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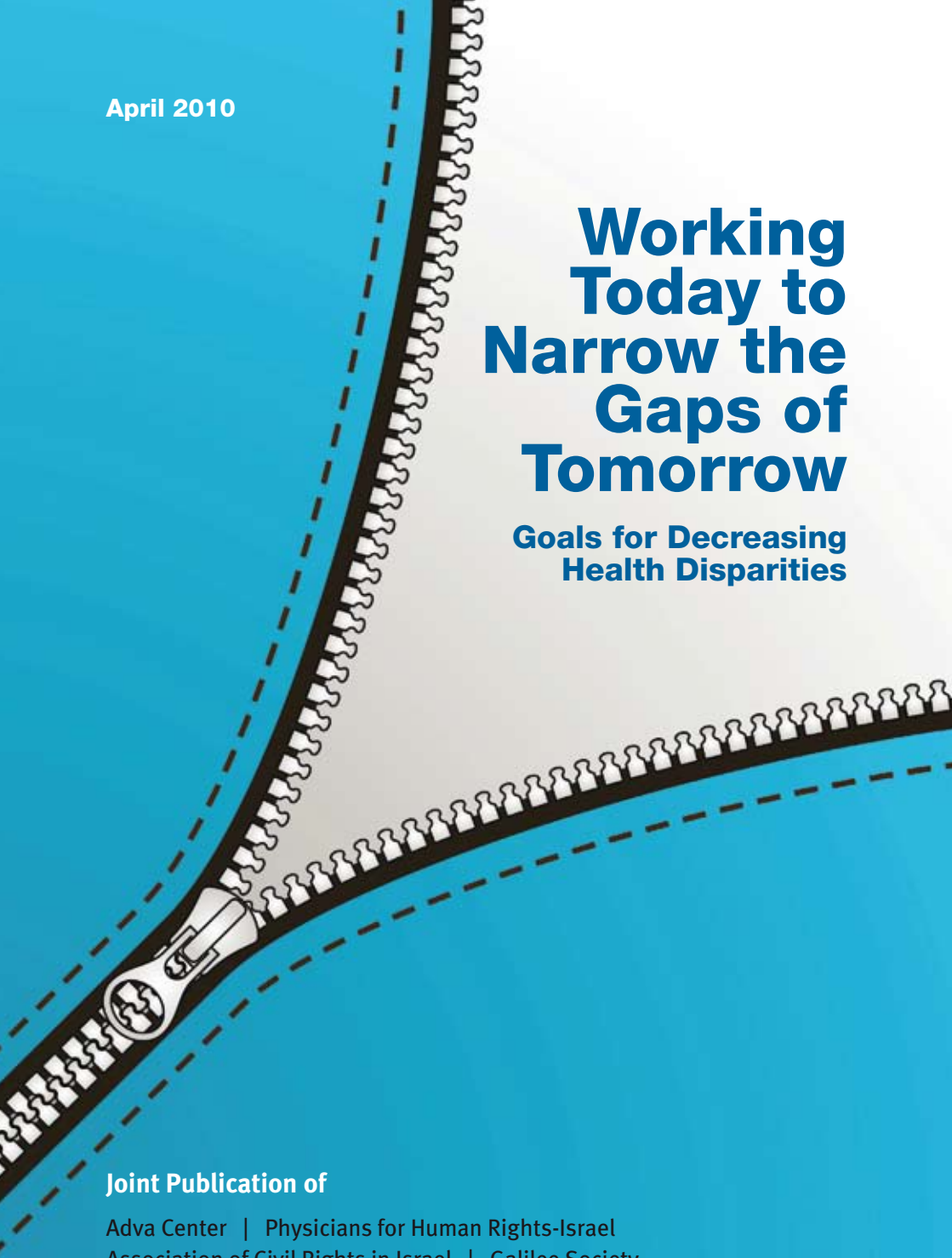
Working Today to Narrow the Gaps of Tomorrow

Goals for Decreasing Health Disparities



Joint Publication of

Adva Center | Physicians for Human Rights-Israel
Association of Civil Rights in Israel | Galilee Society
Tene-Briut for the Promotion of the Health of Ethiopian Israelis

Working Today to Narrow the Gaps of Tomorrow

Goals for Decreasing Health Disparities in Israel

A joint project of
Adva Center
Physicians for Human Rights-Israel
Association for Civil Rights in Israel
Galilee Society-Arab National Society for Health Research and Services
Tene-Briut for the Promotion of the Health of Ethiopian Israelis

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Recently, health disparities between different population groups have received considerable attention. For example, significant gaps have been found between Jews and Arabs, between long-time residents of Israel and newcomers from Ethiopia, and within each of these groups, between persons receiving income support payments and others. Gaps have been found between the center and periphery and between the population groups residing in these areas. The disparities have been increasing rather than decreasing.

Justice, equality and mutual aid – these are the three pillars on which the National Health Insurance Law stands. This law, Israel's most important piece of health legislation, was created to ensure the accessibility of health services to residents who need them. Indeed, in the first years of its existence, the law did reduce some gaps. A lot of water has passed under the bridge since then, and lately health gaps have been increasing and health services have become less equitable than they were in the past. How did this happen? The reasons are to be found in the letter of the law, which failed to deal with existing health gaps and lacked the means to cope with problems of accessibility.

