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The Israeli Medical Association's discourse on health inequity☆

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ABSTRACT

The present paper analyses the emergence and characteristics of Israeli Medical Association (IMA) discourse on health inequality in Israel during the years 1977–2010. The IMA addressed the issue of health inequality at a relatively late stage in time (2000), as compared to other OECD countries such as the UK, and did so in a relatively limited way, focusing primarily on professional or economic interests. The dominant discourses on health inequalities within the IMA are biomedical and behavioral, characterized by a focus on medical and/or cultural and behavioral differences, the predominant use of medical terminology, and an individualistic rather than a structural conceptualization of the social characteristics of health differences. Additionally, IMA discourses emphasize certain aspects of health inequality such as the geographical and material inequities, and in doing so overlook the role played by class, nationality and the unequal structure of citizenship. Paradoxically, by disregarding the latter, the IMA's discourse on health inequality has the potential to reinforce the structural causes of these inequities. Our research is based on a textual critical discourse analysis (CDA) of hundreds of documents from the IMA's scientific medical journal, the IMA's members journal and public IMA documents such as press-releases, Knesset protocols, publications, and public surveys. By providing knowledge on the different ways in which the IMA, a key stakeholder in the health field, de-codifies, understands, explains, and attempts to deal with health inequality, the article illuminates possible implications on health policy and seeks to evaluate the direct interventions carried out by the IMA, or by other actors influenced by it, pertaining to health inequality.

1. Introduction

The publication of the "Black Report" on health inequality in the United Kingdom in 1980 (DHHS, 1980), marked a new era in which awareness of health inequality (measured by indicators such as life expectancy, infant mortality, and morbidity), reemerged (WHO, 2008; Wilkinson, 1996; Marmot and Wilkinson, 2006; Dahlgren and Whitehead, 1993). Inequalities in health are caused by the unequal distribution of power and resources (income, wealth, status, environment, and access to health care) and by the policies that sustain and deepen them, policies of exclusion and the economy of inequality (Farmer, 1999; Maru and Farmer, 2012; Mackenbach, 2012; McCartney et al., 2013).

The phenomenon of health inequality is both reflected in and reproduced by the diverse ways in which various actors explain and conceptualize inequalities in health. These conceptualizations influence the choice of policies and ways of addressing the phenomenon. Since professional healthcare organizations play an important role in framing discourses on health inequality, it is important to understand the ways in which they themselves understand inequalities. Thus the present study analyses the ways in which the Israeli Medical Association (IMA) conceptualizes health inequality. The Israeli case is of interest due to the unique interaction between nationality, ethnicity, class, and gender in Israeli society, and how they translate into health inequality. Moreover, the analysis of the Israeli case demonstrates the paradox of how certain ways of understanding inequalities in health functions as a means of limiting awareness of their main causes, and in doing so, reinforce them.

This paper analyses the appearance and development of IMA's discourse on health inequality in Israel between the years of 1977–2010, exposing the main explanatory frameworks and

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policies applied to address these inequalities. The paper claims that the IMA addresses health inequalities mostly in bio-medical terms, understanding them as a result of an individual's behavior, and in doing so, overlooks the role played by class and the unequal structure of citizenship. This approach reinforces health inequalities, since it does not address the role of class and ethno-national exclusion. As the 2010 Israeli Ministry of Health plan to reduce inequality in health shows, failing to address these issues limits reforms to questions of individual access to health care.

2. Conceptualizing health inequality

Discourses are ways of describing and conceptualizing the world. They shape institutional behavior, political and scientific activity as well as day-to-day behaviors (Bacchi, 1999; Fox, 1997). Discourses have significant effects on the conceptualization of social issues and their transformation into problems that demand intervention. At the same time, they determine the manner in which the policies proposed to address those problems are justified, planned, and carried out (Lupton, 2003).

Though there is a clear difference between discourse and policy, discourse influences policy by shaping the conceptualization of social issues, by constituting those issues as 'problems', and by marking the boundaries of possible solutions. The latter stem from the alternative ways in which the phenomenon is explained (Chadwick, 2000; Crinson, 1998; Fairclough, 2000; Greener, 2004; Marston, 2000; Lupton, 2003). Few researchers have examined the influence of discourse on health policy. Among these, Annas (1995) and Malone (1999) have shown how the use of metaphors from the military, the free market, or various metaphors used in the health services sector, influence approaches and policies to reform health-care services. Moon (2000) analyses the relationship between discourses concerning safety, protection and risk, and the development of a discourse of quarantine in the mental health services sector. Crinson (1998) analyses the way in which consumer discourse informed Labor Party policies toward the NHS under Tony Blair. Greener (2004) adds a historical dimension to Crinson's analysis by demonstrating the connection between the Fabian movement which emphasizes "performance", and "New Labor", which accentuates consumer values. Finally, Kelle (2007) examines the way in which international health organizations invoke the discourse of security.

