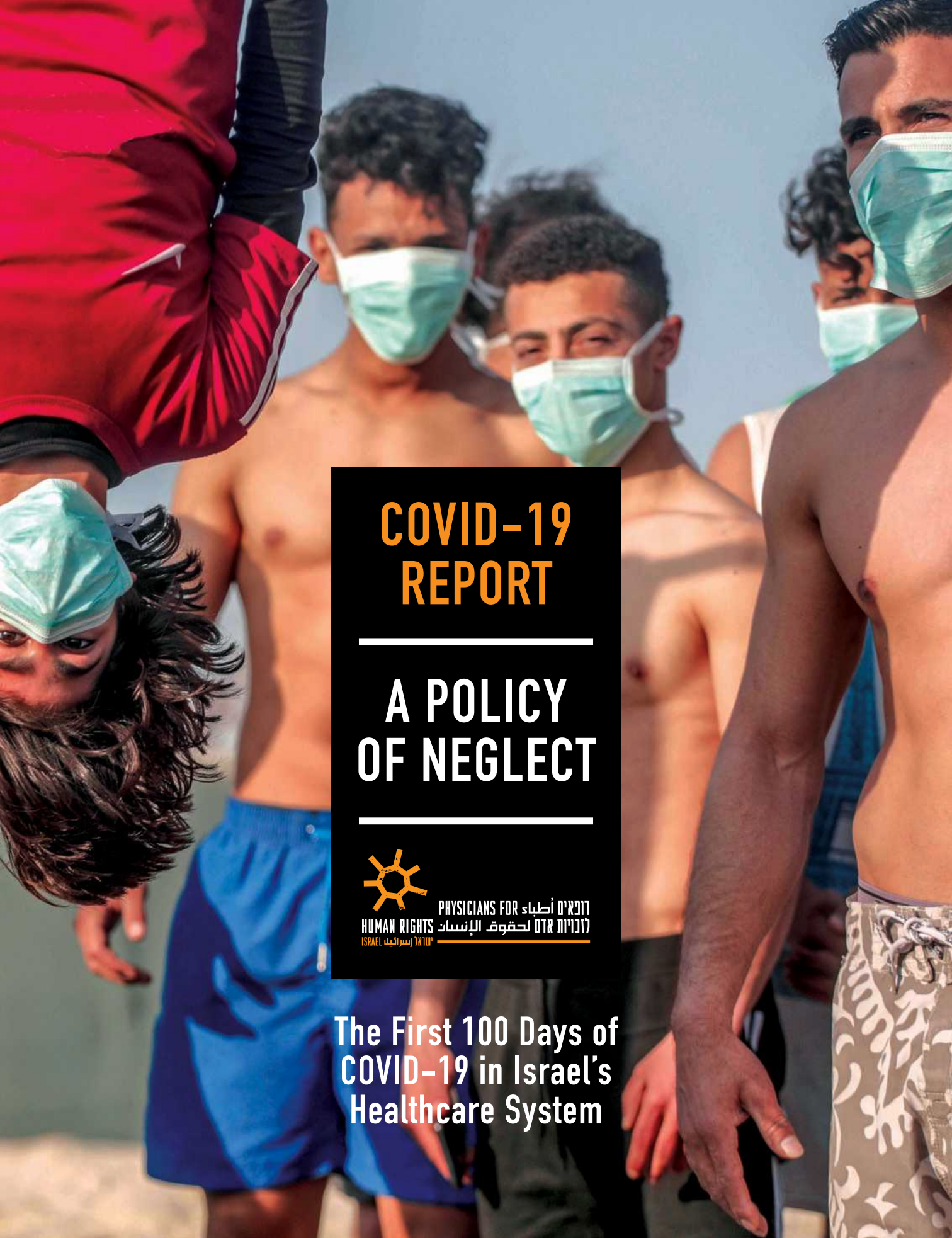

COVID-19 REPORT

A POLICY OF NEGLECT

PHYSICIANS FOR HUMAN RIGHTS ISRAEL
רופאים לזכויות אדם בישראל
أطباء لحقوق الإنسان في إسرائيل

The First 100 Days of COVID-19 in Israel's Healthcare System

“There have been as many plagues as wars in history; yet plagues and wars take people equally by surprise.”

'The Plague', Albert Camus

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מונעים חנוכת
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דורשים 10% הכנסה
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Foreword

After two decades of erosion, the Israeli healthcare system entered the COVID-19 crisis at a time when it was already stretched to the limit. The various phenomena that surfaced during the crisis, as well as those that will only become clear in the future, are largely a product of years of forewarned neglect of the public healthcare system – neglect which is itself a product of an economic policy of austerity, which has severely impaired the quality and availability of health services. In the context of the epidemic, the consequences of defunding those public health services responsible for epidemiological investigations, monitoring morbidity, vaccination and managing epidemic outbreaks, became particularly visible.

At the beginning of the crisis, it was commonly stated in the public discourse that the virus does not discriminate, that all members of society are equally vulnerable to infection. But that was not entirely true. As time went on, it became clear that the virus strikes people with preexisting conditions and the elderly more severely, though what became clearest was the vulnerability of the most disadvantaged communities in Israel – some already recognized and others less: higher rates of infection among impoverished and densely populated communities; marginalized communities of status-less persons residing in Israel who are excluded from public health services and required specialized solutions; communities where testing and information about the virus took a long time to reach, such as Israel's Arab population. Furthermore, whether because of physical isolation or because of institutional definitions that exclude certain groups from the protection of the public health insurance law, certain institutions – nursing homes, the military and the prison system – were forced to prepare to contend with the epidemic

alone or without substantial support or intervention from the Ministry of Health and the public system. The fact that the Ministry of Health was absent from so many institutions, and did not sufficiently monitor many communities, created 'bubbles' of inadequate healthcare provision. During an epidemic, the neglect of a few communities takes on the added outcome of harming the entirety of the population. The kind of ad hoc solutions that developed in the field, as well as the various failures, can guide us to possible avenues for improving the existing systems even well beyond the current crisis.