The narrowing of health gaps requires focused actions on the part of the Ministry of Health. It also requires a broad set of actions aimed at narrowing income and education gaps between social groups. These gaps often lead to health gaps. At the same time that we recommend that the Ministry of Health set goals and action programs, we are aware of the starting line and it is clear to us that the area of health is only one of many areas in which actions need to be taken to reduce health gaps.[1]

The purpose of this position paper is to recommend to the government of Israel **basic principles for a national program for the narrowing of gaps in health status and health services.**
The Ministry of Health, in conjunction with all the bodies in Israel responsible for health, is being asked to determine the indicators that need to be fixed and the actions that need to be undertaken to narrow health gaps. Once such a program has been initiated, the health system will need to constantly re-examine its methodology and goals to make sure that they remain both relevant and realistic.

We recommend that an annual Health Gaps Report be presented to the Knesset, including a current update on health disparities, a delineation of the official goals for the reduction of those disparities, and the progress that has been made by the various ministries. The health of the population of Israel, which should be a national priority, requires high public visibility, along with expeditionary measures and quality control.

Basic Principles for a National Program

Other countries have already implemented programs to narrow health gaps; we can learn from their experiences when formulating the basic principles of such a program. For example: [2]

- The need to designate disparities in health status and in health services as a **national problem requiring government intervention;**
- The **creation of political commitment to the issue**, not only within the Ministry of Health but also on the part of the Prime Minister. The Prime Minister needs to make public declarations regarding his commitment to narrowing health gaps by means of government resolutions;
- The **creation of an inter-ministerial body** (including Health, Social Services, Education, and Industry-Trade-Employment) that will formulate policy and coordinate activities among ministries, to promote the reduction of health gaps and the broadening of health services;
- The **fixing of quantitative goals** – mapping target populations, areas in which work is to be done, foci for intervention, and timetables;
- **Setting aside a budgetary allocation and assigning tasks**. The number of medical and administrative personnel in the periphery of Israel need to be increased, as well as the number of persons who engage in data collection and analysis;
- **Selecting clear, consistent criteria for comparative data collection on gaps**. This requires standardization of data collection done by the health funds;
- **Publishing broad-based health figures on the various indicators**: like health indicators, and the availability and accessibility of health services. In addition to publishing data that is disaggregated by demographic and socio-economic variables, comparative regional data need to be published on the geographic location of health fund clinics and on the essence of the various services provided by the different health funds. Publications need to include an up-to-date picture of the progress being made towards the set goals, in a way that is accessible to the general public (for example, through a web site and/or periodic press releases);
- **Presenting an annual public report on health gaps in the Knesset**;
- **Deepening awareness regarding the existence of health gaps,** among health professionals as well as among the general public. Special training materials need to be created, to include a survey of health gaps and the ways of dealing with them. The program needs to identify special culturally determined health needs, which should be brought to the attention of the medical professions as well as to that of active practitioners;
- **The creation of broad-based cooperation for the narrowing of health gaps** - between government ministries, the health funds, local authorities, patient organizations, social change organizations, and community representatives.

Examples of Health Disparities

Four common illnesses were selected – diabetes, heart disease, breast cancer, and depression/anxiety – in order to illustrate how **quantitative goals can be set** and **how a program of action can be created** to narrow the gaps associated with these illnesses.

The above illnesses are examined in relation to the following population groups: Jews and Arabs, native and long-time Israelis and new immigrants from Ethiopia, and persons receiving income maintenance payments vs. persons not receiving such payments.

These population groups are illustrative; they do not exhaust all the possibilities. Gaps in health status have been found between additional groups: between women and men, secular and ultra-Orthodox Jews, new immigrants and Israeli-born, and, within these groups, between center and periphery, and between persons of various educational levels.

Diabetes

Diabetes is the fourth leading cause of death in Israel – after cancer, heart disease, and cerebrovascular disease (stroke). It is also one of the most common chronic diseases in Israel and the world. According to the "National Program of Quality Indicators for Community Medicine in Israel," the number of persons suffering from diabetes in 2007 (based on figures received from the four health funds) was 292,000.[3] Diabetes is incurable, and its side effects include complications and systemic damage.

It is possible to reduce the morbidity rate of diabetes and to achieve good control of the disease, by means of a healthy life style – physical activity, a balanced diet and the like. Once a person contracts the disease, assuming a healthy life style can improve the quality of life and prevent complications. This approach requires constant and careful monitoring, along with the existence of the social conditions, economic possibilities and suitable environment that make it possible to embark upon the needed changes in one's way of life. For example, patients with low income have more limited access to a balanced diet and to infrastructures that facilitate physical activity. Thus, their chances of contracting the disease are greater and their opportunities for controlling the disease are smaller.

Gaps

In Israel, there are disparities in the morbidity rate, in the degree to which the disease is controlled, in mortality, and in the accessibility of health care services. These disparities stem directly from socio-economic conditions. Below are some of the main findings:

Morbidity

- The morbidity rate of diabetes among persons receiving income maintenance payments from the National Insurance Institute is five times higher than the morbidity rate of persons not receiving income maintenance payments: 14.8%, compared to 3.06%.[4]
- The morbidity rate of Arab men in Israel is 1.8 times that of Jewish men: 12.5%, compared with 7.1%. The morbidity rate of Arab women in Israel is 2.2 times that of Jewish women: 11.5%, compared with 5.3%.[5]
- The morbidity rate of immigrants from Ethiopia (for 2001)[6] is 16%. The incidence of diabetes among immigrants from Ethiopia increases directly in proportion to the time they have been in Israel. Immediately upon arrival, the incidence rate is between 0% and 0.4% [7](that is, almost non-existent), and it rises steadily, as follows:
- After 4 years, 8.9%[8],
- After 7 years, 9.6%,
- After 10 years, 16%.[9]

