TAUB CENTER
FOR SOCIAL POLICY STUDIES IN ISRAEL

POLICY PAPER SERIES

THE PRIVATIZATION OF SOCIAL SERVICES IN ISRAEL: CONSIDERATIONS AND CONCERNS

Reuben Gronau

Policy Paper No. 2012.17

הפרטת השירותים החברתיים בישראל: תהיות וחששות

ראובן גרונאו

נייר מדיניות מס' 2012.17

***

All errors are the author's own. The views expressed herein are those of the authors and do not necessarily reflect the views of the Taub Center for Social Policy Studies in Israel.

Short sections of text, not to exceed two paragraphs, may be quoted without explicit permission provided that full credit is given to the source.

The Taub Center was established in 1982 under the leadership and vision of Herbert M. Singer, Henry Taub, and the American Jewish Joint Distribution Committee, the Center is funded by a permanent endowment created by the Henry and Marilyn Taub Foundation, the Herbert M. and Nell Singer Foundation, Jane and John Colman, the Kolker-Saxon-Hallock Family Foundation, the Milton A. and Roslyn Z. Wolf Family Foundation, and the American Jewish Joint Distribution Committee. For more information go to www.taubcenter.org.il or write to us at info@taubcenter.org.il.

The Privatization of Social Services in Israel:
Considerations and Concerns

Reuben Gronau*

Abstract

Privatization of social services has become one of the most controversial issues in socioeconomic discourse in Israel. This chapter examines whether the statistical data supports this concern. The picture of the scope of social services that have been transferred is unclear: in the past decade there has been no significant change in the transfers from the government to the local authorities, the non-profits and the business sector, or in the relative contribution of public bodies involved in the provision of services. The numbers do not point to a trend of replacing internal activities with purchasing of services – something that would indicate a sharp transition from self-operation to outsourcing. Finally, employment data do not indicate a decline in the number of social service employees as a share of the total number of jobs in the Israeli economy (on the contrary, their share has increased). On the other hand, household contribution to the funding of services (especially health services) has increased, affecting equality. Israel's government must make improvement in service quality an overarching objective of its policy. Consumers of social services are often unable to assess the quality of the services they receive, and are unable to select a service provider of their choice. Thus, the key to privatization of social services is the existence of appropriate quality control. Where this is not possible, services ought to remain government-run. Too often privatization fails to improve the quality of services and also distorts resource allocations.

* Prof. Reuben Gronau, Department of Economics, Hebrew University and Policy Fellow, Taub Center Economic Policy Program. This article is based on a lecture at the "Israel 2021 Conference," September 2011. I am grateful to Avi Ben-Bassat, Momi Dahan, and Soli Peleg for their helpful comments.

"Privatized welfare services are no worse than government services – but neither, I believe, are they better"
(an expert cited in *The Marker*, August 10, 2011).

In 1988, in one of the earliest conferences on privatization in Israel, one speaker began his presentation by saying, "Our topic today is the subject known as 'privatization' [English term used in the original, R.G.]. I myself will use the Hebrew term *hafratah*. True, the word may seem odd and sound awkward when spoken or heard, but such is the fate of many terms which we can no longer imagine how we had spoken before they were coined" (Golomb 1988). The speaker's prophecy was fulfilled and the word has not dropped from the public agenda. There is a special place in the discourse for the "privatization of social services": the transfer of social service activities from the public to the private sector. In the heat of such debates, however, there has not always been a distinction between the transfer of responsibility for the activities from public to private, to changes in the share of household contribution to the funding of such services or to the changes in the output component that is within the direct control of the public sector. In the heat of the debate, the term "privatization" has been used broadly to include also the transfer of services within the public sector, from the government to public non-profit organizations. In doing so, no distinction has been drawn between, for example, university tuition hikes, the private employment of public school nurses, and efforts to shift the provision of mental health services from the government to health funds – three very different issues with respect to the transfer of government-provided services to the private sector.

The debate over the privatization of social services in Israel has reverberated also in the economic literature. Fershtman (2007) has written extensively on the advantages and disadvantages of privatization. Dahan and Hazan (2010) examined changes in the scope of government spending on social services; and the implications of the privatization of specific social

services has been the focus of Paz-Fuchs and Kohavi (2010) and Paz-Fuchs and Leshem (2012).[1]

Privatization is defined as the transfer of economic activity from the public (or government) to the private sector. This shift may have varied aims (like, limiting government involvement in economic activity or the raising of funds), but, like Fershtman (2007), the present chapter will limit its discussion to privatization expressly intended to increase economic efficiency. Efficiency will be defined narrowly in terms of input-output ratio, where output is measured not only quantitatively but also in terms of service quality.

To outside observers, the intensity of the debate over the privatization of social services may appear to be disproportionate to actual information on the phenomenon. Not only is there a lack of data on changes in the cost of services following privatization, but there is only little information on the total scope of privatization in the Israeli economy. Given this dearth of data, the present chapter will try to explore the extent to which the privatization of social services has left its mark on various branches of activity and examine the lessons to be learned from the last 15 years' experience.

1. *Social Services: Background*

Observers of the debate over the privatization of social services in Israel cannot but notice the discrepancy between the fervor of the debate and the paucity of data on the actual trend. Despite the continual discussion of the subject, there is little agreement on its scope. Some of this disagreement results from varying definitions of privatization. Some limit the use of the term to refer to the transfer of responsibility from the government to the business sector, while others use the term to cover those activities where the responsibility remains with the government but the implementation is given

[1] The implications of government policy concerning social services are regularly discussed in the annual reports of the Taub Center for Social Policy Studies in Israel.

to private bodies. For others privatization includes the transfer of activity between different types of government agencies (e.g., from central government to local authorities); or changes in the mode of employment of public employees (e.g., from direct employment to employment via contractors).

These diverse definitions have implications for differences in measurement. There is no organized list of privatized social services, and unofficial lists that do exist do not include estimates of the financial scope of such services. A recent survey (Paz-Fuchs and Kohavi 2010) lists ten services and activities privatized or facing imminent privatization, including the transfer of mental health services to the health funds; the privatization of homes for those with mental retardation; the planned elimination of several public housing programs; the establishment of a private dental care health fund; and the launching of a private pension clearing system. Based entirely on secondary sources, the survey neglects to note the financial scope of each activity, but it seems that only the first three involve significant budgets.[2]

In the absence of financial data for privatized service the reliance must be on aggregate data – though here, again, the ambiguities noted make accurate data difficult to obtain. In 2010, total social spending by the government was NIS 189 billion, of which NIS 85 billion was allocated to transfer (social security) payments and NIS 104 billion for the purchase of other social services.[3] The main components in service consumption were education and health spending, which comprised 80 percent of services, whereas most transfers were intended for social insurance and welfare

---

[2] It is also worth noting that at present both dental health care and the management of retirement saving accounts are part of the business sector, and in this case it is not privatization but nationalization. A follow-up survey (Paz-Fuchs and Leshem 2012) discusses a dozen social service activities, but again, the authors provide no information about the financial scope of these activities.

[3] This is according to Central Bureau of Statistics data. According to Taub Center data which aggregate the government's current and development budgets, government spending on social services for 2010 was NIS 129 billion, of which NIS 53 billion went to social security and NIS 76 billion to direct services.

payments. Social services constituted over one half of government consumption and 60 percent of the government's current expenditure.

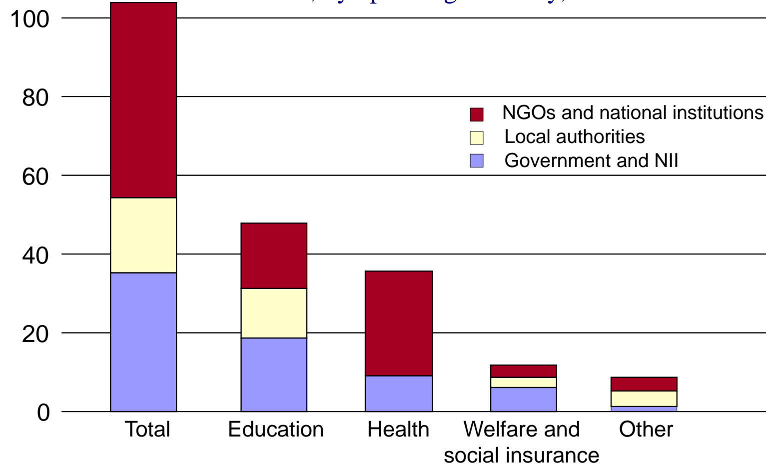
The central government, including the National Insurance Institute (NII), is the main source of funding for social services, but its role in direct service provision is limited. It provides directly only one-third of all services and over 40 percent of its spending on social services is in the form of transfers to other public agencies and organization (local authorities and non-profit organizations).

The major providers of social services in Israel are non-profit organizations, which jointly provide about one half of all public services, including about 75 percent of health services and over one-third of educational services (Figure 1). The central government's portion in the provision of education services is similar to that of non-profits but it provides only a quarter of health services; central government provides over 50 percent of social insurance and welfare services. Local authorities are the third social services provider, providing about 25 percent of all education services, but their share in total provision of the social services does not exceed one-fifth.

Figure 1

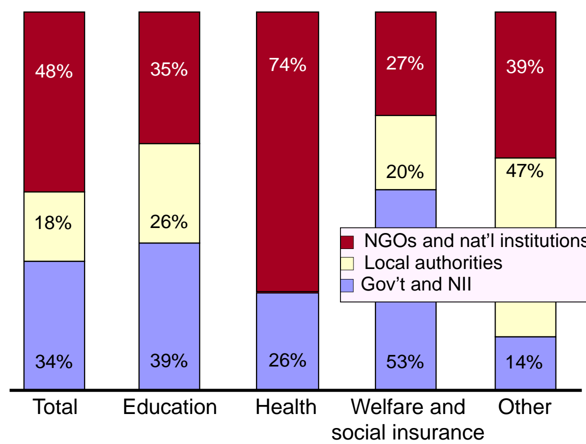
A. Social services consumption

NIS billion, by operating authority, 2010



B. Distribution of social services consumption

in percent, by operating authority, 2010



Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Some believe that the seeds of privatization were sown with the launching of Israel's anti-inflation policy in 1985. On the eve of the anti-inflationary stabilization program, government spending constituted 72 percent of Israel's GDP. Cutting the government share in GDP became a central component of the government's economic policy. This was to be achieved by lowering the deficit, curbing inflationary pressures, reducing debt as a share of the GDP, and shifting resources from the government to the private sector. In tandem with these budgetary changes, the government adopted a series of reforms in the monetary, capital, and foreign currency markets, eliminating its dominant role in these markets and increasing the private sector's access to capital markets.[4] These changes had immediate effect: inflation was curbed, growth was renewed, and the balance of payments and national debt were reduced.

