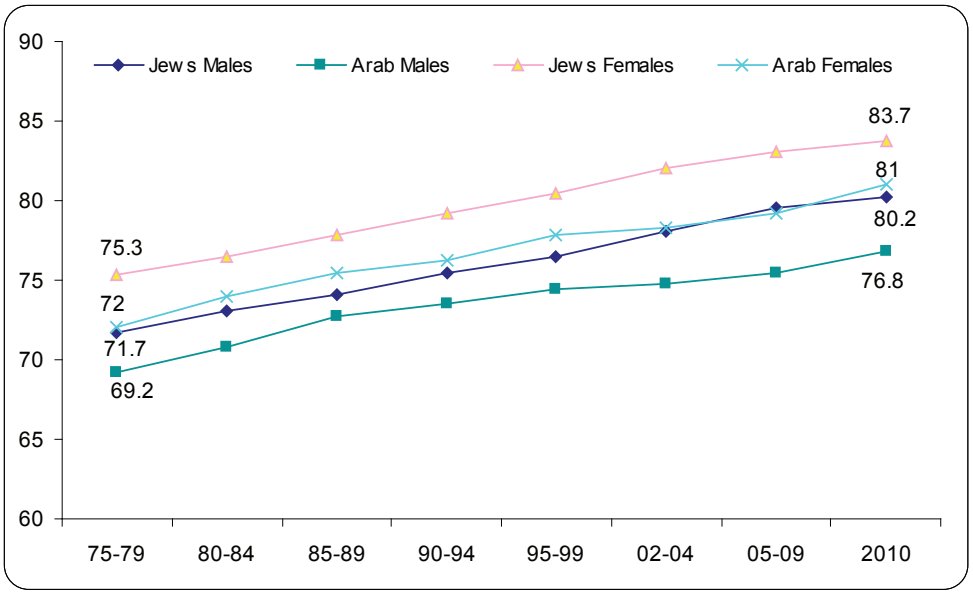
Table 2: Life expectancy in Israel, 2010

	1975-1979	1980-1984	1985-1989	1990-1994	1995-1999	2002-2004	2005-2009	2010
Jewish men	71.7	73.1	74.1	75.5	76.5	78.1	79.6	80.2
Arab men	69.2	70.8	72.7	73.5	74.4	74.8	75.4	76.8
Jewish women	75.3	76.5	77.8	79.2	80.4	82	83.1	83.7
Arab women	72	74	75.5	76.3	77.8	78.3	79.2	81

10 Ministry of Health, "Health of the Arab Population in Israel 2004," Publication 266 (July 2005); Ministry of Health, "Health of the Arab Population in Israel 2008," Publication 329 (November 2010).

11 OECD Health Data 2011, available at http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT (visited on 25 February 2012).

Graph 1: Life expectancy in Israel, 1975-2010



Causes of Death

The leading cause of death among the general population in Israel is cancer. There is almost no difference between the rate of death by cancer among Arab women and Jewish women. The rate is higher for men. Cardiovascular disease is the second highest cause of death. Among Arab men, the rate was 92.6 per 100,000, a figure twice as high as among Jewish men. The rate for Arab women was comparable to that of Jewish men (47.8/100,000), and twice as high as for Jewish women.[12]

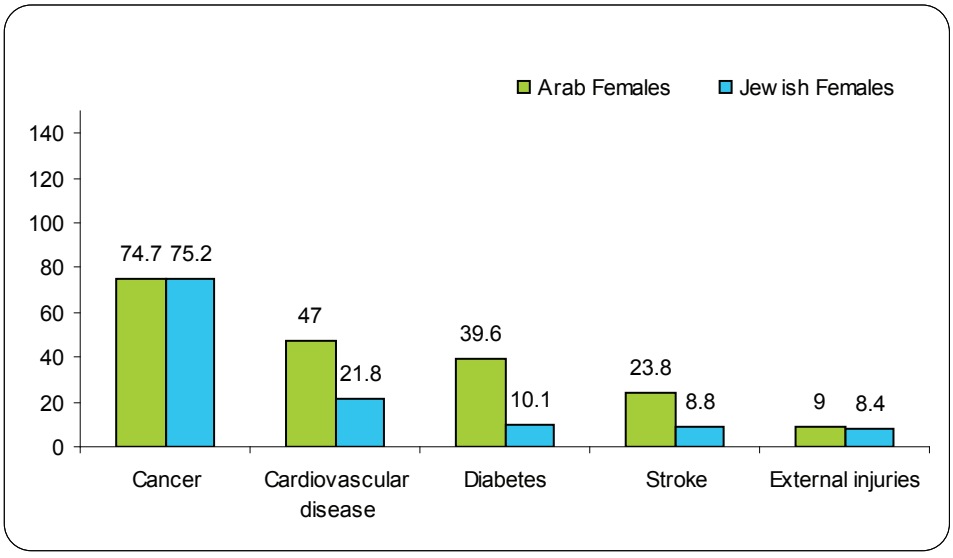
Diabetes is the third greatest cause of death, being responsible for 39.6/100,000 deaths among Arab women and 10.1/100,000 among Jewish women. Stroke was the cause in 23.8/100,000 deaths among Arab women, compared with 8.8/100,000 among Jewish women (*Health in Israel 2010)*.