Controlling Diabetes

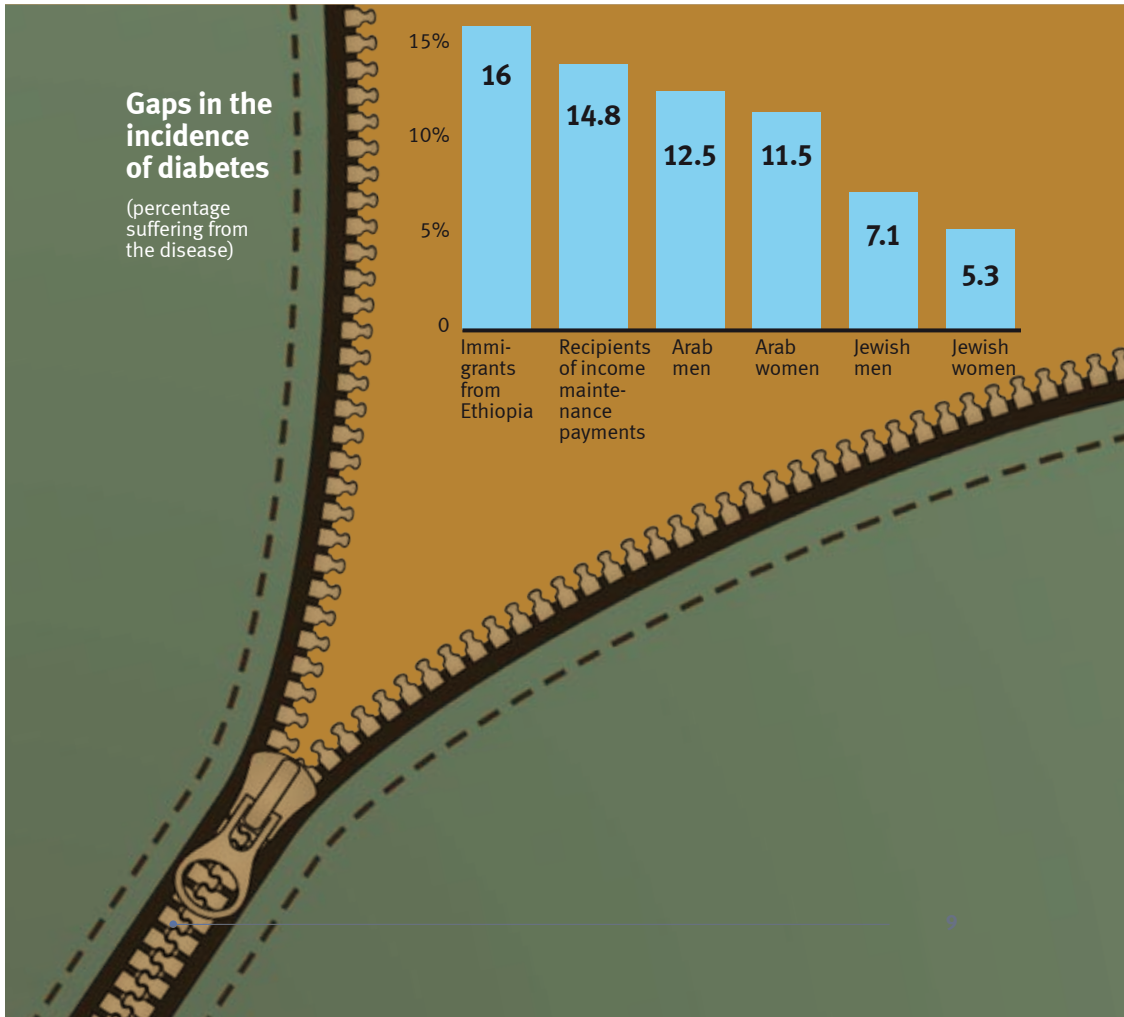
- Percentage of diabetics with poor control: among persons aged 18-64, there is a gap between recipients and non-recipients of income maintenance payments (poor control= HbA1c higher than 9%). This gap ranges between 12% at ages 34-44 to 40% at ages 55-64.[10]
- There are also gaps in the degree of control of persons diagnosed with diabetes who came from Ethiopia and other patients: 9.5±2, compared with 8.1±2.

Mortality

- Mortality from diabetes is higher in the Arab population than in the Jewish one.[11]

Accessibility

- There is evidence that Arab citizens and Ethiopian immigrants have lower access to treatment for diabetes.
- 32% of Arabs in the North suffering from diabetes reported that they did not take medications because of the cost.[12]
- Only 48% of Ethiopian immigrants suffering from diabetes understand all or most of what their physicians tell them, compared with 92% of other patients.[13]



Goals

Following is a list of recommended goals for the reduction of gaps in the area of diabetes. The list is no more than a recommendation; neither does it reflect priorities or costs.

To illustrate, this section relates to three social groups: Arab residents of Israel, Ethiopian immigrants and recipients of income maintenance payments. The picture emerging from the figures points to an urgent need to set quantitative goals for reducing the disparities between Ethiopian immigrants and the general population, as well as between the Arab and Jewish populations. In addition, goals are needed to reduce the gaps within these groups between recipients of income maintenance payments and others.

The goals: (1) reduction of morbidity gaps, (2) reduction of gaps in the degree to which the disease is under control, and (3) an absolute improvement in the average level of sugar in the hemoglobin of diabetics.