There is no doubt that the government's 1985 reforms had a positive structural effect on Israel's economy. Moreover, during the first decade after the reforms, social services (as a share of the GDP) remained unscathed, with most cuts targeting defense and other government budgets (Ben David 2009, Figure 6).[5] From 1984 to 2001, social services as a share of government budgets more than doubled (an increase from 19 to 39 percent), and their share in GDP grew from 16 to 20 percent. An important component in this growth was the increase in spending on housing and immigration absorption in the wake of the massive immigration from the former Soviet Union. The immigration also increased demand for social services, due to the large percentage of unemployed and senior immigrants. No less important for the growth in the weight of social services was the government's change in priorities, which was reflected in increased spending on education, health, labor services, and welfare – from 11 to 19

[4] For a comprehensive survey of the implications of the stabilization policy on the composition of GDP and the labor and capital markets, see Ben-Bassat (2001) and Zeira and Strawczynski (2001).

[5] With budget cuts and national debt reductions, interest payments also constituted a smaller share of the government budget.

percent of the budget. At the same time, transfer (social security) payments rose from 6.5 to 16 percent of the budget.

This trend changed in 2001. The economic crisis of 2001-2003 increased pressures for budget cuts. These cuts were required following the decline in tax revenues and the rising national debt, although this time, they also had an ideological characteristic. Whereas the drastic budget cuts of 1985 were not accompanied by a change in tax policy, the 2001 budget cuts were combined with cuts to direct taxes on labor.[6] The new policy viewed direct tax cuts as an incentive to growth, and the reduction in government size, it was claimed, had a similar beneficial effect.

Figure 2 describes the growth of social services in 1995-2010. Over this period GDP per capita grew by more than a quarter and private consumption grew by almost one-third, whereas social services consumption grew by only 6 percent (over the period total services consumption grew by 46 percent). Thus, while the share in GDP of private consumption grew, the share of social services consumption fell from 15 to 13 percent.[7] The main components of social service consumption are education and health services; it is doubtful that the declining share of these services relative to income and private consumption conforms to consumers' preferences.[8]

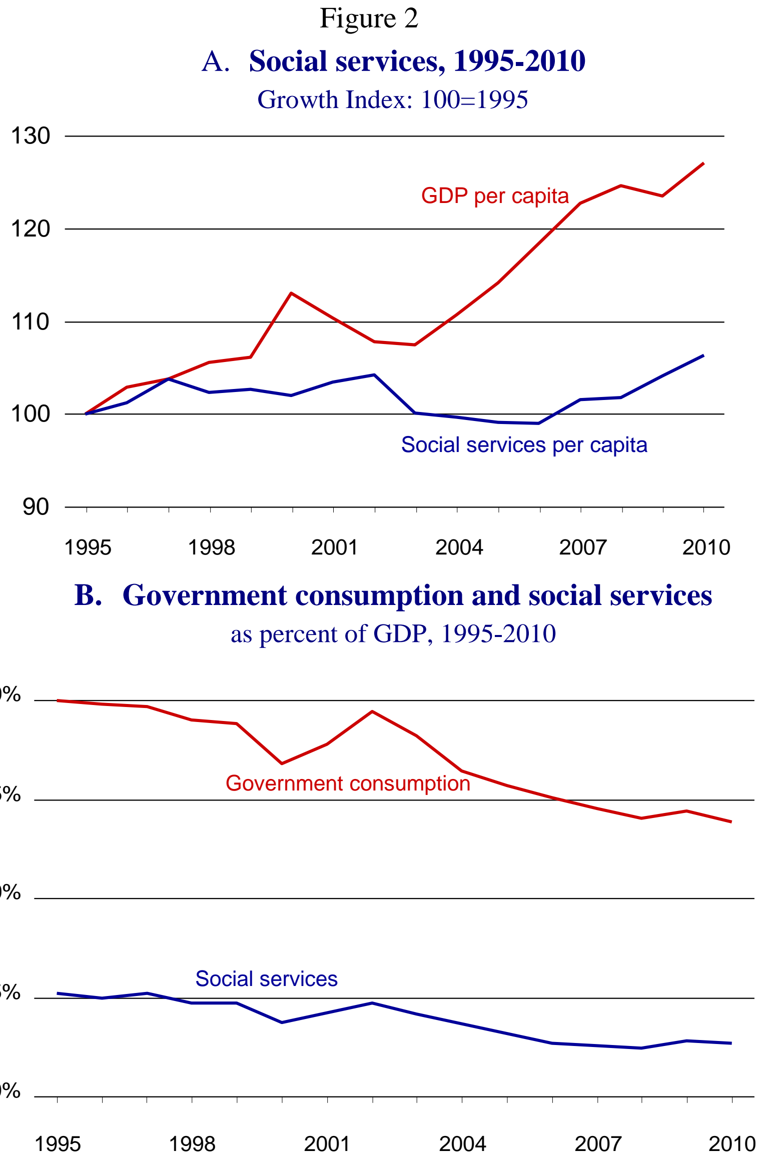
---

6 Reduced public spending as a share of the GDP in the years after 1985 enabled the government to lower the tax burden from 40 to 36 percent in the late 1980s. This rate remained in place until the early 2000s.

7 Government consumption as a share of the GDP fell from 30 to 24 percent. Since the concern here is the transfer of activity across sectors, the focus is on government consumption defined broadly to include local authorities and non-profits. These data differ from those of the Taub Center, which focuses on government budgets and therefore include transfer payments from government budgets but exclude local authority spending and independent spending by non-profits. Nevertheless, the trends seen in Figure 2 are similar to those reflected in Taub Center data.

8 Economists tend to believe that the income elasticity of demand for these services (like for savings) is greater than unitary, that is, consumption of these services as a share of one's income grows with income.

Figure 2



Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Dahan and Hazan (2010) examined whether these changes to social services followed consumers' preferences by comparing them with changes to services in OECD countries.[9] According to their analysis, government health expenditure as a share of GDP was lower in Israel than the OECD average, while education expenditure as a share of the GDP was higher – although this is reversed when demographic differences between Israel and OECD countries are taken into account. (In Israel a larger fraction of the population are young, explaining the higher spending on education, and a smaller fraction are elderly, explaining the lower spending on health.) Spending on social security and welfare services is by all measures lower in Israel than in most advanced countries.

2. *The Privatization of Social Services: A National Accounting Perspective*

Is it possible to learn about the scope of social services that "changed hands" from the national accounting data? Despite its importance in the public debate, the question is not clearly answered by the macroeconomic data. Privatization, such as it was, is not reflected in data on transfers from government budgets to other units and organizations, in the share of social services provided by the central government, or, finally, in the (net) share of government purchases from the business sector.

Figure 3 describes transfers to other units and organizations as a share of central government spending on social services between 1995 and 2010. Although the data are limited to transfers to other public sector organizations (local authorities and non-profits), they do not indicate an increase in the outsourcing of government services. Though transfers as a share of government spending on social services fell over this period from 44 to 40 percent, most of the decrease had occurred by 2001 with the share remaining

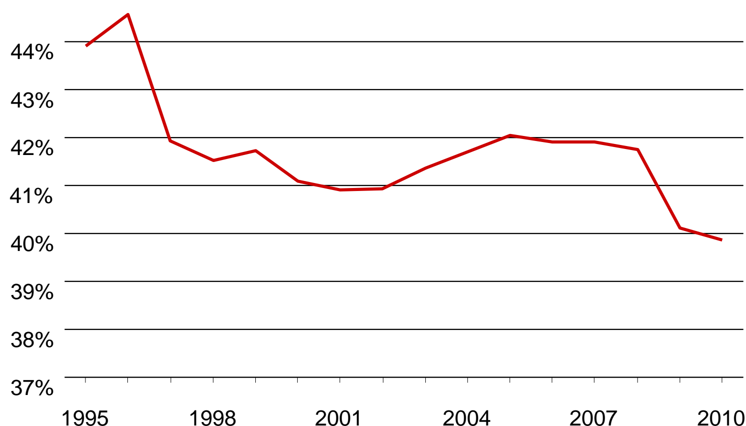
[9] Dahan and Hazan use OECD data and define total government spending broadly to include both capital account and current account spending. Their comparison period is 1994-2008.

constant since. (Transfers as a share of current account spending fell somewhat more steeply, from 47 to 41 percent, but, again, the decrease dates to the period before 2001.)

Figure 3

Transfers to other units* for social services expenditure

as percent of expenditure by government sector on social services, 1995-2010



* Local authorities and NGOs.

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

The changes in the composition of the agency that provide the public services does not indicate a clear trend either. As Figure 4 shows, according to the Central Bureau of Statistics data there have been no significant changes in the share of social services provided respectively by the central government, local authorities, and non-profit organizations. On the contrary, if there was a change, it was the central government's share growing at the expense of other providers: at the expense of non-profit organizations in health and education and at the expense of local authorities

in welfare spending (including social security and welfare, housing, and culture and religion). These findings must be qualified, however, in light of the shifting business orientation of non-profits over this period. Higher education saw an increase in the share of non-funded, tuition- and donation-based colleges, whereas health saw a growth in the business activity of the health funds.[10] This change is not reflected in the data, because the national accounting does not distinguish between business and non-business activities carried out by non-profits.

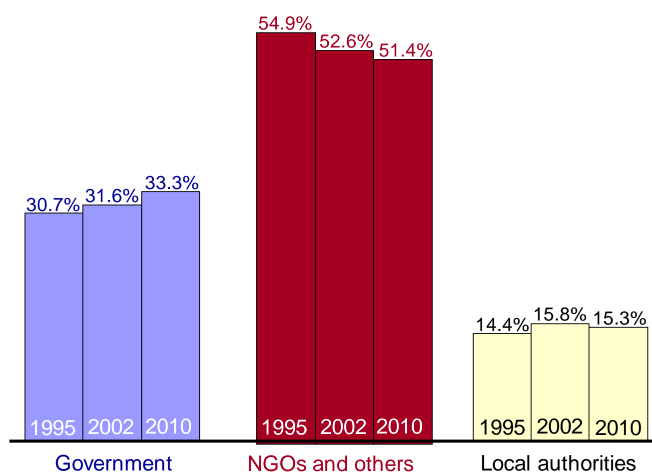
Another important aspect of the public discourse on privatization concerns the production of public services, more specifically the shift from direct government employment to employment via contractors. Since hundreds of thousands of workers are now employed by the government via contractors and manpower firms (estimates in the media range from 100,000 to 300,000 workers), one would expect a significant decrease in the component of labor compensation (salary expenditure) as a share of government consumption on social services and a concurrent increase in government purchasing of services as a share of total government consumption (due to increased purchases from manpower firms). This aspect of privatization is not reflected in national accounting data.

[10] One example that stands out is that of the Assuta network of hospitals and clinics, owned by the Maccabi Health Fund. Assuta Hospital was originally privately owned.