12 Ministry of Health, "Health of the Arab Population in Israel 2010," Publication 333 (August 2011).

Table 3: Cause of death among women in Israel

	Cancer	Heart disease	Diabetes	Stroke	External injuries
Arab women	74.7	47	39.6	23.8	9
Jewish women	75.2	21.8	10.1	8.8	8.4

Graph 2: Various causes of death among women, by nationality
(per 100,000 persons)



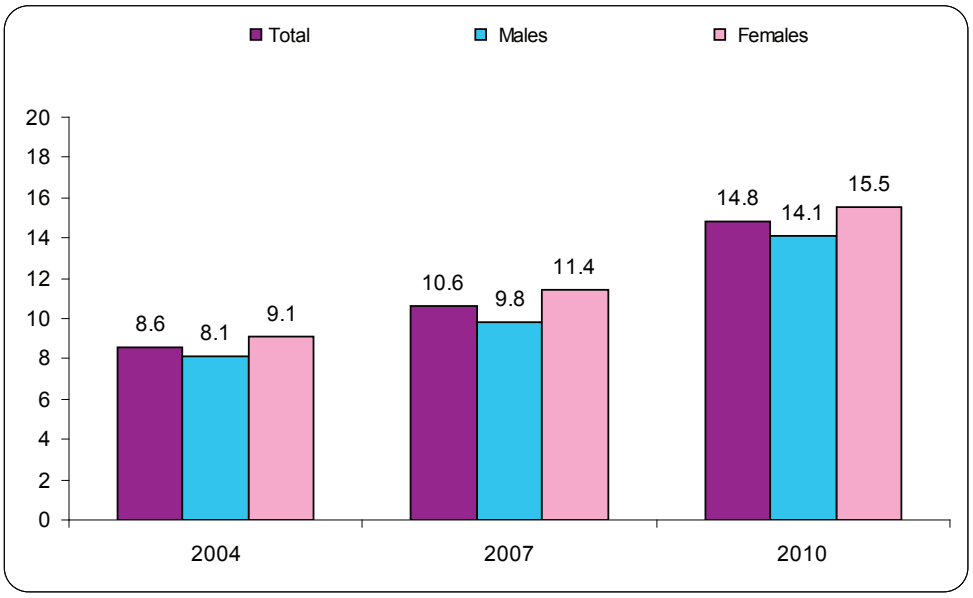
Chronic Illness

In the socioeconomic survey conducted by The Galilee Society, 14.8 percent of the participants reported having at least one chronic illness (15.5 percent of women, 14.1 percent of men). Differences based on geographic area and type of community were found.

Table 4: Incidence of at least one chronic illness among the Arab population in Israel
(by percentage)

	2004	2007	2010
Total	8.6	10.6	14.8
Men	8.1	9.8	14.1
Women	9.1	11.4	15.5

Graph 3: Chronic illnesses among Arabs, by age group and gender
(by percentage)



The survey's data show that about 10 percent of the adult population (age 21 and above) suffer from diabetes (9.3 percent of men, 10.8 percent of women); 10.5 percent have high blood pressure (8.9 percent of men, 12.2 percent of women).

In the 60 and above age group, 41.7 percent (45 percent of women, 38.2 percent of men) suffer from diabetes. High blood pressure is the most common medical condition in this age group, at 45 percent (55 percent of women and 39.4 percent of men).

Table 5: Incidence of selected chronic illnesses among Arab men and women aged 21 and above
(by percentage)

	Diabetes	High blood pressure	Heart disease	Cholesterol	Cancer	Asthma
General	10.0	10.5	4.1	6.6	0.7	1.8
Men	9.3	8.9	4.9	6.4	0.7	1.6
Women	10.8	12.2	3.4	6.7	0.7	1.9

Table 6: Incidence of selected chronic illnesses among Arab men and women aged 60 and above
(by percentage)

	Diabetes	High blood pressure	Heart disease	Cholesterol	Cancer	Asthma
General	41.7	47.5	20.6	24.1	3.4	5.3
Men	38.2	39.4	22.4	20.4	4.2	2.7
Women	45.0	55.0	18.9	27.5	2.6	5.4

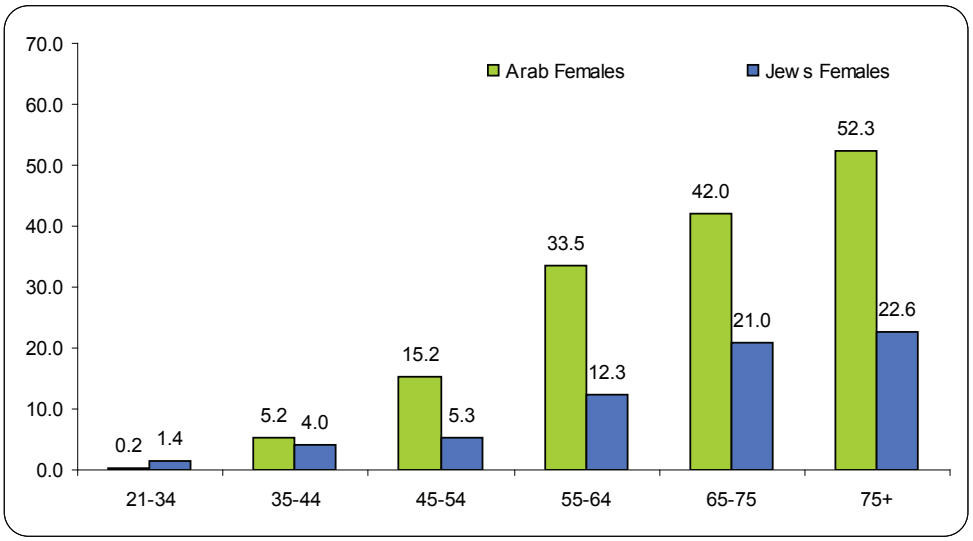
Diabetes

The incidence of diabetes has increased in Israel in the past decade. An Israel National Health Interview Survey for the years 2007-2008 indicated that 7.6 percent of the population aged 21 and above reported they had been diagnosed as having diabetes (8.1 percent of men and 7.2 percent of women), representing an increase of 29 percent and 39 percent, respectively, compared with 2003-2004. The incidence of diabetes rises with age in all groups (Table 7). The largest gap between population groups appears in the over-45 age group of Arab and Jewish women (with the rate of Arab women being 2-3 times higher than for Jewish women).
In the 21 and above age group, 9.3 percent of women have diabetes. The incidence of diabetes reaches 45 percent of all women 60 years or older.