Arab citizens of Israel

- Reducing the morbidity gaps and the gaps in the percentage of patients whose disease is well controlled between the Arab and Jewish populations, by 25% within five years. Re-evaluation of the goal after two and a half years.
- Increasing the percentage of persons suffering from diabetes whose disease is well controlled (HbA1c lower than 7%) by 25% within five years. Re-evaluation of the goal after two and a half years.
- Improving the average level of HbA1c by 25% within five years. Re-evaluation of the goals after two and a half years.

Ethiopian immigrants

- Reducing the morbidity gaps and the gap in the percentage of patients whose disease is well controlled between the population of Ethiopian immigrants and the general population by 25% within five years. Re-evaluation of the goals after two and a half years.
- Increasing the percentage of patients whose disease is well controlled (HbAic lower than 7%) by 25% within five years.[14] Re-evaluation of the goals after two and a half years.
- Improving the average level of HbA1c by 25% within five years. Re-evaluation of the goal after two and a half years.

Recipients of income maintenance payments

- Reducing the morbidity gap and the gap in the percentage of diabetics whose disease is well controlled between recipients of income maintenance payments and others, by 25% within five years. Re-evaluation of the goal after two and a half years.
- Increasing the percentage of diabetics whose disease is under control (HbA1c lower than 7%) by 25% within five years. Re-evaluation of the goal after two and a half years.
- Improving diabetics' average level of HbA1c by 25% within five years. Re-evaluation of the goal after two and a half years.

Heart Disease

Heart disease among adults is the second largest cause of death in Israel. Among the risk factors for heart disease are diabetes, smoking, high blood pressure, a high level of cholesterol, genetic factors and factors connected with life style. Obesity is an indirect – and perhaps also a direct – risk factor. The treatment of heart disease includes changes in life style, like a better diet and increased physical activity. Medical treatments include medications and catheterization or surgery. As in the case of diabetes, low-income persons often have lower access to a proper diet and to infrastructures that facilitate physical activity. Thus, their chances of contracting heart disease and of keeping it under control are lower.

Gaps

In Israel there are gaps in morbidity from heart disease, which affect mortality, and on the incidence of risk factors among different population groups. Most of the existing figures point to gaps between Jews and Arabs.

Morbidity

- The incidence of ischemic heart disease (heart attack or angina pectoris) in men over the age of 21 is somewhat higher among Arab men: 8.9%, compared with 7.8% among Jewish men (2003-2004).[15]
- The incidence of heart disease is somewhat higher among Jewish women: 4.4%, compared with 3.5% for Arab women (2003-2004).[16]
- The percentage of Arab women aged 60 and over reporting having been diagnosed with heart disease was 12.4% in 2007; the corresponding figure for Arab men was 19.3%.[17]

Mortality

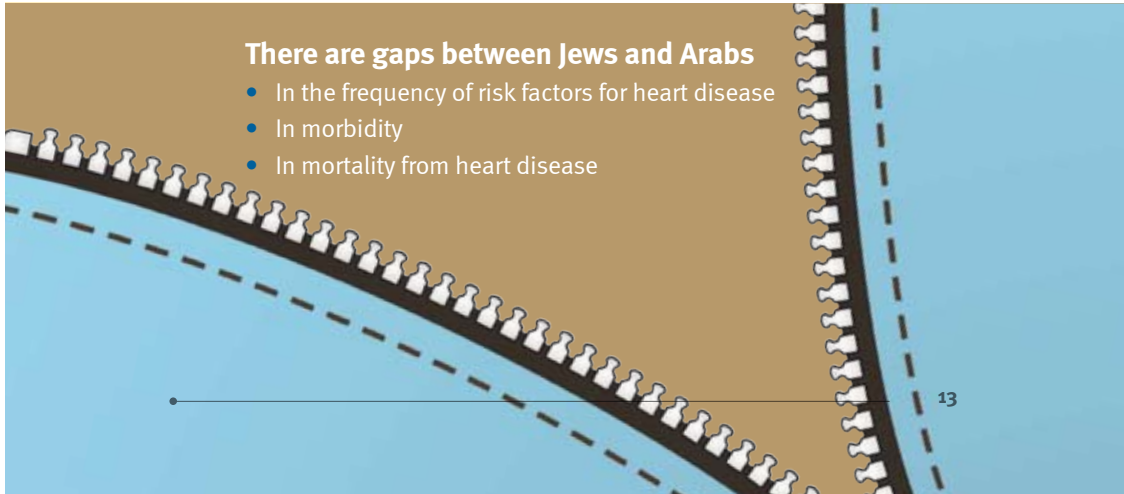
- There are mortality gaps between Jews and Arabs in Israel. In 1999, the mortality rate of Arab men from heart disease (age-adjusted) was 168.3 per 100,000 – 28.4% higher that the death rate for Jewish men – 131.1 per 100,000. The mortality rate of Arab women – 149 per 100,000 – was 66.5% higher than the mortality rate for Jewish women – 89.5 per 100,000.[18]

Risk Factors

- Among patients hospitalized for heart attacks, Arab patients were found to be younger and the percentage of smokers and persons suffering from diabetes higher.[19]
- Arab men are more likely to smoke than Jewish men. More Arabs, especially Arab women, suffer from obesity and diabetes.[20]