Figure 4

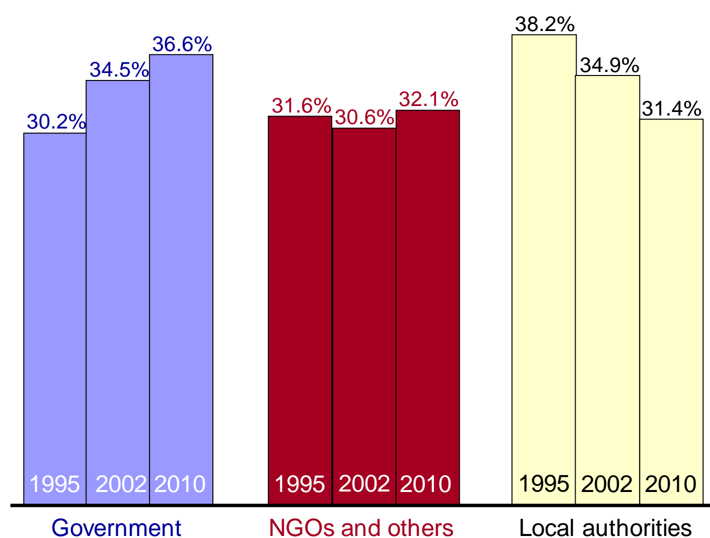
A. Relative weight of the operating authority – education and health

as percent of government sector consumption, 1995, 2002, 2010



B. Relative weight of the operating authority in consumption of social services

as percent of government sector consumption, 1995, 2002, 2010



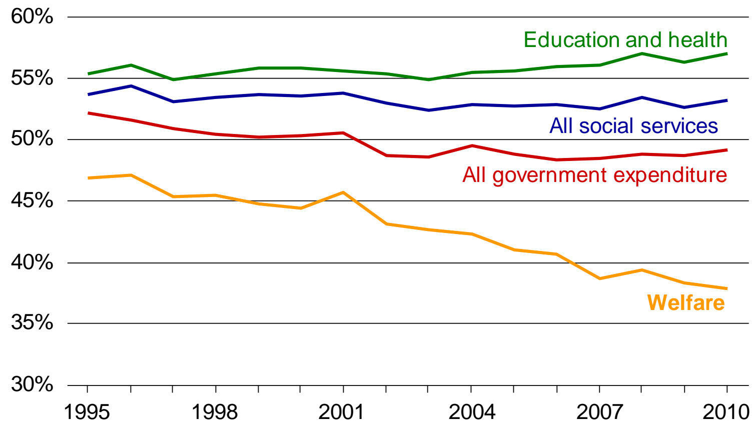
Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Figure 5 shows changes in the labor compensation component and (net) government purchases as a share of total government consumption over time. Although the data indicate a decrease in the share of labor compensation in government output and a certain rise in the share of purchases, the changes consist of no more than a few percent. The shift in inputs in the production of social service is even smaller and is concentrated entirely in welfare services (the share of wages in these services fell from 47 to 38 percent and the share of purchases rose from 42 to 51 percent).[11]

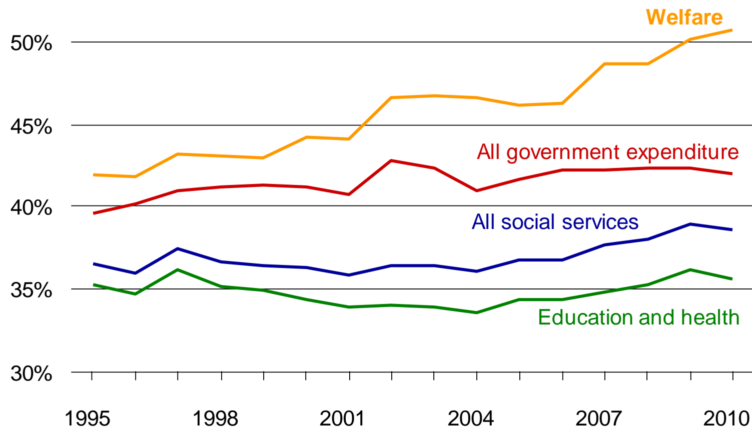
[11] Yuval Mazar at the Bank of Israel, using OECD data, examined (gross) purchases as a share of government spending and found some increase in the purchase share of the central and local authority government. However, he did not examine changes in purchase share in social service or the share of labor compensation in these services.

Figure 5

A. Component of labor compensation in government consumption of social services
1995-2010



B. Component of net purchase in government consumption of social services
1995-2010



Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

In order to examine whether recent changes in the provision of social services in Israel over the past few years match consumers' preferences, Dahan and Hazan (2010) used as a baseline for comparison consumers' preferences in other advanced countries. Another possible approach is to measure the Israeli public's willingness to contribute to the funding of such services. Admittedly, this approach is also not flawless since household funding of services is not always voluntary, and at times the provision of public services is conditional upon private participation (resulting in an "all-or-nothing" demand curve). Nevertheless, the data may shed light on the optimality, both qualitative and quantitative, of government services, especially as household contribution to services becomes increasingly a central issue in discussions of privatization.

Government consumption is measured in the national accounts as the sum of its expenditure on manpower and net purchases from the business sector.[12] This measure deducts from the gross government purchases the household's direct contribution (direct payments and donations, as distinct from the taxes levied to fund government activity). A more comprehensive measure of government's economic activity is given by gross consumption, including the household's direct participation (i.e., services "sold" to the public).

Figures 6A and 6B correspond to Figures 2A and 2B, respectively, replacing net with gross consumption per capita and household spending on these activities for the years 1995-2010. The figures illustrate the sharp growth in household spending on social services: household expenditure grew significantly faster than both GDP and private consumption (2.7 percent versus 1.6 and 1.8 percent, respectively). Though most of the growth occurred in the latter half of the 1990s, it continued throughout the 2000s as well. As Figure 6B shows, household contribution grew from 10 percent of gross consumption in 1995 to 14 percent in 2010.

[12] As noted, this measure differs from Ben-David's (2009), which is limited to expenditures funded from government budgets, and from the definition of Dahan and Hazan (2010) which includes transfer payments.

As Figure 6C shows, household contribution as a share of overall expenditure barely changed in education and welfare but nearly doubled in health. As a result of this, gross public services succeeded in maintaining their share of the GDP constant until 2002; but from then on, even the growth in the households' participation was unable to offset the decline in government expenditures and as a result the share of the social services in GDP declined from 16 to 15 percent.

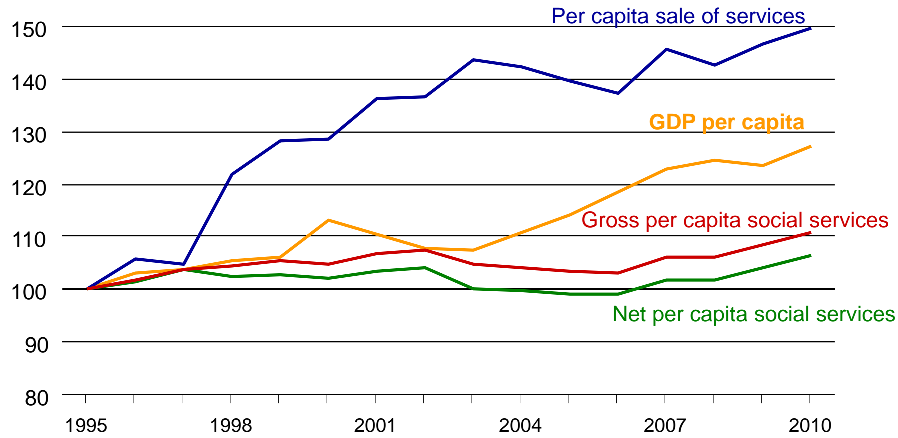
The main beneficiaries of the growth in household spending were non-profit organizations (Figure 6D).[13] Household contribution as a share of non-profit activity (gross consumption) grew over the period from 14 to 22 percent (mostly because of the increased participation of households in health services) and by 2010 was nearly identical for all social services (education, health and welfare). The growth in household spending (a real increase of 2.4 percent) served to compensate the sector for the decline in government financing, preserving its share in the total social services pie.

[13] This period saw a concurrent drop in household contribution to services provided by the central government and municipal authorities.

Figure 6

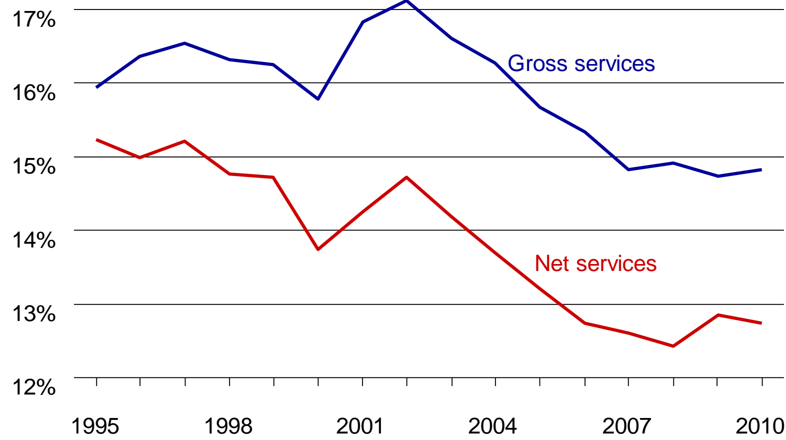
A. Per capita consumption of social services, gross and net, 1995-2010*

Index: 100=1995



B. Relative weight of consumption of social services in GDP, gross and net,

1995-2010*



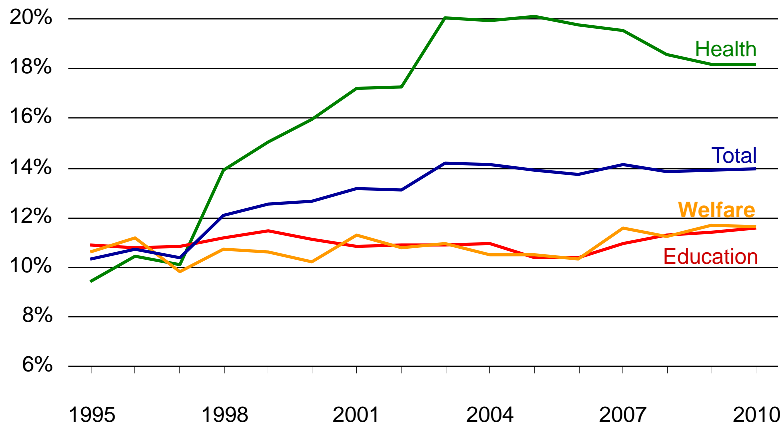
* Figure 2A and 2B respectively revised.