Table 7: Incidence of diabetes of Arabs and Jews in Israel, by age and gender
(by percentage)

		21-34	35-44	45-54	55-64	65-75	Over 75
Arabs	**Men**	0.4	5.8	14.0	29.5	39.7	35.7
	Women	0.2	5.2	15.2	33.5	42.0	52.3
Jews	**Men**	1.0	2.4	7.8	17.5	24.8	21.9
	Women	1.4	4.0	5.3	12.3	21.0	22.6

Graph 4: Incidence of diabetes among women, by nationality and age
(by percentage)



High Blood Pressure and Cardiovascular Disease

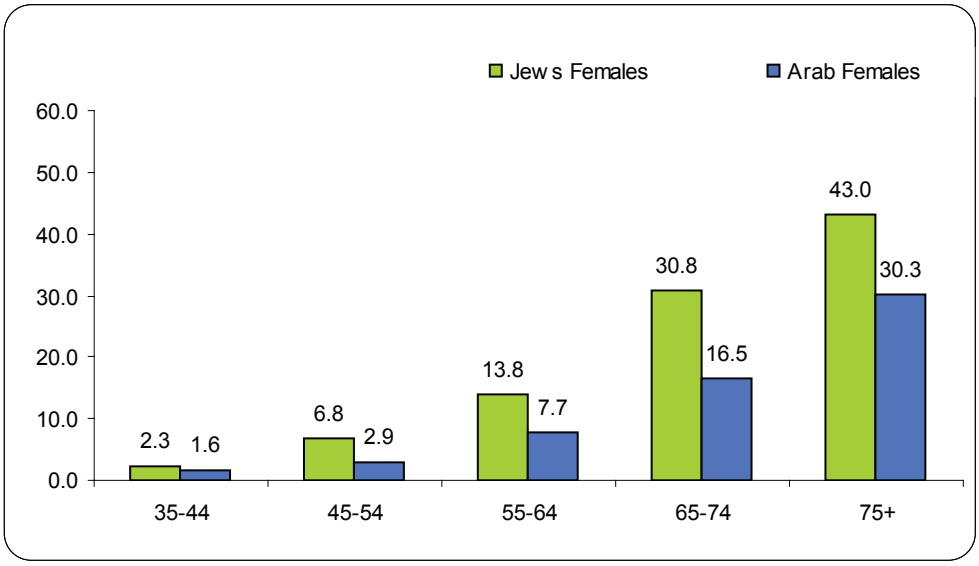
Survey findings indicate that 12.3 percent of Arab women aged 21 and above have high blood pressure, a figure that is 1.4 times higher than for Arab men. In a comparison with Jewish women, the incidence of high blood pressure is higher for Arab women in all age groups (Table 8).

3.4 percent of Arab women suffer from some cardiovascular disease (the figure for Arab men is higher). The incidence of cardiovascular disease increases with age, reaching 30 percent for women aged 65-74 and 43 percent for women 75 and over.

Table 8: Incidence of cardiovascular disease of Arabs and Jews in Israel, by age group and gender
(by percentage)

		35-44	45-54	55-64	65-74	Over 75
Arabs	**Men**	2.0	5.2	17.6	27.1	19.8
	Women	2.3	6.8	13.8	30.8	43.0
Jews	**Men**	1.0	3.0	9.7	21.6	18.2
	Women	1.6	2.9	7.7	16.5	30.3

Graph 5: Incidence of cardiovascular disease among women, by nationality and age group



Breast Cancer

Breast cancer is the commonest form of cancer among women, accounting for 30 percent of cancer cases among women. Since 1970, the incidence of breast cancer has risen more than 600 percent among Arab women, compared with 17 percent among Jewish women. It should be noted that 27.2 percent of breast-cancer cases among Arab women occur in the 40-50 age group; only 15 percent occur under age 40 (*Health in Israel 2010*). The mortality rates are higher among Arab women with the disease, and survival rates of five years following discovery of the disease are lower.

Table 9: Incidence of breast cancer among women in Israel, 1970-2009
(per 100,000 women)

	1970-1974	**1975-1979**	**1980-1984**	**1985-1989**	**1990-1994**	**1995-1999**	**2000-2004**	**2005-2009**
Arab women	10	11	15	19	24	36	43	63
Jewish women	63	64	69	74	86	102	102	104

Graph 6: Incidence of breast cancer among women in Israel, 1970-2009
(per 100,000 women)