During the crisis, health workers, doctors and nurses, lab workers, administrative and custodial staff, were left on their own to deal with a severe lack of resources and manpower. They did so tirelessly and in an inspiring way, but at a great cost. Under the kind of pressure that characterized the start of the outbreak in Israel, many measures were taken, including the institution of a lockdown with the aim of buying time for the healthcare system to prepare and 'flatten the curve'. There were immense investments in the purchasing of ventilators and establishing labs, repurposing medical teams and hospital wards – all of which required reallocating resources from elective and diagnostic procedures. While these kinds of decisions characterized the rationale at the onset of the crisis, they did not contend with the long-term implications of an underfunded system, nor with the need to provide the necessary funding to strengthen it and to bring it to par, at the very least, in line with the OECD average.

In this report we will describe the key repercussions of an underfunded public healthcare system operating with a lack of resources, as well as the inherent danger in the institutional and legal marginalization of particular population groups through the abdication of responsibility on the part of the Ministry of Health. This exclusion, as well as the attempt to improvise temporary solutions during the COVID-19 crisis, will be detailed based on the activities of Physicians for Human Rights Israel during the crisis, as well as the cumulative experience of the years leading up to the crisis, and the responses provided by the establishment if and when they were issued. It is worth noting that even prior to the current crisis, the state of the Israeli healthcare system was a subject of extensive discussion. PHRI ordered an investigation by an accounting firm into the necessary investments required to rehabilitate and advance the healthcare system. From an economic analysis based on our understanding of the desired outlook for the healthcare system – equal, public and prepared to respond to the challenges it faces, the healthcare system is in need of **14 billion ILS.** This figure comprises a one-time addition of 12.6 ILS billion, with the purpose, inter alia, of integrating supplementary health services into the public healthcare basket, training medical staff, investing

in the long-term care program, and more. A further 1.4 billion ILS is needed to be integrated annually into the public healthcare basket and allocated towards the changing needs.

We hope that this report will be utilized by policymakers, and serve as an artifact of discussion in the public discourse regarding the conclusions of the crisis, with the objective of promoting investment in the public healthcare system, and a more equal access for all communities and individuals.

The Israeli Healthcare System Stretched to its Limits

Abstract

Following decades of reduced government investment, Israel's healthcare system entered the coronavirus crisis already stretched to its limits: shortages in lab workers and equipment, shortages of public health infrastructure, shortages of ventilators, ICU beds and medical staff. The fact that the Israeli healthcare system was ill prepared for a pandemic, as forewarned by the State Comptroller's report, is just another indication of these trends. The lack of preparedness forced decision-makers to implement policy that did not always adhere to the values of the National Health Insurance Law. This chapter surveys the changes in the public healthcare system over recent decades and discusses the consequences of sustained cuts to healthcare system budgets. We demonstrate how, to 'buy time' for the system to re-organize, it became necessary to severely decrease the movement of individuals, which came at a cost of significantly undermining privacy rights and leading to unequal treatment of different population groups.

A. Even prior to the pandemic: A system stretched to its limits[1]

The National Health Insurance Law of 1995 was passed, guaranteeing all residents of Israel equal, efficient, and accessible healthcare services. However, the combination of the ongoing erosion of funding, privatization, and demographic

[1] This chapter is based on the Crisis Expert Teams on Health: Nihaya Daoud, Nadav Davidovitch, Hadas Ziv, Rabia Halaila, Ameed Saabneh, Dani Filc, "Outline for treating the 'pre-existing conditions' of the Israeli healthcare system after the crisis", Crisis Expert Teams, Health Team, Position Paper no.1, April 2020 [Hebrew].

growth without the corresponding growth of infrastructure has undermined the availability and quality of healthcare services and led to constant erosion of the right to health. The primary driving force of the sustained cuts to the Israeli healthcare system is reduced government spending in public infrastructure, including the healthcare system, in the name of neoliberalism. This policy can be observed via the following indicators:

Health spending per capita in Israel: In 2018, in terms of **Purchasing Power Parity (PPP)**, Israel's expenditure per capita was 2,780$ – much lower than the OECD average of 3,994$. Moreover, **the rate of routine health spending as a percentage of gross domestic product** (GDP) in 2018 was 7.5% - also much lower than the OECD average of 8.8%.[2] Even if we take into account that Israel is a relatively poor country for the OECD and consider **public health spending** as a percentage of the GDP, Israel is behind, with only 5.0% of GDP compared to an OECD average of 6.5%.[3] In addition, capital investment in health as a percentage of the GDP (2015 data) in Israel is 0.26%, lower than the OECD average of 0.47%.[4] This underinvestment is apparent in the low level of existing capital in the healthcare system in Israel, compared to other developed countries.