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Figure 6 (continued)

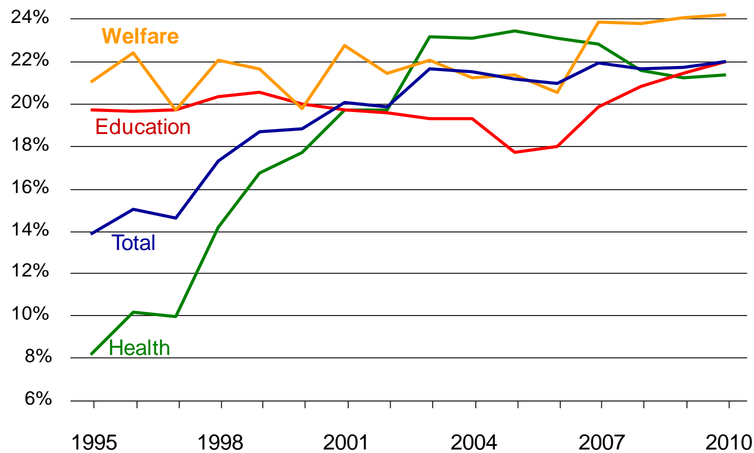
C. Public participation in gross consumption of government sector

by services, as percent of consumption, 1995-2010



D. Relative weight of public participation in gross NGO consumption

by sector, as percent of consumption, 1995-2010



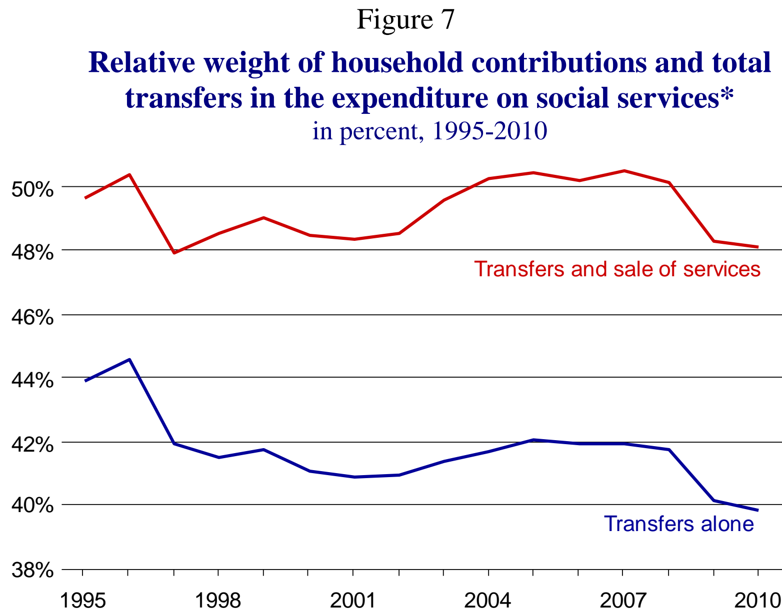
Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Similarly, as Figure 7 shows, direct household contributions offset the decline in government transfers so that the amount of total transfers of this branch did not change.

Figure 7

Relative weight of household contributions and total transfers in the expenditure on social services*

in percent, 1995-2010



* Figure 3 revised.

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Replacing net with gross consumption naturally increases the share of service purchases and decreases the share of labor inputs, yet it did not change the trends over time. The changes in the composition of input in the production of education and health services has been minor, while in welfare the data show a long-term trend of decreasing labor inputs and an increase in the share of service purchases.

3. The Privatization of Social Services: A Labor Market Perspective

In national accounting terms, the value of social services is determined by the value of the inputs devoted to their production. Since the main production input of social services is labor, salary expenses are an important determinant of their value. Similarly, labor quality is a major determinant of the quality of services. It is therefore important to examine how changes in the provision of social services have affected the labor market. To do so, the analysis is based on wage data provided by the National Insurance Institute which cover all social service employees, both public and private. The data show that despite the decline in government-provided social services as a share of GDP, share of the social services sector in total wage expenses has not changed (Figure 8A). Differences between NII and national accounting data may be due to different definitions, but may also indicate growing private involvement in the provision of social services.[14]

Given the decline of social services as a share of the GDP, one would expect employment data to reflect a similar trend. Surprisingly, however, according to NII data, not only did the percentage of social service jobs as a share of total jobs in the economy not fall, it grew from 26 to 30 percent (Figure 8B). This apparent inconsistency is explained by changes in the average wage of social service workers relative to that of private sector employees. Average wage has always been lower in social services than in the business sector, but whereas in the mid-1990s the difference was only 17 percent, in 2010 it was 26 percent. Education is the only sector where average wage kept pace with the rest of the economy; in health and welfare, however, relative wage fell by 13 percent. These trends are especially striking given the changes in the share of salaries in public administration. As Figures 8B and 8C show, the number of public administration positions fell both in absolute and relative terms while wages, already 25 percent

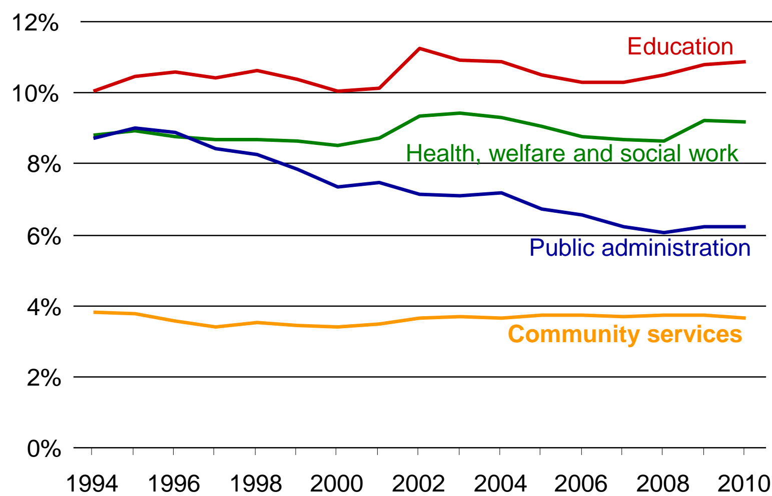
[14] Due to different definitions and a different data base there are discrepancies between the labor costs described in Figure 5A and 8A.

higher than business sector in 1995, soared over the next fifteen years until in 2010 they were nearly 50 percent higher.[15] It is worth noting, however, that most of the erosion in the relative pay of social service employees occurred in the second half of the 1990s, prior to the Ministry of Finance's adoption of the budgetary squeeze policy.

Figure 8

A. Social services component out of total wages in the economy

1995-2010



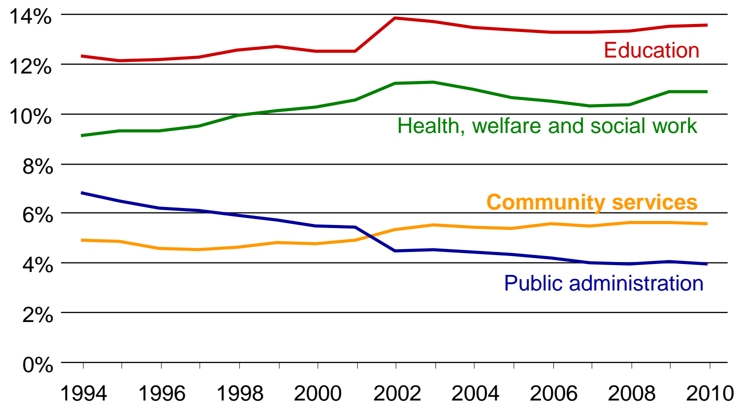
Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

[15] The decline in the number of job positions and the increase in relative pay may be explained by the outsourcing of low-skilled jobs.

Figure 8 (continued)

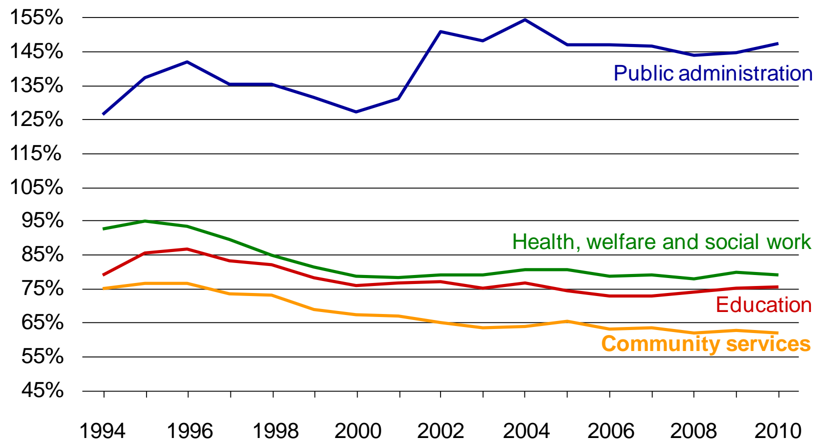
B. Percentage of job positions in social services

as percent of all employee positions, 1994-2010



C. Relative wages in the social services

as percent of the average wages in the business sector*, 1994-2010



* The percent difference between average wage in social services and the average wage in the business sector.

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.

Data: Central Bureau of Statistics.

Between 1995 and 2010 real wages increased by 20 percent in the business sector and by only 6 percent in social services. No detailed data are available about the manpower characteristics in each sector, but it is difficult to believe that some radical change in employee characteristics (in terms of education or seniority) explains this difference. It is equally hard to believe that the difference in pay is explained by differences in the bargaining power of public versus private employers or in the degree of unionization of workers in each sector. A third possible explanation sees the erosion in the relative pay of social service workers as a result of privatization – the transfer of activity from central government to the business sector.

Social service employees are employed in roughly equal numbers by the government directly, by government-owned corporations, by public non-profits, and by private non-profit organizations (25 percent each).[16] While the percentages are equal, relative wages are not. In each type of service (health, education, welfare) government employees enjoy significantly higher salaries than workers in the other sectors in each of the service areas (Figure 9), followed by the employees of public non-profits, corporations, private non-profits and others. Average pay in each sector and service area reflects different occupational mixes (e.g., physicians and nurses in health services) but also the different budgetary limitations facing each type of employer. Although the data should for this reason be approached with caution, they lend support to the claims that the shifting of services to private non-profits involves the employment of cheaper labor and that potential gains in efficiency may be lost due to the resultant decline in service quality.[17]

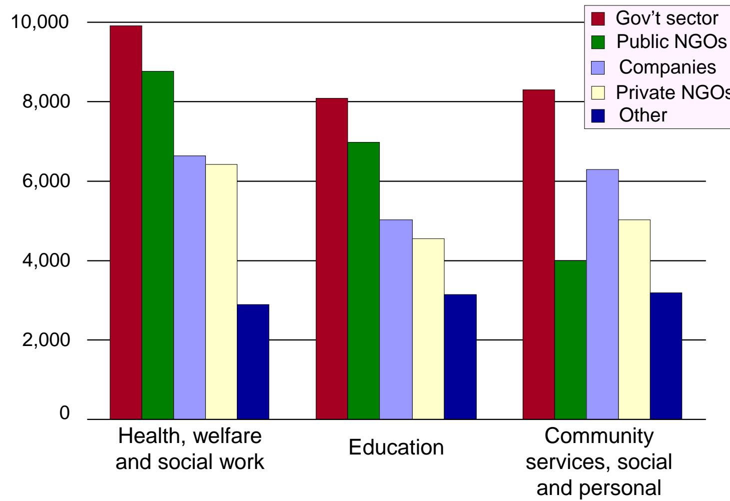
[16] The percentage varies, however, across different services. The government employs about 40 percent of all employees in education, whereas government-owned corporations (including hospitals) employ about one half of all health and welfare employees.

[17] Central Bureau of Statistics data about the distribution of jobs by sector go back only to 2007. Changes in distribution and relative pay over the entire 1995-2010 period can therefore not be examined. Changes since 2007 have not been significant.

Figure 9

Average wage in social services

by branch and sector, 2010



Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

4. The Privatization of Social Services: Some Concerns

As the previous section has shown, quantitative data do not give a clear picture of the extent of privatization in the social services. The data indicate a significant increase in household contribution, but this increase merely compensates the public providers (and primarily non-profits) for the decline in government transfers. The data do not indicate changes in the distribution of activity among public and private providers and among the various public providers (central government, local authorities, and non-profits). Although

a trend of higher (gross) purchases and lower labor inputs is discernible, it is limited to welfare services and not evident in education or health. National accounting data indicate a decline in services as a share of GDP, although this finding refers only to government-funded services; the trend nearly vanishes once household-funded services are taken into account.