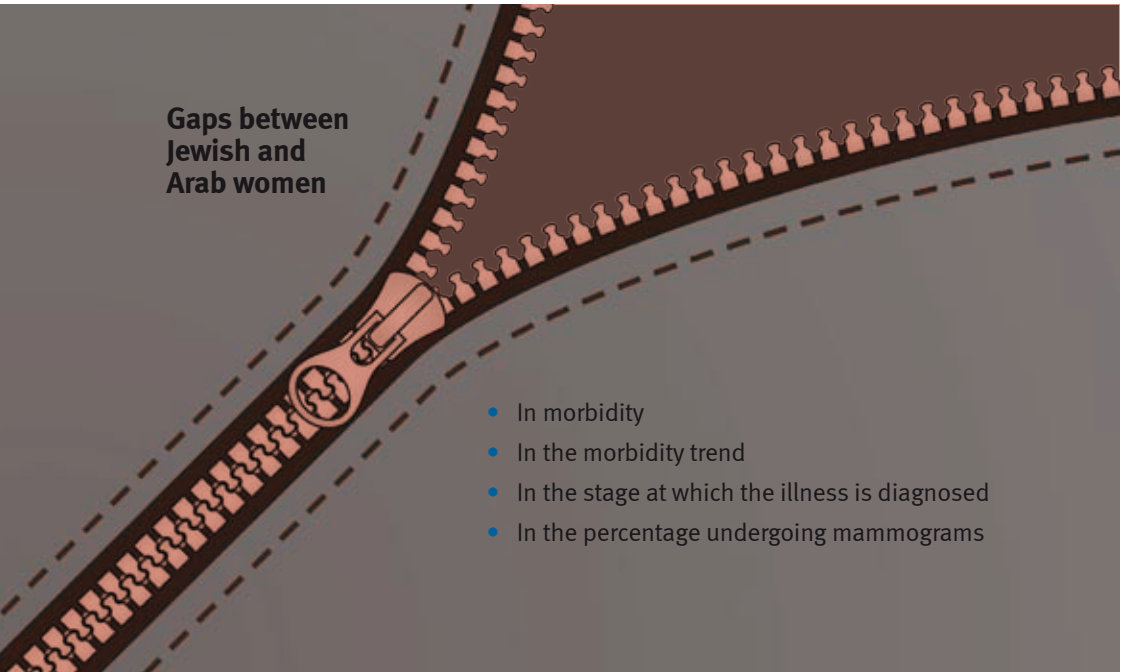
Goals

- Reducing the morbidity gap between Arabs and Jews suffering from heart disease by 25% within five years. Re-evaluating the goal after two and a half years.
- Reducing the gaps between Arabs and Jews in risk factors for heart disease: decreasing the smoking gap by 25% within five years. Re-evaluating the goal after two and a half years.



Breast Cancer

Cancer is the first cause of death in Israel. In contrast to diabetes, morbidity is lower among Arabs and lower among low-income persons. Among the different kinds of cancer, breast cancer is the most common malignant disease among women in Israel, as in other parts of the world. Among Arab women, diagnosis occurs at a relatively late stage of the illness and the survival rate (between one and five years after diagnosis) is lower.



Gaps

In Israel significant gaps have been found between Jewish and Arab women. The gaps are in morbidity, survival rates five years after diagnosis, and in the percentage of women undergoing mammograms.

Morbidity

- Breast cancer is more common among Jewish women. The morbidity rate for invasive tumors (age-adjusted) in 2006 was 84 per 100,000, compared to 59 per 100,000 for Arab women.[21]
- In recent years, the morbidity rate among Jewish women has decreased, while the morbidity rate of Arab women has increased. In 2002, the morbidity rate for Jewish women was 96 per 100,000, compared to 84 per 100,000 in 2006. For Arab women, the morbidity rate in 2002 was 41 per 100,000, compared to 58 per 100,000 in 2006.[22]
- Among Arab women, the disease is diagnosed at a later stage. While 53.5% of Jewish women were diagnosed at Stages Zero or One, only 36.7% of Arab women were diagnosed at this stage. Among Jewish women, 34% were diagnosed at the Third and Fourth Stages, compared with a much higher percentage – 51.9% - for Arab women.[23] (Figures are for 2000-2002.)

Survival

- The relative survival rate[24] (up to a year after diagnosis) of women diagnosed with breast cancer between 1999 and 2002 was similar for Jewish and Arab women. However, the survival rate five years after diagnosis was lower for Arab women – 77.8%, compared with 86.6% for Jewish women.[25] According to a report published by the Center for Disease Control, "It is possible that these gaps in survival rates stem from differences between Jewish and Arab women with regard to the stage at which the disease is diagnosed."[26] This comment refers to the fact that cancer is diagnosed for Arab women at a later stage of the disease.

Mammograms

Mammograms are the most effective means of detection: "Medical experience shows that they can reduce mortality stemming from breast cancer by 17% among the 40-48 age group and by 30% among the 50-75 age group."[27] There are gaps between Jewish and Arab women when it comes to mammogram utilization:[28]

- 51.1% of all Jewish women reported having a mammogram during the two years preceding the survey (2003-2004), compared with 36.3% of Arab women.
- 70.1% of Jewish women between the ages of 50 and 74 reported having a mammogram during the two years preceding the survey (2003-2004), compared with 47.5% of Arab women.
- The proportion of women receiving income maintenance payments who reported undergoing mammograms in 2007 was 56.62%, compared with 62.08% among other women.[29]