A steady increase in private spending on healthcare between 1995-2010 came as a result of the underfunding of the public healthcare system during the same period. In 1995, public spending on healthcare in Israel was 70% of all health expenditures, while in 2010, this number dropped to 60.5%. This trend was mitigated somewhat in recent years, with public spending rising to 61.3% of all health expenditures in 2016 – yet still lower than the 76.5% OECD average share of public spending during the same year.[5] The following are a few indicators demonstrating the gaps in infrastructure between Israel and the OECD averages:

Hospital beds per capita: In January 2019 there were 16,021 beds allocated for general hospitalization (1.8 beds per 1,000 people), compared to the OECD average of 3.6.[6] The rate of hospital beds per capita has been dropping for four decades – in 1980, Israel had 3.3 hospital beds per 1,000 people, and there has been a steady decline ever since.[7] This has led to the severe problem of average occupancy rate of hospital beds in Israel being 94% compared to the OECD average of 75%. In accordance, the average patient hospital stay in Israel is one of the shortest in the OECD, meaning Israeli patients are discharged earlier.

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[2] Health at a Glance 2019, OECD Library, OECD, 2019, Chapter 1: Indicator overview: comparative performance of countries and major trends.
[3] "Comparison of socio-economic indices in Israel and in OECD countries", Knesset, Research and Information Center, 13 December 2017 [Hebrew].
[4] "Health at a Glance 2017: Gross fixed capital formation in the healthcare sector as a share of GDP 2015 or nearest year", OECD Library, OECD.
[5] "Aspects and trends in national health spending – background material for the Public Committee to Strengthen Public Medicine", Ministry of Health, the Administration of Strategic and Economic Planning, June 2013 [Hebrew].
[6] Sick Bed, Davar, July 18, 2020 [Hebrew].
[7] Dror Feitelson, "The graph that shows when overcrowding at the hospitals began – and why", The Marker, February 7, 2019 [Hebrew].

Medical staff: At the end of 2018, there were 38,765 licensed medical doctors in Israel, 29,580 of whom under the male retirement age of 67. Israel has been seeing a steady decline in the rate of doctors per 1,000 people: from the 1998 rate of 3.65 doctors per 1,000 to 3.1 in 2018 (Compared to 3.5 per thousand persons in the OECD).[8] As for nurses, the situation is even more dire. A clear and gradual decline in the rate of nurses in Israel took place between 1995 (6.1 nurses per 1,000) to today (5 nurses per 1,000). In contrast, the OECD average was 9.2 nurses per 1,000 in 2018.[9] Israel's rate of nurses per 1,000 is the fourth lowest among developed countries.[10]

Public health services is one of the most fundamental elements of the healthcare system, whose purpose is to promote the population's health and prevent sickness and death, while diminishing health inequality. Public health services are decisive in promoting the population's health, both by preventing the spread of contagious diseases and by circumventing the levels of chronic illnesses. In Israel, these services are included in the framework of the third amendment to the National Health Insurance Law.[11] Without a requirement for updating budgets, public health services have suffered from ongoing budget cuts harming all elements of activity, quality control and oversight, including those of Family Health Centers (Tipat Halav), whose role is to prevent illness and ensure the proper development of pregnant women, infants and toddlers. While in EU countries, the expenditure rate for public health services out of total health spending is 3%, in Israel it is only 1.2% (2012).[12]

Inequality between Israel's geopolitical center and periphery: Difficulties in transferring medical professionals to the periphery, few hospitals, shortage of medical specialists in the community, reduction in public health services, alongside social and economic inequality have led to increased health inequality between the center of the country and both its northern and southern peripheries. The inequalities in access to healthcare are made more significant in light of other social and economic inequalities between the center and the periphery, and manifest in higher rates of illness in lower socioeconomic clusters, and especially among Arab citizens of Israel.[13]

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[8] "Personnel in the Healthcare 2018", Ministry of Health, Jerusalem, July 2019 [Hebrew].
[9] Health at a Glance, Nurses, OECD, 2017.
[10] Meirav Arlosoroff, "Could it be that the healthcare system is too efficient? The current crisis reveals the problem", The Marker, March 10, 2020 [Hebrew].
[11] The third amendment to the National Health Insurance Law includes the services under state responsibility, meaning under Ministry of Health responsibility: personal preventative medicine, nursing hospitalization, mental health services, rehabilitation devices. See: Anat Eyal, "The Third Amendment: Why it's so hard to get new technologies into the health basket", Hamishmar, April 11, 2014 [Hebrew].
[12] Nihaya Daoud, Nadav Davidovitch, Hadas Ziv, Rabia Halaila, Ameed Saabneh, Dani Filc, "Outline for treating the 'pre-existing conditions' of the Israeli healthcare system after the crisis", Crisis Expert Teams, Health Team, Position Paper no.1, April 2020 [Hebrew].
[13] Emma Averbuch and Shlomit Avni, "Inequality in Health and How to Address It", Ministry of Health, the Administration of Strategic and Economic Planning, Jerusalem, 2019 [Hebrew].

Healthcare in Israel compared to the OECD

	OECD	Israel
Current health spending as a percentage of (gross domestic product (GDP	8.8%	7.4%
Public spending on healthcare	76.5%	61.3%
Health spending per capita in terms of Purchasing Power Parity (PPP)	3,994$	2,780$
Average occupancy rate of hospital beds	75%	94%
Hospital beds per 1,000 people	3.6	1.8
Physicians per 1,000 people	3.5	3.1
Nurses per 1,000 people	9.2	5.0

IN LIGHT OF THE GAPS AND DIFFICULTIES IN PREPARING FOR THE PANDEMIC, THE MINISTRY OF HEALTH WAS FORCED TO ADOPT SEVERE POLICIES OF RESTRICTING FREEDOMS, UNDERMINING RIGHTS AND SOCIAL SERVICES, AND INVADING PRIVACY. THIS APPROACH WAS EXPRESSED BY THE MINISTRY OF HEALTH'S CHIEF OF PUBLIC HEALTH SERVICES SIGAL SADETSKY, WHEN SHE STATED THAT IN ORDER TO DEFEAT THE PANDEMIC, THE GOVERNMENT MUST ADOPT A STRINGENT POLICY OF "LOCKDOWN, PERSONAL MONITORING AND TOTAL SUSPENSION OF INDIVIDUAL FREEDOM."