The lack of clarity of these findings may have to do with measurement difficulties (e.g., of the kind that occurs when the same organization engages in both for-profit and not-for-profit activities). At times, however, it may appear that the transfer of social services from the public to the private sector is still largely a plan in the making rather than a widespread actual phenomenon.[18] Still, the data evokes an uncomfortable feeling with respect to the privatization process. The most worrying signs have to do with wage differences between categories of employers (the central government, government-owned corporations, private non-profits, public non-profits) and with the eroding average wage of social service workers relative to the average wage in the market.

The deterioration of regulation and the damage to service quality: A major aim of the privatization policy is attaining increased wage flexibility leading to improved service quality at lower cost. Wage differences between government employees and workers in other sectors indicate the potential for cheaper service but also the risk of damage to quality. The risk is underscored by the constant widening of wage differences between social service employees and other workers in the economy. The current 25 percent difference is bound to be reflected in differences in the quality of manpower. The low (and still declining) wage status of social service workers is bound to compromise the level of services and to further deprive the government of strong regulatory power, a precondition of any successful attempt at privatization.

[18] A prominent example is the transfer of mental health services from the government to health funds, a plan which has been in discussion over the last decade and a half, but has not yet reached the implementation stage.

Government services have never been known for strong supervision. Numerous public commissions have criticized the Ministry of Education's supervisory efforts, while in the Ministry of Health regulatory powers, ineffectual from inception, were transferred to a large extent to the supervised body, namely the Israeli Medical Association. Enforcement of labor laws (primarily the minimum wage law) has become a joke[19] and even where supervision and enforcement are effective they lack transparency, preventing consumers from making informed choices.[20] In the absence of independent regulators, supervision was left in the hands of the providers: school principals supervise their faculty's teaching quality; hospital administrators supervise the medical staff's service quality, etc. The supervisors grew out of the ranks of the operators in the field. Curtailing the size of government operation due to outsourcing may in turn lead to lower supervisory capacities by depleting the pool of professional personnel from which supervisors can be drawn.[21] Regulation used to be the weak spot of social services even in the days when supervisors have administrative authority over the regulated parties. One can expect the balance of power between regulators and the regulated to tilt even further when the latter are profit-driven, and where serious information gaps exist between supervisors and those they supervise.[22]

In the absence of external regulation, consumers often act as regulators-supreme, especially when they have a choice between several providers. Consumers of welfare services (and at times, consumers of health services)

---

[19] One recommendation of the OECD's May 2010 labor market survey has been to enhance labor law regulation and enforcement nine-fold.

[20] Thus, for example, the government and the local authorities have not published until quite recently the school and hospital quality rankings.

[21] The chances of recruiting private sector executives to serve as public sector supervisors have been proven to be slim.

[22] An extreme case is when the government, aware of its regulatory limitations, transfers supervisory powers to the business sector, as in the case of pre-academic programs in Israel (Paz-Fuchs and Kohavi 2010, Chapter 27). Similar problems have characterized welfare-to-work programs (the *Orot le-Taasuka* program).

are, however, unable to play this role – certainly not when they are children in day care for mentally challenged children or mental health patients. When the consumers are minors it may be hoped that the parents will serve as supervisors, although such supervision is bound to weaken as the child grows older.[23] Similar concerns apply to the mental health system, where the government has attempted to shift supervisory powers to health funds despite examples of ongoing treatment failures at private hospitals.[24]

The stated goal of the privatization of public services has been to increase efficiency while maintaining output (and perhaps improving quality). The underlying assumption of this model is that the private sector's advantages in terms of employment and wage flexibility and its ability to reward employees based on quality will compensate for the conflicting goals of the government and private providers. This assumption overlooks the effects of budget cuts which also affected the providers in the business sector and the tender system used to select the private providers. The obligatory mechanism is the tender system and the deciding criterion in choosing the provider, especially in a time of budget cuts, is often price.[25]

---

[23] Similar worries about regulation over institutions for the mentally challenged were raised in the 2005, 2007, and 2009 State Comptroller Reports.

[24] Unlike other illnesses, mental illnesses are usually long-lasting, requiring long-term and recurring hospitalization. As a result, although medical treatment represents only a small fraction of the expenses, hospitalization costs for each patient are significant. Hospitals and health funds have been trying to gain a foothold in mental health services for years as a way to increase their own resources. In the absence of effective supervision by patients and their families there is reason to fear that resources allocated to treatment might be reallocated to other purposes. Paz-Fuchs and Kohavi (2010, Chapter 10 and 13) discuss the consequences of transferring mental health services from government-run clinics to health funds and hospitals, as well as the transfer of methadone treatment centers from the public to the private sector.

[25] Price is also an easy parameter to measure as opposed to other parameters of service quality.

The result in some cases is that in order to meet the price in their tender the quality of services must be compromised.[26]

In a recent statement, the Head of the Budget Division at the Ministry of Finance articulated the ministry's position on the privatization of services as follows: "There must be a distinction between the privatization of provision and the privatization of responsibility. You cannot convince me that ongoing management of welfare services – for example, homes for mentally challenged children – must be provided at government facilities by government workers, including the security guards and the cleaning staff."[27] While it is true that workers at such facilities ("including the security guards and the cleaning staff") need not be government employees, the budgetary limitations faced by service providers make it highly likely that not only the security guards and the cleaning staff but also the care workers at such institutions will be of lower quality and provide lower-quality service than their government-employed equivalents.[28]

The undermining of equality: Reduced government involvement in the provision of social services has shifted a growing burden onto households. Household spending on social services has increased, sometimes because service is now conditional upon payment, sometimes in order to avoid less or lower-quality service. Growing household spending has, in certain cases, prevented a loss of quality although it has come at the expense of the principle of social equality. These trends are reflected in the changing distribution of household expenses over the period in question.

[26] Infrastructure tenders often try to improve their terms by renegotiating the concession; this is less common in social services, where numerous firms typically compete for each tender.

[27] *The Marker*, August 21, 2011.

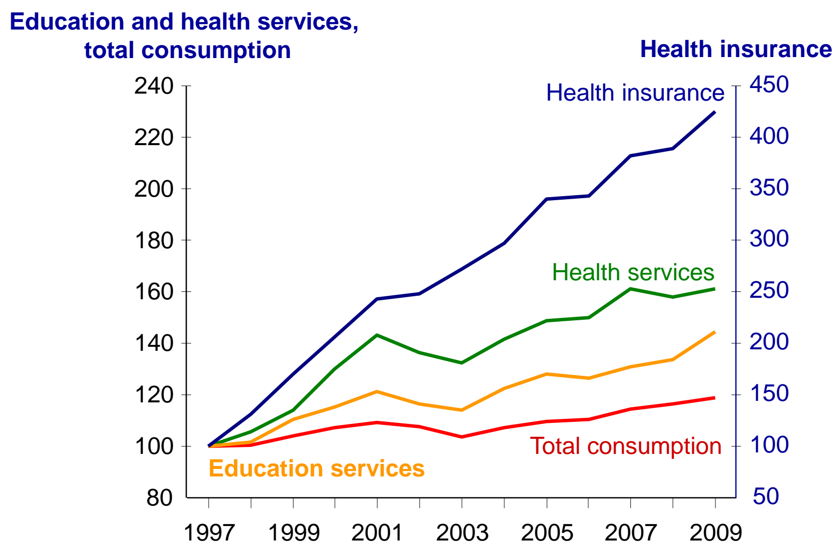
[28] A vivid example for the failures of the tender system is provided by recent developments in public transportation. In order to meet the terms of their tenders, operators had to hire drivers at low pay. To improve the resulting poor service quality the government had to revise its tenders by adding drivers' salaries to the terms.

Between 1997 and 2009 household consumption increased by 20 percent while household spending on education increased by 40 percent and household health spending by 60 percent (Figure 10). In other words, education expenses as a share of overall consumption grew from 4.3 to 5.2 percent, while health expenses as share of overall consumption grew from 3.8 to 5.1 percent. Most of the growth in household health expenses was due to private health insurance payments.

Figure 10

Increase in household expenditure on education and health services

Index: 100=1997, 1997-2009



Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

The declining quality of public health services which is reflected in longer waiting lists and worsening hospital conditions has led to an increase in private insurance, to expand coverage and sidestep the limits on choice imposed by public insurers (especially for surgery). Between 1997 and 2009, spending on private health insurance increased more than four-fold and in 2009, its share in total private health spending doubled to 30 percent of expenditure.[29]

Private spending on education and health is dependent on household income and is thus not equally distributed in the population. As Figure 11 shows, average household spending on education in the uppermost decile is eight times the average in the second decile and 3.7 times the average in the fifth decile.[30] Average household spending on health in the uppermost decile is 4.4 times the average in the second decile for health insurance and 2.8 times for other health services.

Despite these similarities, private spending on health and on education differs in one crucial respect. Whereas the share of private spending on education in total household consumption grows with total consumption, the share of private spending on health in household consumption falls as total consumption grows.[31] As Figure 12 shows, private spending on education is 4 percent of household consumption in the second decile, 5.5 percent in the fifth decile, and 9 percent in the upper decile. By contrast, private spending on other health services is 6 percent of household consumption in the second decile and only 4.5 percent in the upper decile.

---

[29] According to a Ministry of Health report on supplementary insurance (2011), supplementary insurance is purchased by about 75 percent of the insured population. Other private health expenses (including spending on dental care) grew between 1997 and 2009 at a rate similar to that of other household expenses.

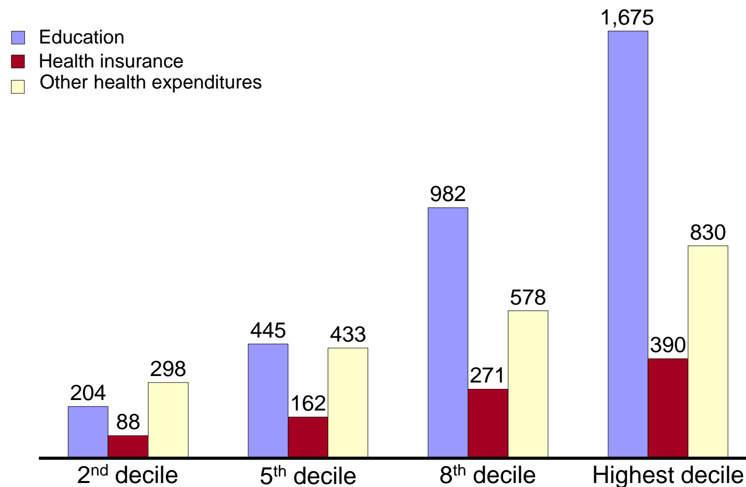
[30] Some of the difference is explained by differences in family size, since family size is positively correlated with income.

[31] Monetary consumption is considered a more reliable indicator of consumers' income over time.