Goals

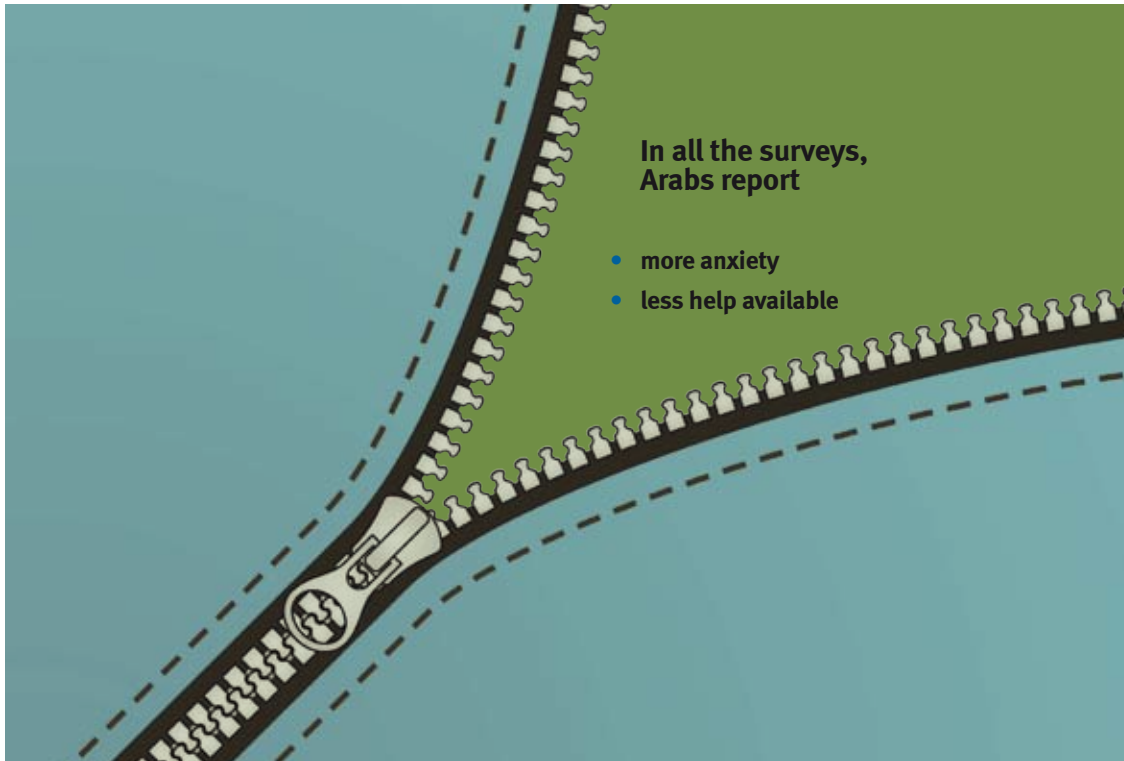
- Reversing the trend of increasing morbidity among Arab women – within five years. Re-evaluation of the goal after two and a half years.
- Making sure that the trend of decreasing morbidity among Jewish women continues.
- Reducing the gaps between Jewish and Arab women in survival one to five years after diagnosis by 25% within five years. Re-evaluating the goal after two and a half years.

Mental Health

Depression, Anxiety and Other Mental Disturbances

Three groups of users of health services in the area of mental health can be discerned: a group of about 70,000 persons who suffer from serious mental illnesses; a larger group of persons who suffer from mental illnesses that have been diagnosed – some of which are defined as serious illnesses; and a still larger group of persons who need mental health services due to temporary or ongoing distress (a minority have diagnosed mental illnesses, but most do not).[30]

Mental distress is a health problem that needs to be treated within the community. Mental health professionals point out – as demonstrated below - that there are large gaps in the opportunities for mental health care between Jewish and Arab localities.



Gaps

In Israel there are gaps between Jews and Arabs in the percentage of individuals reporting mental distress and in the degree of accessibility of mental health services in the community.

Mental Distress

The proportion of Arabs reporting mental distress is higher than the proportion of Jews reporting mental distress, as follows:[31]

Reported suffering from tension or pressure "all the time" or "most of the time" in the four weeks that preceded the survey (2003-2004):

- Arab women: 21.1%
- Jewish women: 14.7%
- Arab men: 16.2%
- Jewish men: 10%.

Reported suffering from despair or depression "all the time" or "most of the time" during the same four weeks:

- Arab women: 7.9%
- Jewish women: 4.7%
- Arab men: 4.5%
- Jewish men: 2.9%.

Accessibility of Mental Health Services

- In Israel, only two mental health clinics are located in Arab localities, one in Um el-Fahum and another in Sahknin (the latter opened its doors in October 2009). It is very possible that this situation explains in part the following findings:
- **Adults:** a higher percentage of Jews (8.6%), compared with Arabs (3.8%), reported seeking help when suffering from tension, pressure or mental distress during the year preceding the survey.[32]
- **Adolescents:** 51% of adolescents suffering from mental disturbances who lived in Arab localities turned to their schools for help, compared with 30% of those living in Jewish localities.[33]

- **Adolescents** with mental disturbances who failed to receive help from mental health professions include:
  54% of those living in Jewish or mixed Jewish/Arab localities;
  91% of those living in Arab localities.[34]
- A much higher proportion of **mothers of adolescents** with mental disturbances who lived in Jewish or mixed Arab/Jewish localities – about 46% – sought help for their children, than mothers of adolescents with mental disturbances living in Arab localities – 9%.[35]

Goal

Doubling the accessibility of mental health services for Arab citizens within five years. Re-evaluation of the goal after two and a half years.

Steps Recommended

The following are illustrations of steps that can be taken to reduce health disparities in Israel. The examples listed below are presented for illustrative purposes only; they do not include all the steps that need to be taken at the national, local, community and individual levels. We would like to point out that it is crucial to work on several dimensions at one and the same time, through cooperation between government agencies and other actors in the health system.