B. Combatting the coronavirus: flattening the curve to buy time for the healthcare system

"Lockdown, personal monitoring and total suspension of individual freedom."

(Sigal Sadetsky, Chief of Public Health Services, Ministry of Health) [14]

Israel's preparation for the COVID-19 epidemic

News of the coronavirus outbreak in China reached Israel during December 2019. However, in January-February, the Ministry of Health in particular and the Israeli government in general prepared for the arrival of the virus to Israel and the outbreak of a pandemic by focusing on limiting flights and quarantining travelers who visited countries experiencing an outbreak. The healthcare system's readiness for the pandemic was low, as expressed by the February 2020 State Comptroller's report on the matter. The report determined that "**The Ministry of Health, health maintenance organizations and the hospitalization system are not properly prepared for the possibility of a pandemic**."[15] However, only a few steps were taken to boost the healthcare system's readiness. Shortcomings in these preparations included the following:

Severe shortage of ICU beds: At the start of the crisis, there were 300 ICU beds in Israel, approximately 3.3 per 100,000.[16] This rate is very low, even lower than the UK (which is relatively low for the EU), and quite far from countries like Germany with 29.2 and Italy with 12.5.[17]

Lack of clear guidelines for medical staff regarding protection at work: Medical staff reported contradictory guidelines that changed almost every day. They were also forced to grapple with a shortage of personal protective equipment (PPE). As a result, dozens of medical professionals were infected with the virus, and thousands sent into quarantine.[18]

Insufficient readiness for enforcing the lockdown and supervising traveler arrivals at Ben Gurion Airport: The Ministry of Health requested the enforcement of quarantine for the thousands of Israelis returning from abroad, but only eight inspectors were assigned to the task.[19]

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[14] Noa Landau and Jonathan Lis, "'Total Suspension of Individual Freedom': Inside Israel's Secret Coronavirus Debate", Haaretz, March 19, 2020.
[15] Adrian Filut, "Israel's State Comptroller Report Reveals Failure to Prepare for a Pandemic", CTech by Calcalist, March 24, 2020.
[16] Asaf Oni, "Israel has only half of the ICU beds needed, even before the coronavirus", Globes, March 12, 2020 [Hebrew].
[17] Niall McCarthy, "The Countries With The Most Critical Care Beds Per Capita", Statista, March 12, 2020.
[18] Ronny Linder, "Dropping like flies: Entire hospital wards sent into quarantine – and the hospitals will start working in shifts", The Marker, March 21, 2020 [Hebrew].
[19] Maytal Yasur Beit-Or, "Inspectors and reporting hotlines: This is how the Ministry of Health will enforce the quarantine on those returning from the Far East", Israel Hayom, February 17, 2020 [Hebrew].

Significant delays in purchasing sanitation, treatment and personal protective equipment: The media exposed that in light of the shortage of emergency and protective equipment, the various authorities found themselves competing for equipment.[20] The police were reportedly short on tens of thousands of protective kits, and the Ministry of Health had no stock of medical equipment for patients,[21] despite the expectation of tens of thousands infected.[22] Oddly, the Mossad was put in charge of procurement, with chief Yossi Cohen heading the national acquisitions "war room." The Mossad acquired ventilators, protective goggles, surgical masks and N-95 masks, gloves, sanitation equipment, protective suits, coronavirus tests, medication, and more.[23]

Delays in acquiring equipment and hiring staff required for testing: As the virus spread, a shortage of testing kits – particularly swabs – was reported, and later a lack of lab equipment and staffing to conduct and analyze the tests. In addition, various government ministries procured equipment without coordinating, in addition to private individuals and companies who acted on their own initiative to acquire equipment. This lack of coordination with the Ministry of Health resulted in the acquisition of the wrong equipment. The Ministry of Health also took too long transferring responsibility for testing to the Health Funds, instead conducting testing in one lab at Tel Hashomer, for a relatively long period of time.

These shortcomings in acquiring equipment led to a situation in which the healthcare system failed to reach the necessary testing targets needed to combat the pandemic. In the first few weeks of the crisis, only 600-700 tests were conducted per day, after which this number gradually rose to 1,200, 2,000 and a high of 8,000 per day. The aspirational goal presented by the Prime Minister – 30,000 per day – was not met.[24] In addition, the total reliance on 'Magen David Adom' (Israel's national emergency medical, disaster, ambulance and blood bank service) to conduct and transport the tests created chaos throughout the system, because MDA has no computer system capable of communicating with the Ministry of Health and the Health Funds. Occasionally tests were in transit for more than three days between the various labs, and many tests were lost.[25] Moreover, it became clear that despite the rise in the number of tests conducted per day, the labs were not capable of processing them due to a shortage of staff, labs, sampling equipment and raw materials. The media also reported that at a