Figure 11

Household expenditure on education and health services

NIS, by gross income decile, 2009



Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

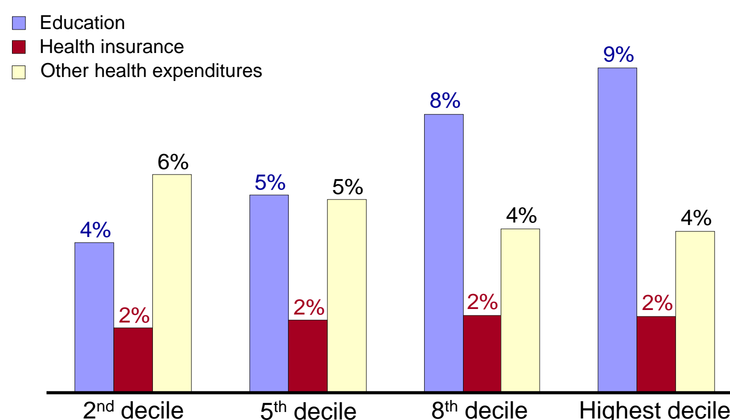
Private spending on education and health may be seen as a tax imposed on private consumers. In these terms, cutbacks in government-provided education services impose a progressive tax on households while cutbacks in government-provided health services serve as a regressive tax on households.

Figure 12 shows that spending on health insurance is not sensitive to income levels. If the income elasticity of health insurance is indeed unitary (that is, if consumers want to spend a fixed share of their income on insurance), it follows that the growth in insurance spending in recent years has been the result not of growing households incomes but of the deteriorating quality of public health services. In any case, whether progressive or regressive, the shifting to households of a growing share of

spending on social services distances society from principles of social equality which ought to guide government action.

Figure 12

Household expenditure on education and health services
as percent of all expenditures, by gross income decile, 2009



Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Differences in the quality of services enjoyed by consumers at different income levels are further increased by the positive correlation between household income and local authority resources. Unequally distributed across different communities, local authority resources amplify inequality in social service spending. Education services provide a striking example. As the primary instrument for implementing the government's (pre-academic) education policy, local authorities fund approximately 30 percent of regular education budgets while the central government funds about 60 percent.[32] However, as has been shown by Ben-Bassat and Dahan (2009, Figure 7),

[32] Central Bureau of Statistics, *Statistical Abstract of Israel*, No. 61 (2010), Table 10.14.

there is a significant gap of approximately 60 percent between spending per pupil in the lowest three socioeconomic clusters (mostly Arab localities) and in the upper seven clusters. While in the upper seven clusters spending per pupil ranged in 2006 from NIS 6,400 to NIS 10,300, in the lowest three clusters spending per pupil was only NIS 4,000 to NIS 5,200. While government funding for the two groups differed only slightly (6 percent), local funding was more than four times higher in the first group than in the second, and parent contributions were more than six times higher. Parent contributions were only 4 percent of total spending in the lower group, and reached roughly 20 percent in the higher group. Comprehensive data on health spending per patient by locality is unavailable, but partial evidence points to similar differences between localities in the center of the country and the periphery.

Effect on resource allocation: Household contributions to the funding of social services have implications beyond their effect on social equality, and affect the macroeconomic efficiency of the industry. To meet households' expectations for improved quality services, service providers must increase inputs. This is reflected in the form of increased capital inputs (improved facilities, computerization and medical equipment) and more personnel. Due to the importance of personnel quality as a determinant of service quality, providers must overcome public-sector labor arrangements in order to reward their employees for effort and improved service. This creates a dual system where some activity conforms to free-market rules while the majority must conform to the old rules. In some cases the split is between different providers, while in other cases (most prominently in hospitals) the two systems exist side by side, where the same provider plays according to two different sets of rules. Flexible employment and performance-based incentives may contribute to efficiency when they become system-wide. Often, however, adamant opposition by labor unions leads to the opposite result, with higher pay in the private sector leading to system-wide pay raises without change to the terms of employment, making services more costly, and sometimes the dual compensation system results in the deterioration of quality in the public sector. This occurs when private

providers succeed in luring away outstanding public employees, or when employees divide their time between public and private employers. In other cases, workers themselves contribute to the decline in service quality in an attempt to enjoy the private sector's higher pay. The emergence and growth of private hospitals and colleges is an instance of the first type of misallocation,[33] and the allegation that physicians have contributed to longer waiting lists illustrates the second.[34] The equilibrium where two types of incentive systems exist side by side in the same sector is unstable, and increases the likelihood that it will deepen the differences in service quality.

5. Conclusions and Lessons

The policy of the privatization of social services is a relatively new instrument in the arsenal of government economic policy; but despite its recent appearance it has quickly become one of the most controversial issues in socioeconomic discourse. Privatization involves the transfer of activity from the government to the business sector. Whereas the privatization of infrastructure services has involved the shifting of both provision and overall responsibility to the business sector, the privatization of social services has involved provision alone, with the government retaining overall responsibility, and private firms and organizations serving merely as contractors. The debate regarding who should provide such service sometimes reflects conflicting worldviews about the role of government

---

[33] Physicians dividing their time between public hospitals (their primary employers) and private hospitals have, in some cases, been the cause of medical malpractice suits. University faculty moonlighting in private colleges have, similarly, a damaging effect on the teaching quality at universities.

[34] A slightly different example is provided by the establishment of private law schools. Israel's private law colleges were established because of the strict admission criteria at university-affiliated law schools. However, the same professors who had set those criteria, purportedly to maintain high teaching and academic standards, were those who then flocked to teach at private schools at higher pay.

versus the free-market. The economist in general ignores such concerns and considers the criterion of efficiency alone – assessing whether the transfer of services is likely to reduce their cost or improve their quality.

Economic considerations in favor of leaving responsibility for the provision of social services in the hands of the government have to do with the difference between these services' direct and immediate benefit to individuals and their overall social benefit. Since the former is often only a small component of the latter, consumers' choices may lead to the underproduction of social services. Moreover, the allocation of social services, especially in the form of social security transfer payments, reflects the public's preference for equality. Since equality, like security, is a public good, the government should be responsible for its financing.

Demand for social services depends on the population's demographics, education level and income. In the absence of negotiability, however, the socially and economically desirable level of social services is hard to determine. As for supply, the production costs of social services, as those of private services, depend on the quality and the labor costs of the services in question. The quality of workers providing the service and the degree of effort invested in their provision determines to a large extent the quality of the service itself. A system of quality-rewarding incentives is thus a prerequisite of high-quality services. The absence of such a system in the government sector is the weak point in their provision by the government.

In addition, variance in quality requires a credible system of regulation. Whereas in the private sector consumers exercise ultimate supervisory powers, determining the desirable quality of service and selecting a provider from among those available, in social services, particularly in welfare, consumers often find it difficult to determine the desirable quality of service and face limited choices. Consumers' inability to enforce quality standards calls for strict and skilled external regulation. The catch is that public administrators have largely failed to develop independent supervisory agencies and adequate regulatory methods to ensure appropriate quality levels over time: such is the case in education, health and welfare. In the

absence of adequate supervision, quality levels are left to be determined at the implementation level.

In the private sector, the implementation level is administratively subordinate to decision makers. The supply of social services in Israel is characterized by decentralized service supply channels, with the central government joined by local authorities, the General Federation of Workers (the *Histadrut*) and local non-profits. Roughly one-half of service consumption by the government sector is provided by non-profits, one-fifth by local authorities, and only one-third directly by the central government. Non-profits and local authorities enjoy a great deal of autonomy, and in the absence of administrative oversight the central government often meets difficulties in realizing its goals. It was against this backdrop that an initiative was launched in the 2000s to expand the circle of service providers to include the business sector.

Despite the lively public debate on privatization in the last decade, whose echoes were heard in the social protests of the summer of 2011, information is limited in scope and often contradictory. More specifically, there is almost no comparative research on the cost and quality of services before and after privatization.[35]

Over the last 15 years the government sector's social service consumption grew more slowly than did both GDP and private consumption. Based on experience from other advanced economies, and assuming that health and education services are no less sensitive to changes in income than other private consumer products this trend did not conform to consumer preferences and was reflected in a growing share of services funded directly by households. The precise extent to which economic activity shifted between sectors is less clear.

Though the money transfers from the central government to other public sectors declined over the period in question, most of the decrease occurred in the late 1990s and not in the last decade. The decrease was offset by

[35] One of the only initiatives to withstand rigorous assessment was the *Orot le-Taasuka* welfare-to-work program, eliminated despite its success in returning transfer allowance recipients to employment.

direct household spending. The relative importance of the various public providers of social services (central government, local, non-profits) did not change either. Neither is there an indication that government-provided social services involved the substitution of labor inputs with external purchases on a scale indicating a significant shift from self-operations to outsourcing. Moreover, employment data do not indicate a decline in the share of employees in this industry in total employment. The share of positions in the social services not only didn't decline, it actually experienced a rise.

The most striking employment-related trend was the relative decline in the wage of social service workers, though, again, most of the decline occurred in the late 1990s, before the full adoption of the privatization policy. Whether this change is the result of eroded wages (though most social service workers are unionized) or of a shift from "costly" government employees to "cheap" non-government labor, it is hard to believe that such extreme changes in relative wage do not lead to changes in employee quality and in the workers' effort.

National accounting and employment data raise doubts about the precise extent of the privatization of social services: has privatization been limited in scope, a strategy yet to be fully realized, or have statistics yet to catch up with institutional and organizational changes, therefore not giving a full picture regarding the extent of privatization? Either way, the falling relative wage of employees in the social service industry gives cause for concern that budget cuts may damage the quality of services even more than they affect their scope. This worry is reinforced by the character of tenders for social service concessions, many of which stress the cost criterion above all other requirements, forcing the successful operator to use cheap labor, with negative consequences for quality. Since in many of the services facing privatization consumers cannot supervise for quality (notable examples are health services and shelters for those with mental handicaps), supervision must be carried out by external regulators; and since the transfer of services to non-government providers has also depleted government-employed

supervision and regulation personnel, supervision itself is often outsourced to private companies.

The erosion of the quality of social services is reflected in the composition of household expenditures. Spending on education and health rose since the late 1990s at a faster rate than other consumption components. Especially striking is the exceptional increase in household spending on supplementary health insurance. More than any other type of expense, this expenditure reflects the public's disappointment with the quality of health services offered universally free of direct charge. Since private household spending is differential, depending on the resources available to each household, its increase contradicts with principles of social equality that the government strives to maintain. This expenditure could be regarded as a tax that the government imposes on its citizens by allowing social services to deteriorate. Such "taxation" is progressive in the case of education but regressive in the case of health expenditures. The resulting differences in spending between socioeconomically divergent communities are a further cause of inequality in Israeli society.

The increase in household contribution to the funding of social services has yet another dimension. The increase in private spending has led to the growth of a business sector alongside the public sector, except that each is playing by different rules with a fragile balance between the two. Flexible employment and compensation rules allow the business sector to recruit the best public sector workers. In many other cases, workers divide their time and loyalty between private and public employers, with the quality of public services compromised as a result. At times the same provider hosts both "public" and "private" services at differential prices, encouraging consumers to switch from the former to the latter. In each of these cases, the result is both increased inequality and decreased efficiency.