Creating a Basis for Intervention: Setting up Databases

- Collecting comparative data about health gaps, emphasizing the availability and accessibility of services. Data collection on the national level (like that of the "National Project on Quality Indicators in the Community," the National Cancer Register and the surveys conducted by the Ministry of Health and the Central Bureau of Statistics) needs to include variables like country of origin, ethnic origin and socio-economic level.
- Publishing on-going figures in a transparent way that is accessible to the general public.
- Encouraging research that examines the reasons for gaps in health outcomes and suggests possible ways to close those gaps.

Legislation

- Changing the system of incentives for the health funds, so as to encourage investments in populations whose health status is lower than that of the general population.

- Creating a new system of incentives for other actors in the health system – hospitals, local authorities and service providers – in order to encourage investment in populations with low health status.
- Abolishing co-payments for services and medications in the health benefits package under the National Health Insurance Law. The first co-payments that should be abolished are those for preventive and secondary services, along with the co-payments charged persons with chronic illnesses for medical services and medications.

Training and Increasing the Number of Health Personnel

Posts and scholarships need to be allocated and targeted for Ethiopian Israelis and Arab citizens, so that members of these communities take up paramedical professions, like dietitian, and specialize in needed areas, like endocrinology and the treatment of diabetes.[36]

Arab and Ethiopian researchers should be encouraged to study diabetes by providing them with research grants.

Suitable training should be offered to Arabs working in the field of mental health, including specializations in psychiatry and psychology, in order to fill the need for Arabic-speaking professionals.

Grants and benefits should be made available to Arab students specializing in psychiatry. Such a step should be accompanied by the designation of psychiatry as a profession in demand for Arabic speakers, like the current designation of anesthesiology.

Availability of Services

- Steps need to be taken to close the gaps in the availability of multidisciplinary services for the treatment of persons with diabetes, heart

disease, members of high-risk groups for breast cancer and persons in need of mental health services, in different geographical areas, with the emphasis on the gaps between the center and periphery.

- The readiness of Arab women to undergo mammograms needs to be increased by means of a more effective diffusion of mammogram machines, so that Arab women will not have to travel for more than an hour for a check-up. This can be done by increasing the number of mobile mammogram units.
- Breast clinics need to be set up in Arab localities (today there is only one – in Nazareth).
- Mental health clinics need to be set up in Arab localities, and their staff members need to be Arabic speakers.
- The Ministry of Health needs to create additional posts for Arab psychiatrists, so that they can receive specialization in hospitals.

Cultural Appropriateness

- Medical and nursing schools need to institute special programs that emphasize the issue of cultural appropriateness.
- The sick funds should train multi-disciplinary teams for clinics and branch offices where cultural differences are relevant.
- In addition to the existing indicators utilized by sick funds, indicators should be created for special population groups, like Ethiopian immigrants and Arab citizens. Such indicators have already been developed from the conclusions reached by Tene-Briut [37] and the Galilee Society, organizations that are signatories to the present document.
- Language obstacles need to be reduced between the health system and patients whose mother-tongue is not Hebrew. One successful initiative that responds to this need is the translation service that breaches the divide between doctor and patient by means of a real-time telephone service.[38] The translators, who speak different languages (Amharic, Tigris, Arabic, Russian), should receive special training and be available to the medical services.
- Systematic work needs to be done to take advantage of the educational tools developed by voluntary organizations in Arabic and Amharic – and to continue to develop them, accompanied by professional quality control.
- The Ministry of Health should employ psychiatrists, psychologists, social workers and health education experts to develop programs appropriate to the Arab population.

Cooperation in the Promotion of Health

Health promotion programs need to be formulated, in cooperation with the local community and the local leadership. Such programs should emphasize the importance of not smoking, of engaging in physical activity, and of eating a balanced diet; they also need to be culturally appropriate. Nutrition programs need to be based on the Arab or the Ethiopian kitchen, whichever is relevant.

Financing needs to be found for the creation of infrastructures for sports activities, to include lectures and explanations about the importance of physical education. Physical education teachers need to come from the local community. Preference needs to be given to localities where Arab citizens and Ethiopian immigrants reside.

Arab localities and localities in which Ethiopian immigrants reside should be allotted additional teaching hours in health promotion.

A program should be created, in cooperation with the local leadership, whose aim is to increase the percentage of Arab women who undergo mammograms.

Health gaps exact a heavy price on the individual as well as on the social level, in the form of excess morbidity and mortality. For this reason, they constitute a national problem that requires government intervention.

Endnotes

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4 Israel National Institute for Health Policy and Health Services Research, and Health Council, 2008: 44 (Hebrew).

5 Israel Center for Disease Control (INHIS): 62 (Hebrew).

6 The following information is based on Jaffe, A. and Levit, B., 2001.

7 Rubinstein, A., E. Graf, E. Landau, et al, 1991.

8 Cohen, MP, E. Stern, Y. Rusesecki, and. A. Zeidler, 1998.

9 Todjman & Jaffe, unpublished data.

10 Israel National Institute for Health Policy and Health Services Research, and Health Council, 2008:54 (Hebrew).

11 Israel Center for Disease Control (INHIS) (Hebrew).

12 Khatib, M., S. Efrat and D. Deeb, 2007.

13 In research conducted by Tene-Briut and the Endocrinology Unit at the Hillel Yaffe Hospital, by Todjman et al, 2004.

14 The level of blood sugar – HbA1c - is the standard tool used to determine the level of control of the disease. A blood sugar level of less than 6% is considered normal. The level recommended by the World Health Organization is less than 7%.