[20] Navit Zomer and Merav Krystal, "Coronavirus chaos: Israel is being emptied of masks, and their prices are skyrocketing", Ynet, May 26, 2020 [Hebrew].
[21] Ido Efrati, "Concern over shortage of protective masks in Israel due to spread of coronavirus around the world", Haaretz, March 11, 2020 [Hebrew].
[22] Boaz Efrat and Maya Horodniceanu, "Ventilator failure exposed: only 1,437 machines available in Israel", Walla, March 26, 2020 [Hebrew].
[23] Itamar Eichner, "Mossad reveals full extent of its massive coronavirus gear haul", Ynet, May 26, 2020.
[24] Gali Weinreb, "Was the stated goal of 10,000 coronavirus tests per day even realistic?", Globes, April 5, 2020 [Hebrew].
[25] As raised in an interview with a lab director at one of the Health Funds on April 4, 2020. See also Yoav Even, "Ministry of Health official: 10,000 tests were lost", Mako, April 13, 2020 [Hebrew].

relatively early stage, private labs offered to assist with the testing but received no answer, and the Ministry of Health contacted them only after the virus had become widespread.[26]

In light of the gaps and difficulties in preparing for the pandemic, the Ministry of Health was forced to adopt severe policies of restricting freedoms, undermining rights and social services, and invading privacy. This approach was expressed by the Ministry of Health's Chief of Public Health Services Sigal Sadetsky, when she stated that in order to defeat the pandemic, the government must adopt a stringent policy of "**lockdown, personal monitoring and total suspension of individual freedom**."[27]

Determinants of health: Poverty as a risk factor for illness during the COVID-19 pandemic

The relationship between poverty and health is inextricable, as numerous studies have demonstrated.[28] In accordance, despite the commonly heard claim that the virus doesn't distinguish between different people, analysis of data published two months since the outbreak indicates that illness rates are exceptionally higher in poorer population clusters. The data collected by the Ministry of Health clearly substantiates the relationship between poverty and COVID-19 infections – the more well-off a given town was from a socioeconomic standpoint, the higher the testing rates were. In contrast, the data shows that most of the COVID-19 deaths occurred in disadvantaged communities.[29]

Similar to data from other countries including the United States[30] and the UK[31] confirms these findings - demonstrating that people living in poverty-stricken areas are infected by the coronavirus at higher rates than the rest of the population. In Israel, 62% of COVID-19 patients are from lower socioeconomic backgrounds. The socioeconomic cluster with the highest number of COVID-19 patients is cluster 2, with 7,911 infected people. This cluster includes 19 Arab towns, 9 Haredi towns, 9 non-orthodox Jewish towns and 2 mixed cities.[32]

The relationship between the COVID-19 pandemic and poverty in Israel is evident in much more than the geographical areas of infections. Despite the wide-

[26] Sagi Cohen, "Ministry of Health missed opportunities to expand testing", The Marker, June 8, 2020 [Hebrew].
[27] Noa Landau and Jonathan Lis, "'Total Suspension of Individual Freedom': Inside Israel's Secret Coronavirus Debate", Haaretz, March 19, 2020.
[28] Nadav Davidovitch, Dani Filc and Rami Adut, "Poverty and health – reason, result, and repeat", The Association for Civil Rights in Israel and Physicians for Human Rights, 2014 [Hebrew].
[29] Avi Dabush, "Not a disease of the elderly; a disease of the poor", Haaretz, April 24, 2020 [Hebrew].
[30] "US must improve COVID-19 strategy to keep tens of millions from falling into poverty, urges rights expert", UN New, April 17, 2020.
[31] Polly Toynbee, "Poverty kills people: after coronavirus we can no longer ignore it", The Guardian, May 05, 2020.
[32] Doron Avigad, "Virus of the lowest decile: Why did more poor people get COVID-19?", The Hottest Place in Hell Magazine, May 24, 2020 [Hebrew].

ranging expected consequences of the pandemic on the national and global economy, the financial burden of the pandemic has fallen first and foremost on the population living under the poverty line. Here too, the population most vulnerable to the consequences of the coronavirus is the Arab population, in which a disproportionate number of workers were fired from their jobs or put on unpaid leave.[33] Another group whose livelihood has been more severely harmed is the Haredi community – with the exception of Eilat, most of the cities in which unemployment has risen over 30% are Haredi cities (and Jerusalem). In addition, analysis of the data indicates that most of those fired during the pandemic earn an income that is lower than the national average - with most earning a monthly salary of between 5,000 to 7,000 NIS.[34]

These statistics demonstrate that pandemic-mitigating strategies must first and foremost target the needs of its disadvantaged populations – whether ethnic or cultural minorities, or groups with a lower socioeconomic status.

COVID-19 testing

The principle of equality in healthcare is at the heart of the National Health Insurance Law, according to which the quality of healthcare services is not dependent on a person's place of residence, ethnic origin, or financial ability. The national struggle against the pandemic laid bare the lack of national awareness of the needs of disadvantaged communities – ethnic and national minorities, and the poor – first and foremost regarding the non-Jewish population in Israel.

The shortage of testing and accessible information was more strongly felt by residents of the geopolitical periphery of Israel – and the Arab residents of Israel in particular.[35] Accordingly, many civil society organizations, including PHRI, contacted the Ministry of Health and members of the Knesset in an attempt to raise concerns about the lack of access to testing in Arab communities in East Jerusalem, the Triangle region, the Galilee and the Negev. Only after these inquiries, and relatively late into the period of fighting the pandemic, were four drive-in testing facilities opened by MDA and the Home Front Command in East Jerusalem, Jisr az-Zarqa, Fureidis and Rahat.[36] Despite the clear inequalities in the

[33] Israeli Employment Service analysis indicates that while in March, the rate of new unemployment claims by Arab citizens was 17.3%, it rose to 24.9% in April. See: Sivan Klingbail, "Maybe the Arabs beat the coronavirus, but they will pay the price of the economic crisis", The Marker, May 24, 2020 [Hebrew].