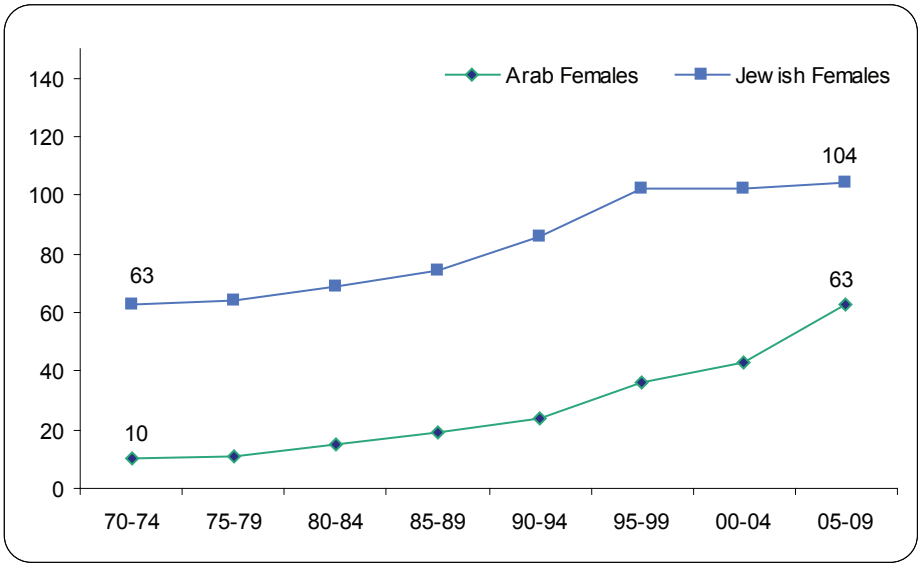


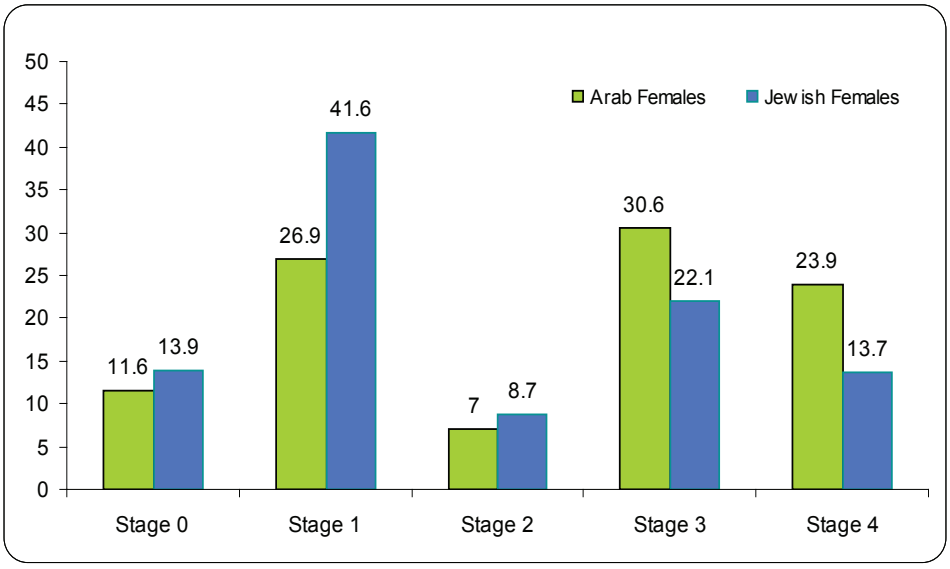
Table 10: Relative increase in incidence of breast cancer, 1979-2009

1970 to 1990	1990 to 2009	1970 to 2009
2.4	2.6	6.3
1.4	1.2	1.7

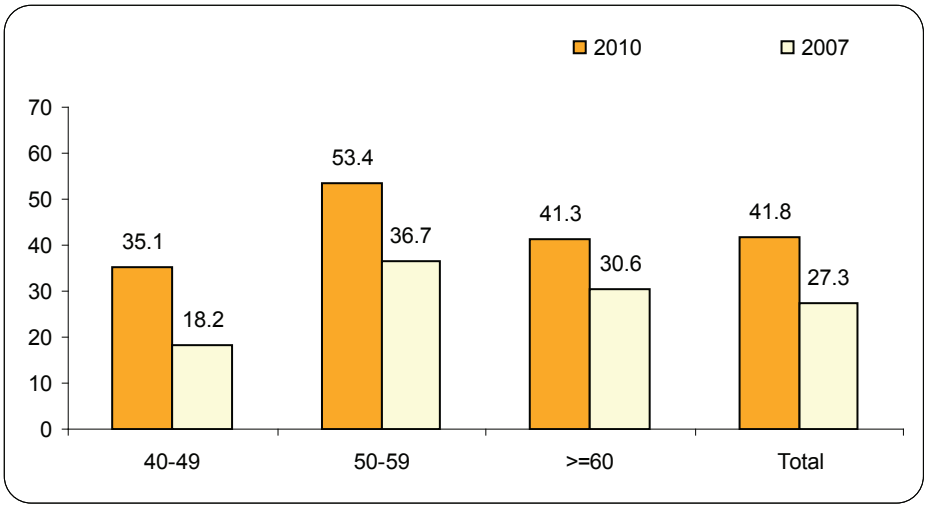
In 45 percent of the cases in which Jewish women fall ill to breast cancer, the disease is diagnosed early (Stage 1); for Arab women, the figure is 31 percent. The situation is the opposite for women initially diagnosed in an advanced stage (Stages 3 or 4): 43 percent for Arab women, compared with 31.4 percent for Jewish women.

In recent years, there has been an increase in the percentage of Arab and Jewish women who undergo mammograms. In 2007, 27.3 percent of Arab women took a mammogram test; in 2010, the figure was 41.8 percent.