15 Israel Center for Disease Control (INHIS): 61 (Hebrew).

16 Israel Center for Disease Control (INHIS): 61 (Hebrew).

17 Galilee Society and Al-Ahali, 2008: 259-260.

18 Israel Center for Disease Control, 2005: 99 (Hebrew).

19 Israel Center for Disease Control, 2005 (Hebrew).

20 Jabara et al, 2007; Kark et al, 2006.

21 Israel Cancer Registry website.

22 Ibid.

23 Tarabeia, Jalal, et al, 2007.

24 Relative survival is defined as the ratio between the probability of a person with cancer surviving after a period of five years and that of a person of his age without cancer surviving during the same period.

25 Israel Cancer Registry, "The Survival of Persons with Malignant Diseases in Israel," October 2009 update. Website of Israel Ministry of Health (Hebrew).

26 Israel Center for Disease Control, 2005: 141 (Hebrew).

27 Israel National Institute for Health Policy and Health Services Research, and Health Council, 2008: 27 (Hebrew).

28 Israel Israel Center for Disease Control (INHIS): 49-50 (Hebrew).

29 Israel National Institute for Health Policy and Health Services Research, and Health Council, 2008: 28.

30 Gross et al, 2009: 2-3 (Hebrew)..

31 Israel Center for Disease Control (INHIS): 81, 83 (Hebrew).

32 Levav et al, 2007:110.

33 Mansbach-Kleinfeld, Ivonne et al, 2010, "Service Use for Mental Disorders and Unmet Need: Results from the Israel Survey on Mental Health among Adolescents," in *Psychiatric Services*, Vol. 16, No. 3.

34 Ibid.

35 Ibid.

36 The number of specialist endocrinologists who speak Arabic is low in comparison with the need. There are no Amharic-speaking endocrinologists. According to unofficial statistics at the Israel Association for Endocrinology, it has about 20 Arab members (who work only part-time); only seven of them are certified.

37 http:www.tene-briut.org.il

38 This initiative was successfully carried out by Tene-Briut,, with the professional guidance of the Translation Department at Bar Ilan University. See again: http:www.tene-briut.org.il.

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Interviews

Dr. Bella Kaufman, Haim Sheba Hospital
Professor Micha Eldar, Haim Sheba Hospital
Dr. Graziella Carmon, Director of the Mental Health Clinic, Um el-Fahum
Mr. Muhammad Khatib, past Director of the Galilee Society
Dr. Ivonne Mansbach-Kleinfeld, Ministry of Health
Dr. Anat Yaffe, Hillel Yaffe Hospital

This position paper is the result of the collaborative work of the following organizations:

Adva Center
is a think tank that analyzes social and economic trends and measures public policy in Israel against the yardsticks of equality and social justice. Adva makes policy recommendations and engages in advocacy work and public education to increase the chances that its recommendations will be adopted. Adva also conducts projects designed to empower disadvantaged groups.

Physicians for Human Rights - israel (PHR)
believes that every person has the right to health, in the broadest sense of the term, based on the principles of human rights and social justice and on the ethics of the medical profession. Israel is obliged to implement that right equitably for all the populations under its legal or effective control: Israeli residents, Bedouins residing in unrecognized villages in the Negev, detainees, migrant workers, persons lacking civil status, refugees and persons requesting asylum, and Palestinian residents of the occupied territories. PHR is a non-profit NGO, which opposes the occupation and strives to end it, viewing it as a source and excuse for the violation of human rights. PHR works for human rights in general and the right to health in particular, both in Israel in the occupied territories. Its activities include medical and legal work, the dissemination of information and reports, and lobbying legislative and executive officials.

The Association for Civil Rights in Israel (ACRI)
is the oldest and largest human rights organization in Israel. Since 1972, it has striven for the defense of the entire spectrum of human rights and for their promotion, wherever there are human rights violations by Israeli agencies or their proxies. ACRI does this through a plethora of legal, educational and public actions: court petitions, a hot line for public complaints, educational workshops, the promotion of legislation and social policy, media and internet campaigns and more. Since 2007, ACRI has been working with additional organizations to promote and protect the human right to health, which, in the opinion of ACRI, can only be realized in the framework of a public, equitable health system.

The Galilee Society – The Arab National Society for Health Research & Services
is an NGO that strives to achieve equality in the areas of health and environment for the Arab population of Israel and for its empowerment through the development of its capabilities to improve its own health, environmental and socio-economic conditions. The Galilee Society operates five centers: the Regional Center for Research and Development, the Center for Health Rights, the Center for Environmental Justice, the "RIkaz" databank, and the "Elmaisam" Center for the Study and Use of Medicinal Plants. In addition, the Society conducts projects to promote the health of the Bedouin population of the Negev, including a mobile clinic that provides primary health services to mothers and children, in cooperation with the Ministry of Health.

Tene-Briut – Community Based Health Promotion for the Ethiopian-Israeli Community
is an NGO founded in 1998 to promote the health of Ethiopian Israelis, a cultural minority with its own language, and distinct culture. Tene- Briut developed culturally competent health education information that it delivers in community settings to raise awareness of preventative behaviors and to improve the ability of the community to access the existing healthcare services available to them. Tene-Briut delivers its programs throughout Israel through its team of professional Ethiopian Israelis, including a medical interpreter service by phone. Tene-Briut also strives to create awareness within the health care system of the importance of cultural competence in the delivery of services, and the Tene-Briut team delivers workshops and lectures to medical professionals in hospitals and clinics, and to decision makers in the government.