[34] Noam Dvir and Zeev Klein, "The economic crisis left by the coronavirus: Over 27% unemployment, at the top – Eilat", Israel Hayom, May 10, 2020 [Hebrew].

[35] Nader Butto, "Coronavirus in the Arab sector: It's not an outbreak, where were the tests until now?", Walla, April 22, 2020 [Hebrew].

[36] The first drive-in facilities were established in Tel Aviv, Beer Sheva, Haifa and Jerusalem from March 17-24. In contrast, drive-in facilities in Arab towns were first established in April. See: Furat Nassar, "Tonight: 'Drive-in' facility for coronavirus testing to be established in Haifa", Mako, March 21, 2020 [Hebrew]; Editorial, "This is how the IDF helps the Arab sector", Israel Hayom, April 15, 2020 [Hebrew].

number of tests allocated to Arab towns, only a minority of Arab residents were infected with the virus, and with the exception of isolated cases including Hura and Deir al-Asad, no significant outbreak took place.[37]

In contrast, the shortage of tests had a disastrous impact on the fate of the elderly population, especially residents of nursing homes and other residential facilities for senior citizens. The Ministry of Health did not assign appropriate significance to the danger of infection in nursing homes housing a dense concentration of a population at high risk of infection.[38] The severe shortage of resources led to tests not being allocated to asymptomatic staff and residents of eldercare facilities – even when residents were diagnosed with COVID-19.[39] As a result, the country witnessed mass infection in eldercare housing – Migdal Nofim in Jerusalem, Vizhnitz in Bnei Brak, Ad 120 in Rishon LeZion, and Mishan in Beer Sheva. In some of these institutions, COVID-19 testing was conducted partially or as a sampling, and in most cases, testing was not conducted at all.[40]

The inappropriate allocation of COVID-19 tests has long-term and severe consequences, including on public trust in the healthcare system and the ability to monitor the virus and take the necessary steps to prevent its ongoing spread. Particularly while there is no vaccine, the healthcare system must ensure fair and proper access to all population groups.

Cultural-specific access to information about the COVID-19 pandemic

One of the basic conditions for minimizing inequality in health is promoting cultural-specific accessibility to information for diverse population groups and communities. The commitment to cultural-specific accessibility was raised by the 2011 Ministry of Health Director General circular, **"Cultural and linguistic adjustment and accessibility in the healthcare system" (July 2011), which established standards for cultural accessibly for health organizations**."[41] However, during a pandemic caused by a virus without a vaccine or recognized medical treatment, and while the primary national tool fighting the pandemic is based on active participation and awareness of the population about the risk of infection, the critical information was not made sufficiently accessible.

Data obtained by PHRI in the early weeks of the COVID-19 crisis exposed the Ministry of Health's lack of readiness to convey organized messaging in Arabic.

[37] "Due to a coronavirus outbreak in a few Arab towns in the Galilee, the residents have been instructed to stay at home", Ynet, April 15, 2020 [Hebrew].
[38] Amir Kurtz, "According to the state, most nursing homes are private, so they can handle the situation by themselves", Calcalist, April 12, 2020 [Hebrew].
[39] Sivan Hilai, "Nursing home failure: The seniors are not being tested, it's criminal negligence", Ynet, March 30, 2020 [Hebrew].
[40] Amir Kurtz, "According to the state, most nursing homes are private, so they can handle the situation by themselves", Calcalist, April 12, 2020 [Hebrew].
[41] "Decrease in the impact of cultural differences in healthcare service utilization", Ministry of Health [Hebrew].

This information came from various Arabic-speaking communities, and especially from East Jerusalem and the Negev Bedouin. For example, data collected by the I'lam Media Center indicates that the budget allocated by the Ministry of Health for Arabic language campaigns was only 4.1 million NIS, some 10% of the budget, while the Arabic-speaking sector comprises approximately 20% of Israel's entire population. The aforementioned figure also included a campaign unconnected to COVID-19, meaning that in practice, the budget was even lower.[42]

A survey of 600 participants conducted by PHRI further revealed existing gaps in the Ministry of Health's efforts in making information accessible in multiple languages. Exposure to information in the native languages of Arab citizens was ranked as very low, compared to exposure to information in Jewish society.[43] Moreover, PHRI received reports of a shortage of Arabic-language telephone representatives on MDA hotlines, which further limited access for Arabic-speakers to healthcare services during the pandemic.[44] The absence of information for the Arabic-speaking population could have been abated by enlisting the hundreds of Arab medical students who volunteered to assist in the effort to prevent the spread of the virus by raising awareness within the Arabic-speaking communities. Surprisingly, their offer was rejected by the Ministry of Health administration.[45]

Despite the lack of solutions provided by the state to the needs of Bedouin society, Bedouin citizens demonstrated praiseworthy resilience. Civil society organizations such as AJEEC-NISPED, the heads of local authorities, police, religious and social leaders and more, made heroic efforts to distribute the guidelines to the population. Actors on the ground recruited imams to distribute messages, closed the mosques for prayer, and local authority heads uploaded videos to social media. These efforts proved fruitful, as most of the community was exposed to the distributed messages. However, certain cafes and restaurants stayed open but were later closed by the police.[46]