Graph 7 Incidence of breast cancer among women in Israel, by stage of diagnosis



Graph 8: Arab women taking mammogram test, 2007 and 2010
(by percentage)



Overweight

The percentage of overweight (Body Mass Index>30) Arab women is higher than among Jewish women in all age groups.[13] The findings of the survey conducted by The Galilee Society in 2010 show that the percentage of Arab women who are overweight increases with age (from 6.7 percent for women aged 21-34 to 45 percent for the 50-64 age group). In the 65 and above age group, the percentage falls to 27.8 percent (22.2 percent for Jewish women). Also, 20.8 percent of women in the 21-34 age group and 42.3 percent in the 35-49 age group are overweight (BMI 25-30), compared with 18.3 and 26.4 percent, respectively, of Jewish women.

Table 13: Women in Israel, by BMI, age 21-34 (by percentage)

	Underweight	Proper weight	Overweight	Obese
Arabs	24.2	48.3	20.8	6.7
Jews	25.8	50.2	18.3	5.7

Table 14: Women in Israel, by BMI, age 35-49 (by percentage)

	Underweight	Proper weight	Overweight	Obese
Arabs	3	33.5	41.3	22.2
Jews	15.5	47.5	26.4	13.7

Table 15: Women in Israel, by BMI, age 50-64 (by percentage)

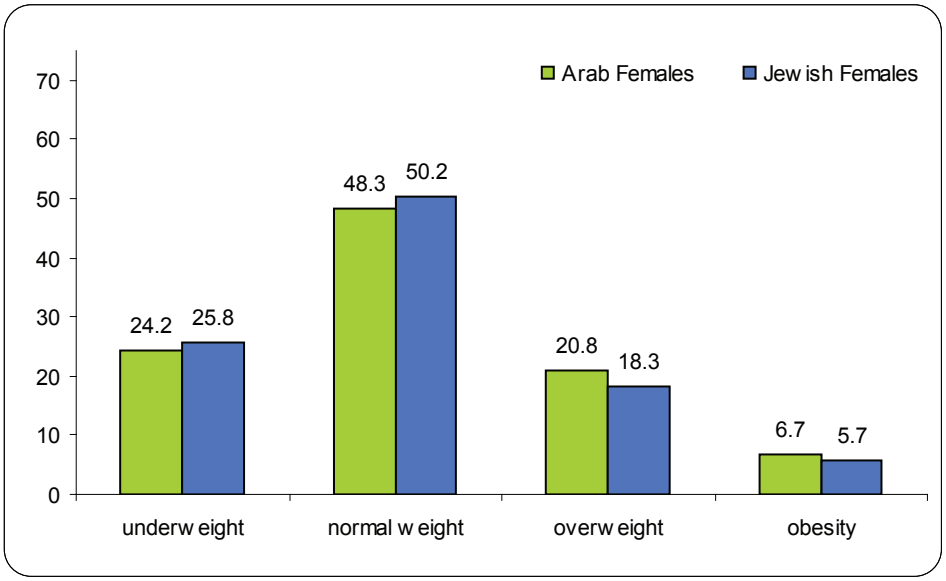
	Underweight	Proper weight	Overweight	Obese
Arabs	1.6	17.8	35.7	45
Jews	4.1	37.9	38.3	19.7

Table 16: Women in Israel, by BMI, age 65 and over (by percentage)

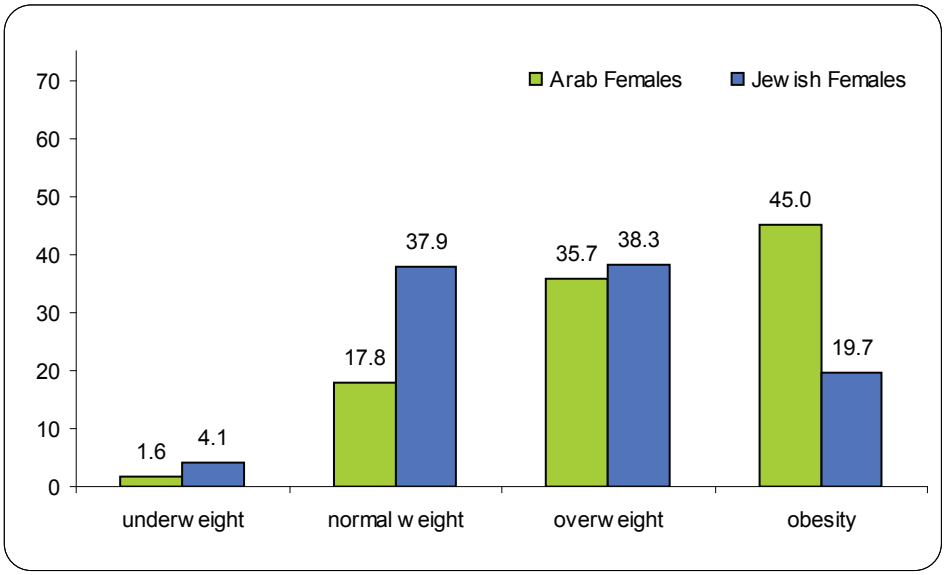
	Underweight	Proper weight	Overweight	Obese
Arabs	0	27.8	44.4	27.8
Jews	3	33.5	41.3	22.2