What are the lessons to be learned from the trends that characterized the social services in the past decade and their privatization?

- Efficiency has two aspects: cost reduction producing a given output or, alternatively, an increase in the output (or quality) at a given cost. The primary lesson from recent trends is that any shifting of activity from the government to other organizations, public or private, ought to involve an improvement in service quality. This should be the objective of privatization and the criterion governing the order of social services to be privatized. This policy should be separated altogether from a policy whose goal is to reduce the social services expenses. International comparisons show that the component of spending on education and welfare (standardized to demographics and income inequality) as a share of GDP is lower in Israel than the OECD average. Restoring education and welfare budgets should be accompanied by efforts to improve service quality.[36] Where the transfer of services from government to non-government providers involves a tender, the successful contractor must be chosen on the basis of service quality. Such criteria are harder to define than pricing criteria; but without clear, measurable, and preference-ordered quality criteria, tenders based on pricing criteria are bound to compromise service quality.
- Making service quality the overarching goal of government policy in the social services requires strict supervision of the level of services. The most efficient regulator is the consumer. To enable consumers to play this role, privatization must be accompanied by an expansion of consumer choice among different providers.[37] Needless to say, social services should not be controlled by private monopolies, as both

[36] The reform efforts accompanying recent pay agreements in the teaching and health systems are a step in the right direction.

[37] This principle is put into practice in Israel's National Health Insurance Law which increases competition by allowing consumers to choose among several health funds. In a recent article, Lavy (2010) shows that greater school choice in Tel-Aviv's high school system has decreased drop-out rates and improved pupil achievement.

efficiency and choice require competition. Where consumers lack choice and mobility (as is often the case in social services), quality standards must be enforced with special stringency. Just as Israel's military would not consider privatizing the production of its tanks without the strictest quality control mechanisms in place, so should no social service be privatized without the appropriate quality control. Effective quality control is a precondition of any transfer of services from government to other providers. Where adequate supervision is unavailable and consumers themselves cannot control for quality, service provision should remain with the government.

- Increasing budgets for social services does not exempt the government from reassessing its priorities concerning the provision and funding of such services. The distinction between social services and private ones is not an absolute one; it is dependent on the social return of the service relative to the private return and to the contribution of the service to the public feelings of social equality. Dental care, for example, is not perceived as a social service, and has been an exception to the medical services.[38] Similarly, government financing of early childhood education has been limited and the government has been reluctant to accept responsibility for it despite recent legislation. Many other social services have long been directly provided by non-government public agencies, with government involvement limited to funding. Yet other services, such as higher education, are financed partly by the government and partly by private payments and donations.

A central consideration in the rate of financial participation of the government in these services, alongside private participation, is the gap between private return in education and social return, and the difference in the private and social rates of discount. In this respect, current subsidies to higher education at the expense of early childhood education reflect a failure in priorities. Return on educational investments is highest in the formative

[38] Recently the Ministry of Health extended public health care to dental care for children below the age of 14 (currently provided by the health funds).

stage of early childhood, whereas the financial burden on parents of young children (who are themselves often younger and therefore less affluent) is often greater than in later stages of parenthood. In higher education, by contrast, especially in the more popular fields of study (law, business, the social sciences), differences between private returns (in terms of increased earning power) and social returns on investment are minimal (some of these subjects are, in fact, characterized by oversupply); investment risks are relatively small; and the ability of many parents to assist their children financially is greater.[39] Ironically, the same students who oppose university tuition hikes are the same ones who in a matter of a few years will bear the much greater burden of childcare expenses.

In the past, higher consumer contributions to the funding of services were intended to offset the decline in government funding, and to prevent the erosion of quality. Naturally, this trend has been perceived as increasing indirect "taxation" and as detrimental to equality. To win public support for this increased direct burden on households, such steps must be accompanied by commensurate increases in government funding.[40] Increasing consumer funding would increase their bargaining power regarding service quality and offer providers competitive incentives. Improving the quality of government-provided social services would curb the emergence of private organizations (such as private hospitals and colleges) which threaten the public system. Differential allocation of government budgets may compensate for the inequality caused by increased household contributions.[41]

---

[39] In the absence of a private credit market, students who cannot fund their studies may be offered publicly subsidized credit.

[40] Supplementing university tuition hikes with increased government funding was a central recommendation of the Shochat Committee on Reform in Higher Education (2007). The recommendation was rejected, however, by student unions. The tuition hike recommended by the Shochat Committee was NIS 5,000 annually, or NIS 15,000 for a full three-year baccalaureate degree. By comparison, unsubsidized childcare centers often charge NIS 25,000 a year.

[41] Academic scholarships may compensate for increased university tuition; "balancing grants" may compensate for unequal resource distribution at the

The sooner the government internalizes these principles, the sooner "privatization" will cease to be a pejorative term. The resultant growth in the variety of service providers may, in fact, prove to be a boon for Israeli society.

---

municipal level. The government's most recent pay agreement with the Israeli Medical Association illustrates how the government can compensate for differences in the quality of health services in regions of varying socioeconomic status.

Appendices

Appendix Table 1. **Social services consumption, by operating authority**

in NIS billion, 2010

	Total		**Education**		**Health**		**Welfare**	
	Gross	Net	Gross	Net	Gross	Net	Gross	Net
Gov't and NII*	36.46	35.27	18.94	18.66	9.80	9.10	7.72	7.51
Local authorities	20.85	19.14	13.86	12.57	0.15	0.13	6.84	6.45
NGOs and national institutions	63.32	49.39	21.25	16.58	33.36	26.21	8.71	6.60
Total	**120.63**	**103.80**	**54.05**	**47.81**	**43.31**	**5.44**	**23.26**	**20.56**

in percent

	Total		**Education**		**Health**		**Welfare**	
	Gross	Net	Gross	Net	Gross	Net	Gross	Net
Gov't and NII*	30%	34%	35%	39%	23%	26%	33%	37%
Local authorities	17%	18%	26%	26%	0%	0%	29%	31%
NGOs and national institutions	52%	48%	39%	35%	77%	74%	37%	32%

* National Insurance Institute.

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 2. **Index of social services consumption of the government sector and its share of GDP**

Index: 100=1995, 1995-2010

	GDP per capita	Social services per capita-net	Social services per capita-gross	Consumer participation in social service expenditure	Service weight net in GDP	Service weight gross in GDP
1995	100	100	100	100	15.2%	15.9%
1996	103	101	102	106	15.0%	16.4%
1997	104	104	104	105	15.2%	16.5%
1998	106	102	104	122	14.8%	16.3%
1999	106	103	105	128	14.7%	16.3%
2000	113	102	105	128	13.7%	15.8%
2001	110	103	107	136	14.3%	16.8%
2002	108	104	108	137	14.7%	17.1%
2003	108	100	105	144	14.2%	16.6%
2004	111	100	104	142	13.7%	16.3%
2005	114	99	103	139	13.2%	15.7%
2006	118	99	103	137	12.7%	15.3%
2007	123	102	106	145	12.6%	14.8%
2008	125	102	106	143	12.4%	14.9%
2009	124	104	109	147	12.8%	14.7%
2010	127	106	111	150	12.7%	14.8%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 3. **Rate of transfers to other units and consumer participation in government sector expenditure for social services, 1995-2010**

as percent of total expenditure

	As percent of transfers out of current expenditure	As percent of transfers out of total expenditure	Percent of consumer participation out of total expenditure	As percent of transfers and consumer participation of total expenditure
1995	47%	44%	6%	50%
1996	48%	45%	6%	50%
1997	44%	42%	6%	48%
1998	43%	42%	7%	49%
1999	44%	42%	7%	49%
2000	43%	41%	7%	48%
2001	42%	41%	7%	48%
2002	42%	41%	8%	48%
2003	43%	41%	8%	50%
2004	43%	42%	9%	50%
2005	44%	42%	8%	50%
2006	43%	42%	8%	50%
2007	43%	42%	9%	50%
2008	43%	42%	8%	50%
2009	42%	40%	8%	48%
2010	42%	40%	8%	48%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 4. **Distribution of social services consumption by operating authority, 1995-2010**

	Net			Gross		
	Gov't	Local authorities	NGOs / others	Gov't	Local authorities	NGOs / others
1. Total						
1995	31%	19%	51%	29%	19%	53%
1996	31%	19%	50%	29%	18%	52%
1997	31%	19%	50%	29%	18%	52%
1998	32%	19%	49%	29%	19%	52%
1999	31%	20%	49%	29%	19%	53%
2000	32%	20%	49%	29%	29%	53%
2001	32%	20%	48%	29%	19%	52%
2002	32%	19%	48%	29%	18%	52%
2003	32%	20%	48%	29%	18%	53%
2004	32%	19%	49%	29%	18%	53%
2005	31%	19%	50%	28%	18%	54%
2006	31%	19%	50%	28%	18%	54%
2007	32%	19%	49%	29%	18%	54%
2008	33%	19%	48%	29%	18%	53%
2009	33%	18%	48%	30%	17%	53%
2010	34%	18%	48%	30%	17%	52%

Appendix Table 4. (continued) **Distribution of social services consumption by operating authority, 1995-2010**

	Net			Gross		
	Gov't	Local authorities	NGOs / others	Gov't	Local authorities	NGOs / others
2. Education and Health						
1995	31%	14%	55%	29%	14%	57%
1996	32%	14%	54%	30%	14%	56%
1997	31%	14%	54%	29%	14%	57%
1998	32%	15%	54%	29%	14%	56%
1999	31%	15%	53%	28%	15%	57%
2000	32%	15%	53%	29%	15%	57%
2001	32%	16%	52%	29%	15%	56%
2002	32%	16%	53%	28%	15%	57%
2003	31%	16%	53%	28%	15%	57%
2004	31%	16%	53%	28%	15%	58%
2005	31%	15%	54%	27%	14%	59%
2006	31%	15%	54%	28%	14%	58%
2007	32%	15%	53%	28%	14%	57%
2008	32%	15%	52%	29%	14%	57%
2009	33%	15%	52%	29%	14%	57%
2010	33%	15%	51%	30%	14%	56%

Appendix Table 4. (continued)

	Net			Gross		
	Gov't	Local authorities	NGOs / others	Gov't	Local authorities	NGOs / others
3. Housing, Culture and Religion, Social Security and Welfare						
1995	30%	38%	32%	28%	36%	36%
1996	31%	39%	31%	28%	37%	35%
1997	31%	39%	30%	29%	37%	34%
1998	31%	40%	29%	29%	38%	34%
1999	31%	40%	29%	29%	38%	34%
2000	32%	38%	30%	29%	37%	34%
2001	33%	37%	30%	30%	35%	34%
2002	34%	35%	31%	32%	34%	35%
2003	34%	34%	31%	31%	33%	36%
2004	35%	34%	31%	33%	32%	35%
2005	34%	34%	31%	32%	33%	36%
2006	33%	35%	33%	30%	33%	37%
2007	34%	34%	33%	31%	31%	38%
2008	34%	34%	32%	31%	32%	37%
2009	36%	31%	33%	33%	29%	38%
2010	37%	31%	32%	33%	29%	37%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 5A. **Labor compensation and net outsourcing costs, as percent of government social services consumption, 1995-2010**