Another community hit with public criticism during the COVID-19 pandemic has been the Haredim (ultra-Orthodox communities). This is primarily due to the fact that during the period immediately following the initial outbreak in Israel some individuals among the Haredi population were not adhering to the social distancing rules.[47] Accordingly, published figures indicated that a high percentage of those

[42] Anat Bein-Lubovitch, "Is the government neglecting public education about the coronavirus in the Arab sector?", Globes, April 19, 2020 [Hebrew].
[43] Danny Zaken, "The Arab sector is in a public messaging vacuum; I feel like the national explainer to Arabs", Globes, March 31, 2020 [Hebrew].
[44] "Model for developing local emergency response in Arab local authorities to address the challenges of the coronavirus", Sikkuy, April 22, 2020 [Hebrew].
[45] See: Letter from PHRI to Ministry of Health Director General about granting work permits in the healthcare system to graduates of medical studies abroad, April 2, 2020 [Hebrew].
[46] Meirav Arlosoroff, "In contrast to the Haredi: The Bedouin in unrecognized villages are obeying the Coronavirus guidelines", The Marker, March 23, 2020 [Hebrew].
[47] Asaf Malchi, Gilad Malach and Shuki Friedman, "How is the Haredi sector addressing the coronavirus?", Israel Democracy Institute, March 26, 2020 [Hebrew].

infected with the virus were Haredim.[48] While this may be attributed in part to the refusal of some Haredi leaders to follow Ministry of Health guidelines, the lack of a sufficient culturally-appropriate awareness campaign cannot be ignored. There was a failure to use targeted channels for addressing the Haredi lifestyle, targeted messaging about dense living conditions, and other factors which make following the guidelines particularly difficult for this community. Many of these shortcomings were subsequently remedied. The failure to make the information properly accessible to the Haredi population may be one of the factors driving the high rates of infection among this group.

In summary, the healthcare system lacked the connections that would have enabled it to properly distribute the messages and make information culturally accessible to communities and civil society organizations. Indeed, in the places in which civil society organizations, non-profits and various community leaders filled the void left by the Ministry of Health, the harm was relatively reduced. This demonstrates the need to strengthen relationships between the health authorities and communities, even beyond the current crisis.

A freeze on elective procedures

One of the strategic decisions made by the healthcare system was cancelling and postponing almost all procedures that were not lifesaving or connected to COVID-19. Aiming to preserve the high level of readiness for the arrival of an inundation of COVID-19 patients, the public hospitals decided to suspend all elective procedures (non-emergency surgeries and treatments) and to decrease activity to some 50% of normal levels – most of which in emergency fields such as obstetrics, dialysis and oncological operations.[49]

PHRI received reports from medical personnel at hospitals and in the community which indicated that the decisions described above harmed a large number of people living with chronic conditions or health issues not deemed to be life-threatening, and who were subsequently put on waiting lists to receive treatment. Many suffer from chronic pain, anxiety, and uncertainty about when they will be able to receive treatment. Other patients are in stable condition but are at high risk of complication. In other cases, people fell ill but did not go to the hospital out of fear of contracting the virus.

[48] Sami Peretz, "Deri admits that 70% of those infected are Haredi – during the next wave will we all stay at home again?", The Marker, May 12, 2020 [Hebrew].
Maytal Yasur Beit-Or, "Report: Most of those infected with the coronavirus are in Haredi towns", Israel Hayom, April 6, 2020 [Hebrew].
[49] Ronny Linder, "Private healthcare is collapsing: the breaks were put on the entire treatment chain; people will pay with their lives", The Marker, April 21, 2020 [Hebrew].

Moreover, this decision disproportionately harmed disadvantaged populations. Persons with no safety net, access to technology, with low health literacy, or with high rates of chronic illness, lost connection with their health professionals and their health deteriorated as a result. In some cases, doctors were forced to exercise their own personal judgment, choosing to visit their patients while wearing protective suits to limit the risk of infection. At some point, the Ministry of Health understood the price that society would pay for the lack of diagnoses and prevention, and patients' reluctance to go to the hospital, and began a widespread public campaign of doctors encouraging patients to visit the hospital. In the future, we must be careful not to undermine routine healthcare, even during a pandemic, to avoid causing illness and death in some areas, in an attempt to prevent them in others.

Restricting freedom in the name of health: democracy in lockdown

The global outbreak struck during an unprecedented political crisis in which a transitional government had been in place for over a year through three consecutive parliamentary elections. A state of emergency was declared prior to the establishment of a governing coalition and parliamentary committees, which led to a situation, unlike in other Western democracies, in which there was no parliamentary oversight of the crisis for a significant period of time. The lack of an effective legislative authority led to a situation in which most of the actions taken to handle the outbreak, at the most critical stages, were authorized by regulations based on a standing national state of emergency, in force since 1948, rather than through primary legislation.[50]

Despite the fact that, like Israel, most Western democracies applied restrictions on freedom of movement, association and business activities, Israel's government allocated significantly more resources than other countries to tracking and undermining the privacy of those infected with the coronavirus. This was made most apparent by the specific decision to utilize the resources of the Israel Security Agency (Shin Bet) to that end, backed, pushed, and initiated by Ministry of Health professionals. The extent to which privacy was undermined is evident in the High Court's decision to deny extending security service tracking without legislation. The court accurately described both the invasion of privacy and the lack of transparency associated with the Shin Bet tracking. This led the court to demand that the government consider alternatives with greater transparency that would be more voluntary and less invasive.[51] A comparative analysis of methods

[50] Lila Margalit, "Emergency authorities and parliamentary oversight during the coronavirus crisis: A comparative survey", Israel Democracy Institute, May 7, 2020 [Hebrew].
[51] Mordechai Kremnitzer, "Israel's High Court identifies the danger in Shin Bet tracking and reminded the government of the role of the Knesset", Haaretz, May 27, 2020 [Hebrew].