13 Ministry of Health, "Health of the Arab Population in Israel 2008," Publication 329 (November 2010).

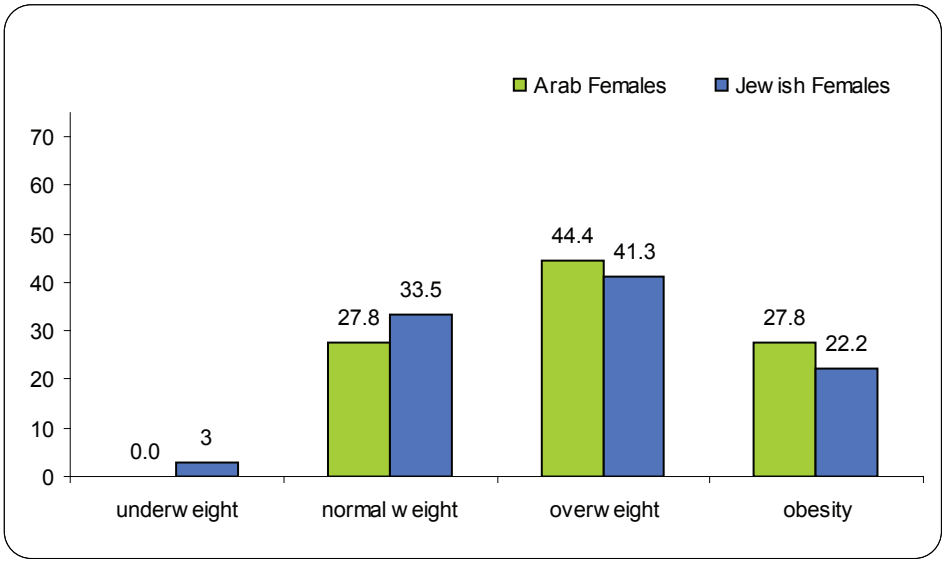
Graph 9: Weight category of 21-34 year old women in Israel
(by Body Mass Index)



Graph 10: Weight category of 50-64 year old women in Israel
(by Body Mass Index)



Graph 11: Weight category of women 65 years old and older in Israel
(by Body Mass Index)



Use of Health Care Services

The Israel National Health Interview Survey for the years 2007-2008 shows that women use health services more than men. For example, 24.7 percent of women reported that they visited a specialist physician in the previous month, compared with 19.5 percent of men. In a survey conducted by the Central Bureau of Statistics in 2009, 6.9 percent of women visited a family physician in the previous month, compared with 5.5 percent of men. Arab women visited their family physician at a slightly higher rate than Jewish women (44 percent versus 39.2 percent), and made many more follow-up visits (18.5 percent compared with 10.4 percent).

It should be noted that Jewish women visit specialist physicians more that Arab women do. According to the national survey, 26.3 percent of Jewish women reported they had visited a specialist physician in the past month, compared with 1.3 percent of Arab women. Regarding national health, in general, all Arab women are covered by national health insurance pursuant to the State Health Insurance Law, of 1994. However, 40 percent of Arab women do not have supplemental health insurance, compared with 8.8 percent of Jewish women. Only 0.9 percent of Arab women have private health insurance; the relevant figure for Jewish women is 2.1 percent.

State Budget Allocations for Women

The state budget for the years 2010-2011 is not favorable to women (Jewish and Arab). The taxation policy expressed in the budget expands the social gaps in general, particularly between the genders. Analysis of the budget indicates two important changes that would significantly affect women in the country, especially women from the middle and lower classes of the population: one, the continuing decrease in direct taxes on income, and two, the ongoing broad cutback in public services in which two-thirds of women are employed.[14]

Most women do not benefit from the drop in direct taxes since the tax is based on level of income. Also, women continue to bear the burden on indirect

14 Yael Hasson, "Through a Gender Lens: Looking at the National Budget Proposal and the Budget Arrangements Law for Fiscal Years 2011 and 2012" (Women's Budget Forum, 2011).

taxes, such as value added tax and the excise tax on gasoline, which are fixed amounts and apply to everyone. Also, some 80 percent of salaried women do not benefit from the tax reduction (which shall continue until 2016) since the reduction applies to salaried employees in the top thirty percent of income bracket. We see from the figures that the higher one moves up the income ladder, the greater the number of men and the fewer the number of women, so few women actually benefit from the tax reduction (Table 17).

Table 17: Net increment to annual income resulting from income-tax reduction, female salaried employees without children, male salaried employees, 2010-2016, by deciles of income for 2008

Decile	Men				Women			
	Men (thousands)	Gross monthly earned income NIS	Net annual increment NIS	Total increment for man in each decile (NIS millions)	Women (thousands)	Gross monthly earned income NIS	Net annual increment NIS	Total increment for woman in each decile (NIS millions)
1	72.4	1208	-	-	167.1	1226	-	-
2	73.8	2788	-	-	165.8	2738	-	-
3	99.3	3806	-	-	140.1	3754	-	-
4	120.9	4527	-	-	118.6	4521	-	-
5	126.9	5312	-	-	112.7	5297	-	-
6	129.6	6234	-	-	110.0	6260	-	-
7	137.2	7501	-	-	102.2	7484	-	-
8	139.3	9438	767	106.8	100.1	9407	748	74.9
9	156.4	13154	3756	587.4	83.0	12827	3285	272.6
10	189.1	25820	13811	2611.7	50.3	24048	12539	630.7

Notes:
1. In NIS, after income tax.
2. Calculated on the basis of gross earned income figures by gender and income decile for 2008.
3. The calculation was updated to July 2009 after the approval of the Budget Arrangements Law of 2009.

Source: Yael Hasson, "Through a Gender Lens: Looking at the National Budget Proposal and the Budget Arrangements Law for Fiscal Years 2011 and 2012" (Women's Budget Forum, 2011).