	Labor compensation				Net outsourcing costs			
	Total gov't expen-diture	Total social service	Edu-cation and health	Welfare	Total gov't expen-diture	Total social service	Edu-cation and health	Welfare
1995	52%	54%	55%	47%	40%	37%	35%	42%
1996	52%	54%	56%	47%	40%	36%	35%	42%
1997	51%	53%	55%	45%	41%	37%	36%	43%
1998	50%	53%	55%	45%	41%	37%	35%	43%
1999	50%	54%	56%	45%	41%	36%	35%	43%
2000	50%	54%	56%	44%	41%	36%	34%	44%
2001	51%	54%	56%	46%	41%	36%	34%	44%
2002	49%	53%	55%	43%	43%	36%	34%	47%
2003	49%	52%	55%	43%	42%	36%	34%	47%
2004	49%	53%	55%	42%	41%	36%	34%	47%
2005	49%	53%	56%	41%	42%	37%	34%	46%
2006	48%	53%	56%	41%	42%	37%	34%	46%
2007	48%	52%	56%	39%	42%	38%	35%	49%
2008	49%	53%	57%	395	42%	38%	35%	49%
2009	49%	53%	56%	38%	42%	39%	36%	50%
2010	49%	53%	57%	385	42%	39%	36%	51%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 5B. **Labor compensation and gross outsourcing costs, as percent of government social services consumption, 1995-2010**

	Labor compensation			Gross outsourcing costs		
	Total social services	Education and health	Welfare	Total social services	Education and health	Welfare
1995	48%	50%	42%	43%	42%	48%
1996	48%	50%	42%	43%	42%	48%
1997	48%	49%	41%	44%	43%	49%
1998	47%	48%	41%	44%	43%	49%
1999	47%	49%	405	44%	43%	49%
2000	47%	48%	405	44%	43%	50%
2001	47%	48%	41%	44%	43%	50%
2002	46%	48%	385	45%	43%	52%
2003	45%	47%	385	45%	44%	53%
2004	45%	47%	385	45%	43%	52%
2005	45%	47%	37%	465	44%	52%
2006	46%	48%	36%	45%	44%	52%
2007	45%	48%	34%	46%	44%	55%
2008	46%	49%	35%	47%	45%	54%
2009	45%	48%	34%	47%	45%	56%
2010	46%	49%	33%	47%	45%	56%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 6. **The social services component in wages and job positions in the economy, 1994-2010**

	Social services wage expenditures as percent of total wage expenditure				**Social services positions** as percent of total positions			
	Edu.	Health, welfare and social work	Com-munity service	Public admin	Edu.	Health, welfare and social work	Com-munity service	Public admin
1994	10%	9%	4%	9%	12%	9%	5%	7%
1995	10%	9%	4%	9%	12%	9%	5%	6%
1996	11%	9%	4%	9%	12%	9%	5%	6%
1997	10%	9%	3%	8%	12%	9%	5%	6%
1998	11%	9%	4%	8%	13%	10%	5%	6%
1999	10%	9%	3%	8%	13%	10%	5%	6%
2000	10%	9%	3%	7%	13%	10%	5%	5%
2001	10%	9%	3%	7%	12%	11%	5%	5%
2002	11%	9%	4%	7%	14%	11%	5%	4%
2003	11%	9%	4%	7%	14%	11%	6%	5%
2004	11%	9%	4%	75	13%	11%	5%	4%
2005	11%	9%	4%	7%	13%	11%	5%	4%
2006	10%	9%	4%	7%	13%	11%	65	4%
2007	10%	9%	4%	6%	13%	10%	6%	4%
2008	11%	9%	4%	6%	13%	10%	6%	4%
2009	11%	9%	4%	6%	14%	11%	6%	4%
2010	11%	9%	4%	6%	14%	11%	6%	4%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 7. **Average wages in the social services**
as percent of the average wage in the economy, 1994-2010

	Education	Health, welfare and social work	Community services	Public administration
1994	79%	92%	75%	126%
1995	85%	95%	77%	137%
1996	87%	93%	77%	142%
1997	83%	90%	74%	135%
1998	82%	85%	73%	135%
1999	78%	81%	69%	132%
2000	76%	79%	67%	127%
2001	77%	78%	67%	131%
2002	77%	79%	65%	151%
2003	75%	79%	64%	148%
2004	77%	80%	64%	154%
2005	74%	81%	665	147%
2006	73%	79%	63%	147%
2007	73%	79%	63%	147%
2008	74%	78%	62%	144%
2009	75%	80%	63%	145%
2010	76%	79%	62%	147%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 8. **Positions, wages and labor costs in social services by industry and sector, 2010**

	Total	Gov't sector	Public NGOs	Private companies	Private NGOs	Other
Salaried positions (thousands)	**879.5**	**211.8**	**210.9**	**252.1**	**178.0**	**35.7**
Education	396.9	164.3	118.2	36.2	69.8	8.4
Health, welfare, social work	319.1	29.1	54.5	159.6	60.2	15.7
Community services, social and personal	163.5	18.4	29.2	56.3	48.0	11.6
Average wage (NIS)	**6,638**	**8,341**	**7,039**	**6,327**	**5,316**	**3,062**
Education	6,750	8,071	6.986	5,015	4,573	3,144
Health, welfare, social work	7,073	9,606	8,780	6,633	6,407	2,913
Community services, social and personal	5,521	8,278	4,007	6,302	5,028	3,204
Total expenditure on salaries (NIS billion)	**70.1**	**21.2**	**17.1**	**19.1**	**11.4**	**1.3**
Education	32.15	15.91	9.91	2.18	3.83	0.32
Health, welfare, social work	27.08	3.46	5.74	12.70	4.63	0.55
Community services, social and personal	10.83	1.83	1.40	4.26	2.90	0.45

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 9. **Household expenditure index on education and health, 1997-2010**

Index: 100=1997

	Total consumption	Education	Health services	Health insurance
1997	100	100	100	100
1998	100	102	106	131
1999	104	110	114	170
2000	107	115	130	206
2001	109	121	143	243
2002	108	116	136	248
2003	104	114	132	272
2004	107	123	142	297
2005	110	128	149	340
2006	110	127	150	343
2007	114	131	161	382
2008	116	133	158	389
2009	119	144	161	425

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

Appendix Table 10. **Expenditure on education and health services out of total household expenditure, 2009**

by gross income deciles

	Deciles				
	1	**2**	**3**	**4**	**5**
Households in population (thousands)	212.8	213.0	212.3	212.5	212.7
Average persons in household	1.82	2.80	3.16	3.23	3.49
Average standard persons in household	1.79	2.39	2.62	2.65	2.83
Wage-earners in household	0.23	0.41	0.78	0.95	1.20
Monetary consumption expenditure (NIS)	3,963	5,025	6,418	7,527	8,263
Consumption expenditures – Total	**5,582**	**6,740**	**8,518**	**9,785**	**10,842**
Health	313	386	414	474	595
Health insurance	79	88	114	141	162
Other health expenditures	234	298	300	333	433
Education	177	204	305	363	445
Relative money consumption expenditure					
Health	7.9%	7.7%	6.5%	6.3%	7.2%
Health insurance	2.0%	1.8%	1.8%	1.9%	2.0%
Other health expenditure	5.9%	5.9%	4.7%	4.4%	5.2%
Education	4.5%	4.1%	4.8%	4.8%	5.4%

Appendix Table 10. (continued)

Deciles					
6	**7**	**8**	**9**	**10**	**Total**
212.5	213.0	212.2	212.8	212.5	2,126.2
3.63	3.66	3.78	3.90	3.92	3.34
2.92	2.94	3.03	3.11	3.12	2.74
1.46	1.67	1.82	2.05	2.08	1.27
9,621	11,558	12,969	14,864	18,949	9,914
12,630	**14,834**	**16,755**	**19,486**	**24,937**	**13,009**
656	719	849	1,044	1,220	667
190	226	271	312	390	197
466	493	578	732	830	470
643	789	982	1,176	1.675	676
6.8%	6.2%	6.5%	7.0%	6.4%	6.7%
2.0%	2.0%	2.1%	2.1%	2.1%	4.4%
4.8%	4.3%	4.5	4.9%	4.4%	4.7%
6.7%	6.8%	7.6%	7.9%	8.8%	6.8%

Source: Reuben Gronau, *State of the Nation Report 2011-2012*, Taub Center.
Data: Central Bureau of Statistics.

References

English

Ben-David, Dan (2009), "Public Expenditures: A Look at Israel's National Priorities," in Dan Ben-David (ed.), *State of the Nation Report: Society, Economy and Policy 2009,* Taub Center for Social Policy Studies in Israel, pp. 49-95.

Hart, Oliver, Andrei Shleifer, and Robert W. Vishny (1997), "The Proper Scope of Government: Theory and an Application to Prisons," *The Quarterly Journal of Economics, 112*, No. 4, pp. 1127-1161.

Lavy, Victor (2010), "Effect of Free Choice Among Public Schools," *Review of Economic Studies, 77*, pp. 1164-1191.

Schmidt, Klaus M. (1996), "Incomplete Contracts and Privatization," *European Economic Review, 40*, pp. 569-579.

Taub Center for Social Policy Studies in Israel, *Israel's Social Services*, various years.

Zeira, Joseph and Michel Strawczynski (2002), "The Decline in Government Size in Israel Since 1985," in Avi Ben-Bassat (ed.), *The Israeli Economy, 1985-1998: From Government Intervention to Market Economics*, MIT Press.

Hebrew

Ben-Bassat, Avi (2001), "Obstacles to a Market Economy in Israel," in Avi Ben-Bassat (ed.), *From Government Intervention to a Market Economy: Israel's Economy, 1985-1998*, Am Oved.

Ben-Bassat, Avi and Momi Dahan (2009), "The Local Authority Crisis: Efficiency Versus Representation," in Avi Ben-Bassat and Momi Dahan (eds.), *The Political Economy of Local Authorities*, The Israel Democracy Institute.

Ben-Bassat, Avi and Momi Dahan (2006), *Power Balance in the Budgeting Process*, The Israel Democracy Institute.

Central Bureau of Statistics, *Statistical Abstract of Israel*, various years.

Dahan, Momi and Moshe Hazan, (2010), *Government Budget Priorities*, prepared for the conference "Women Designing Policy," March 2011.

Fershtman, Chaim (2007), *The Limits of Privatization*, Van Leer Institute, Discussion Paper No. 5.

Golomb, David (1988), “Symposium: Privatization: Necessity or Trend?” *The Israel Economic Quarterly*, pp. 135-136.

Ministry of Health (2011), *Public Report on Supplementary Health Services*, 2010.

Paz-Fuchs, Amir and Zohar Kohavi (2010), “On the Seam Between Public and Private: Privatization and Nationalization in Israel,” The Van Leer Jerusalem Institute, *Annual Report 2010*.

Paz-Fuchs, Amir and Elad Leshem (2012), “Between Public and Private: Privatization and Nationalization in Israel,” The Van Leer Jerusalem Institute, *Annual Report 2011*.