Few attempts have been made to examine the influence of discourse on policy regarding health inequality. Carslile (2001) examines the relationship between three discourses explaining health inequality (poverty and lack, psycho-social stress, and individual deprivation), and the different policy proposals that seek to address health inequality in England. Raphael (2000) examines the absence of any mention of socio-economic inequality in the public health discourse on health inequality in Canada.

Medical discourses on health inequality not only influence policy, they also influence patient conduct, mainly through doctor/patient interaction. Foucault's concept of "governmentality" as the "conduct of conducts," emerging from the interaction between the "technologies of power" and the "technologies of the self," allows us to understand the dual influence of discourse (Foucault, 1988; Fries, 2008). Policies and government practices belong to the former; especially taking into account the increasing role medicine plays in the machinery of power (Foucault, 1980). The latter includes the ways in which physicians conceptualize health inequalities and frame individual patients' "operation" "on their own bodies and souls, thoughts, conducts, and way of being", in order to attain a state of health (Foucault, 1988). As Foucault (1997) argues, the "techniques of the self" are integrated into hierarchical structures of domination.

There are a number of ways of conceptualizing and explaining inequalities in health. One way is by focusing on biomedical causes (i.e. biological differences, and more specifically, genetic differences) (Gottfredson, 2004). A second approach explains health inequalities as a result of cultural differences and the effect of these differences on an individual's behavior and life-style (Smith et al., 1994). A third conceptualization accentuates psycho-social mechanisms, i.e. the deleterious influence of stress related to subordinate social status (Wilkinson, 1996; Marmot and Wilkinson, 2006). Another approach proposes a "materialist" explanation, which sees health inequalities as resulting from the unequal distribution of wealth, power, and other resources (Muntaner and Lynch, 1999). Finally, the integrative eco-social approach sees health as a dynamic product of the interaction between biological, social, economic, and environmental factors (Krieger, 2001). The different agents active in the field of health and healthcare adopt different conceptualizations of inequalities in health, or more commonly, adopt different combinations between the abovementioned ideal types.

3. The Israeli case

In Israel, inequalities in health status and among health indicators are grounded on class, ethnicity, nationality, religiousness, education, profession, and place of residence. For example, infant mortality is more than twice as highamong Muslims than among Jews, Diabetes is 3.6 times more prevalent among low income households and the chances of women with lower levels of education to die from a heart disease have risen in the past two decades from two times to five times, compared with more educated women (Epstein and Horev, 2007; Horev, 2008; Averbuch and Avni, 2014; Manor et al., 2011; Gross et al., 2007).

The tensions between universal citizenship as guaranteed by the Declaration of Independence and the definition of Israel as a Jewish state have produced and reproduce the unequal distribution of resources and power between Israeli Jews and Israeli Arabs. Thus, Israel has been characterized as an "ethnic democracy" (Smooha, 1990), "ethno-republicanism" (Peled, 1993) or an "ethnocracy" (Yiftachel, 2006).

The complex interaction between the limitations of the Israeli economy in the early 1950s, the adoption of a capitalist, state-led model of economic development privileging labor intensive industries and the euro-centrism that characterized the state's political leadership, resulted in a dual labor market, built along national and ethnic lines (Krampf, 2015; Neuman and Silber, 1996).

Class inequalities created by Israel's early model of economic development, significantly deepened since the transition to a neoliberal/post Fordist socio-economic model in the mid-1980s (see among others Filc and Ram, 2006; Gottwein, 2004; Ram, 2008).

Additionally, several scholars have depicted the ways in which ethnic categories and racialization within the Jewish ethnic group structure not only economic inequality, but also inequalities in political power and cultural dominance through the exclusion of "Mizrahi" Jews (Swirksi, 1981; Shenhav, 2003; Shohat, 1991).

Moreover, religion and religiousness also influence inequalities in health. Researchers have shown inequalities between secular and moderately religious groups and the very religious Jews or Muslims (Idler, 2014) in cardiovascular morbidity, general morbidity, and life expectancy (Friedlander et al., 1985; Kark et al., 1996). Finally, gender inequalities pervade the economic, cultural, political and juridical fields (Byniamin, 2006; Dahan-Kalev, 2001; Herzog, 2000; Yzreheli, 1999).

Inequalities in health due to the unequal distribution of resources along the abovementioned axes exist since the State's first days. However, the health establishment became aware of health