As stated, the excise tax on gasoline is an indirect tax. When it goes up, the price of public transportation goes up as well. Women account for some 60 percent of persons using public transportation. Thus, women in general, and

women from the lower economic class in particular, are especially harmed by increase in the gasoline excise tax.
The tax reduction leads to a drop in social services and the budgets earmarked for them. Analysis of the 2011-2012 budget shows that the cross-the-board cutbacks in public services will harm women primarily, since they constitute the majority (about 70 percent) of public employees (76 percent of employees in the education system, 72 percent in the health system, and 85 percent in the social-welfare system). The cutbacks in government spending on social services are reflected also in a drop in per capita outlay over the past decade (NIS 12,162 in 2001 compared with NIS 11,465 in 2010). In the 2011-2012 budget, the figure rises to NIS 11,954, but this figure is still lower than it was in 2011. It does not meet the needs that have arisen in the past decade as a result of the steady drop in per capita outlay.

Stage Budget Allocations for Health

The regular budget of the Ministry of Health for the 2011 fiscal year amounted to NIS 19.9 billion, plus a conditional expenditure in the sum of NIS 3.3 billion. Since 2008, the state's budget for health has risen an average of 9 percent a year (Table 18). In 2012, the budget increase was NIS 20.6 billion. The 2012 budget has three main components: development; basket of health services (pursuant to the State Health Insurance Law – this component also includes treatment of long-term illness, mental-health services, and public health. In 2011, an additional NIS 427 million were allocated for technology and to add services to the basket; of this sum, NIS 127 million were for child dental care. Another NIS 380 million were added to the budgets for 2012 and 2013. Through 2013, the additional allocation for technology and services to the basket amounts to NIS 1.2 billion. The government will also allocate additional funds to the sick funds for population growth and aging in a sum of 1.2 percent a year (in 2008-2010, the increase was 0.9 percent a year). The government also increased allocations to the sick funds by NIS 50 million for the purpose of developing community medical services, community based alternatives to hospitalization, and meeting quality standards.[15]

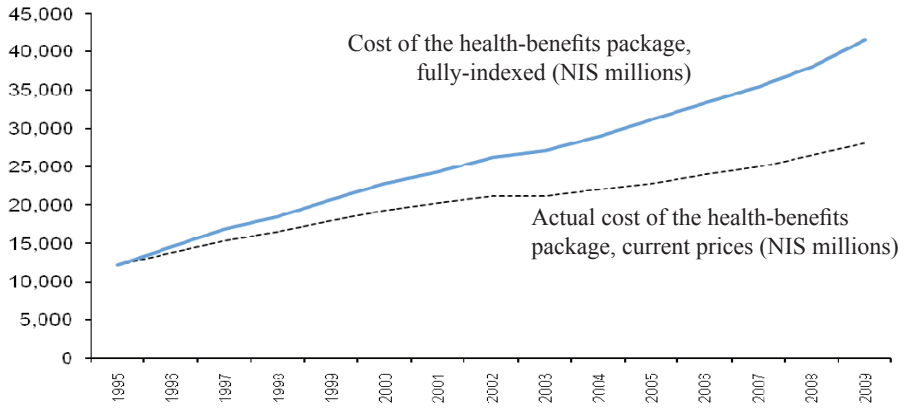
15 The statistics are taken from the following documents: Proposed State Budget for 2011-2012, Fundamentals and Multi-Year Budget Plan (Jerusalem, October 2010); Proposed Budget for 2011-2012 and Explanatory Notes: Ministry of Health and Related Sections, Booklet 15 (Jerusalem, October 2010); Proposed Budget for 2009-2010 and Explanatory

Table 18: Health budget for 2008-2012

Section	2008	2009	2010	2011	2012
Regular budget	15,338,839	16,125,627	18,144,776	19,867,335	20,627,752
Public health	679,488	754,001	754,800	764,528	766,192
State Health Insurance Law	11,704,465	12,242,546	13,999,738	15,514,320	16,070,669
Mental Health Medical Centers	529,450	570,396	611,582	35,406	36,198

In the 15 years that have passed since enactment and implementation of the State Health Insurance Law, the health budget has eroded. In 2009, the gap between actual funding of the basket of services and the requisite funding based on updated indicators amounted to NIS 13.3 million (Graph 12).[16]

Graph 12: Cost of the health-benefits package, 1995-2009
Actual cost and fully-indexed cost



Source: Adva Center, "The Proposed Budget and Budget Arrangements Law for 2011- 2012: Tight-Fisted on Civilian Expenses," PowerPoint presentation, 3 November 2010.

Notes: Ministry of Health and Related Sections, Booklet 15 (Jerusalem, October 2009); Budget Provisions for 2008 Fiscal Year: Ministry of Health, Booklet 15 (Jerusalem, January 2008).

16 Adva Center, "The Proposed Budget and Budget Arrangements Law for 2011- 2012: Tight-Fisted on Civilian Expenses," PowerPoint presentation, 3 November 2010.

In the years 2011 and 2012, the development budget is still lower than it was in 2001 (NIS 289.2 million in 2012 compared with NIS 401 million in 2001), despite the slow increase in the overall budget over the past ten years. It is important to note that the primary need for development lies in the periphery, especially in the South.

Health Budget Allocations for Women

The health of women is affected by social and cultural matters related to their rights as women and also by their ability to exercise their right to achieve effective use of health services and access to them. In general, any change in the national budget, and in the health budget in particular, has long-term effects on women. These effects are greater for women in the lower economic and social segments of the population, which includes Arab women.
The direct, immediate effect of the health budget on women is evident in a number of facts that arise from numerous surveys and research studies:

- More than 70 percent of persons employed in the health field are women (13,605 of the 18,788 persons engaged in health occupations);[17]
- Women use health services more than men, for various reasons, such as longer life expectancy, higher incidence of chronic illnesses, special needs unique to women (pregnancy, giving birth, fertility);
- Women are primarily responsible for dealing with the health of the children in the family, are the principal caregiver, and are the ones who accompany the ill member of the family when obtaining healthcare services.

Summary and Recommendations

The right to health is a fundamental right that is derived from the right to life, to liberty, and to dignity. The right is enshrined in several international conventions and Israel is party to most of them. By becoming a party to these conventions, the state commits itself to ensure their implementation by

17 Abraham Fund, "Integration of Israel's Arab Citizens in the Healthcare System: A Success Story?" (April 2011).

legislative action, by allocating resources, and by taking measures to reduce the gaps between the various groups in society, including the gaps between women and men and between the different women's groups in society. These international conventions also prescribe principles for action that each State Party is required to adopt.

There are three major principles: human dignity, protection, and fulfillment. The obligation to ensure human dignity requires the state to refrain from interfering in its citizens realizing their right to health and must grant freedom of choice toward this end. The state's obligation to provide protection requires it to act to prevent any third party (service providers, economic bodies and institutions, and so forth) from interfering in realization of the right to health. The obligation to enable fulfillment requires the state to adopt appropriate measures that will enable complete fulfillment of the right to health, facilitate fulfillment, provide assistance depending on the individual's needs, and to initiate actions to promote health.

Women are considered a vulnerable group in Israeli society in health matters. The many surveys and research studies conducted in Israel paint a dismal picture of Israeli women's health. As for Arab women, the picture is especially grave: they score worse than all other groups in the relevant health indicators – illness and death, life expectancy, use of health services, and in some health practices. Arab women are the victims of dual discrimination – as women in patriarchal Arab society, which limits their freedom of action, and by the state, which often does not enable women to exercise their rights and fails to provide them equal opportunity to advance and integrate.

The state budget expresses government policy in various spheres of life – in the economy, education, health, defense, and so forth. Thus, the budget, both *in toto* and in the manner in which it is distributed, has a direct effect on the life of everyone in the country. The effect is especially important with respect to minority groups, such as Arabs and vulnerable groups like those of women, children, and the elderly. The importance of examining the budget from various aspects is clear. Gender is one of these aspects.

The state budget for the years 2011 and 2012 do not aid the weak groups in Israel society. The state's attempts to reduce public services greatly harm these groups, particularly women. The primary beneficiaries of the change in tax policy, which ostensibly is to benefit all citizens, are the strong groups. In gender matters, the main beneficiaries are men, and not women, the elderly, and the persons at the lower rungs of the economic ladder, whose condition

has worsened. On the health front, the budget does not comport with the needs of the health system and the citizens.

Of all groups, women are injured most severely by the government's economic policy on health as reflected in the health budget. The primary reason is that, on the one hand, women constitute the main workforce in the health system and, on the other hand, women, and primarily Arab women, are the main consumers of healthcare services, given their severe health condition in comparison with men.

The poor health of Arab women in Israel results from a variety of causes: social, cultural, economic, political, and environmental. To remedy this, we believe that the state must take overall responsibility and institute broad and comprehensive national programs that consider all the factors affecting health and provide a suitable response to the needs of women, particularly Arab women, in allocating budget resources (funding, infrastructure, human capital, and so forth) in order to bring about change and improve the health indicators in this population group. The state must also reexamine the state budget from the gender aspect and take steps to adopt a policy of funding to benefit women, even including a policy of affirmative action in favor of women.

Therefore, we call for the acceptance of three fundamental principles in planning and setting an order of priorities in the state budget that will bring about the necessary change and improvement in the health of Arab women in Israel. The three basic principles are the following:

- Improvement in the living conditions of Arab women;
- Reduction in inequality in distribution of the state budget with respect to power, funding, and resources at the national, regional, and local levels;
- Ongoing and systematic monitoring of the health of Arab women, dissemination of information, and improvement and development of capabilities.

Implementation of these principles requires appropriate preparation and, primarily, adoption of a budget that will ensure availability of all the necessary monetary resources. In making the budgetary changes, we call for suitable budgetary allocations to achieve the following objectives in the fields of health, education, and economy.

Health

- Increase in the percentage of Arab women in the labor market in general,

and in the healthcare system in particular, by adding positions in the healthcare frameworks at various state government levels (headquarters, districts, sub-districts) and at the local authorities level;
- Increase the percentage of Arab women employed in universities, colleges, and other academic frameworks;
- Increase research in women's health as an integral part of the information apparatus in the sick funds and other treatment frameworks;
- Provide special funding for programs to advance the health of Arab women;
- Expand and increase early diagnostic services, such as mammograms, and made them readily available, in Arab communities, to the women there;
- Expand national programs to detect breast cancer that includes Arab women in the 40-50 age group;
- Expand the national program to promote an active and healthy lifestyle, such that it includes a larger number of Arab towns and villages.

Education
- Reduce the drop-out rate, giving priority to areas and communities with high drop-out rates, such as the Negev area;
- Improve health in the schools (infrastructure, health-promotion programs, safety, welfare, and the like) in order to promote the health of women, who constitute a large portion of workers in education, as well as the health of the school pupils.

Economy
- Expand taxation reform to benefit also working women, particularly Arab women;
- Increase special initiatives that provide suitable employment opportunities for Arab women in health, technology, business, and other fields.