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used abroad indicates that the use of the Shin Bet's tracking methods was not proportionate, as other and more efficient methods existed.[52]

The approach described above continued even after the establishment of a unity government, which under public pressure to pass legislation to replace the state of emergency regulations, considered a bill entitled "Special Authorities for Handling the Novel Coronavirus Law (temporary provisions), 2020." The law would authorize the government to pass regulations in order to "restrict activity of the population in the private and public sphere in a variety of areas of life, in accordance with the areas currently regulated by the state of emergency regulations." The bill attracted significant public criticism, both because only a few days were allotted for public comment, and because of the wide-ranging authorities granted to the government by the bill. For example, one of the heavily criticized provisions authorized the government to criminalize the violation of restrictions, and authorizing police to enter homes without warrants in order to enforce and monitor adherence to the regulations.[53]

At the same time, the draconian methods sought by all of those appointed to manage the crisis, including the prime minister, cannot be separated from the lack of preparedness and insufficiency of the healthcare system prior to the outbreak. The insufficient conditions did not allow for more flexible and community-specific solutions that would maximize public benefit. The healthcare system acted fully aware of its lack of preparedness in handling a pandemic outbreak, whether it be its limited testing and treatment resources or its inability to harness public support and cooperation to handle the crisis.

C. Chapter summary

Three months since the outbreak of the coronavirus crisis, the impact on Israeli society paints a complex and difficult picture. In contrast to the claims that the 'virus doesn't distinguish between different people', it is clear that the virus has caused more harm to the most disadvantaged populations – senior citizens, people with disabilities, Haredim, Arabs, and people from a low socioeconomic background. These groups are characterized by a diminished ability to stay informed about quarantine and social distancing guidelines, have a low level of trust in the Ministry of Health, and have limited access to healthcare services.

[52] Gedaliah Afterman, Daniel Cohen, Liron Shilo, Maya Shabi, Ziv Mozer and Laura Ortega, "Using technological tools in the fight against the spread of COVID-19", Abba Eban Institute for Diplomacy, May 2020 [Hebrew].
[53] Daniel Dolev, "Expected changes in coronavirus law: restricted police authority, stronger Knesset oversight", Walla, June 2, 2020 [Hebrew].

From this perspective, the COVID-19 pandemic and its impacts serve as a reflection of the condition of Israel's healthcare, even during normal times.

The lack of solutions to meet the health needs of these disadvantaged populations cannot be separated from the sweeping, centralized and opaque manner in which the healthcare system operated. The decision-makers managing the crisis charted a broad and severe course not suited to the needs of disadvantaged communities and those with special needs, with only one goal in mind – preventing the spread of the virus. Indeed, an expert panel appointed by the National Security Council to address the ongoing crisis failed to include any women, Arabs, epidemiologists, or experts in public health, welfare or education.[54]

The healthcare system entered this crisis already stretched to its limits and unable to successfully handle it through healthcare services, leading to a severe lockdown. The lack of preparedness and the failure to acquire protective equipment, testing and other necessary material during January-February, before the expected outbreak took place, led the Israeli government to severely restrict social and individual rights in order to prevent massive human casualties and 'buy time' for the healthcare system to prepare. These steps indeed proved themselves, but the price paid by the residents of Israel – financially, socially and constitutionally – as a result of the massively severe restrictions are likely to have long-term impact.

With the goal of reinstating public trust and rehabilitating the relationships with disadvantaged communities who did not receive proper treatment during the pandemic, the healthcare system must adhere to civil democratic values – transparency, prioritizing awareness over enforcement, and involving communities in education and planning. In addition, it is clear that even during an economic crisis – and perhaps precisely during such a crisis – investment is needed in the healthcare system, both in order to be prepared for the next pandemic, and because investing in health is consistent with the objective of economic recovery, social resilience and addressing the needs of the most disadvantaged. In order to prevent massive cuts to the system like those of the past few decades, decision-makers must change their approach. PHRI has called for the appointment of a national investigative committee, which would be an appropriate first step towards this end.

[54] Shani Ashkenazi, "One new team is born in an improvised manner, and the second has no women or doctors: this is how Israel is developing its strategy to return to normal", Globes, April 11, 2020 [Hebrew].

The Incarcerated during the COVID-19 outbreak

Abstract

When the COVID-19 outbreak arrived in Israel, the Israel Prison Service (IPS) sought to prevent the spread of infection in incarceration facilities by implementing strict policies, including broad restrictions on the rights of the incarcerated. These included preventing visits, banning therapeutic and leisure activities, banning employment, short prisoner visits to the outside, and cancelling non-urgent medical treatment by medical specialists not employed by the IPS. Preventing such treatment is a problem within itself, as medical services provided by the IPS do not meet the basic standard for Israel's health services. Further, the doctors that the IPS employs are not medical specialists.

Although this policy has thus far achieved its aim of preventing infection among inmates, the conduct of the IPS was not transparent, and did not include sufficient steps in reducing unnecessary harm to the rights of the incarcerated. Ongoing restrictions on the rights of inmates, particularly regarding their access to health services, are liable to have severe consequences on the health and welfare of the incarcerated population, where morbidity rates are high. Among other reasons, this situation was a result of the refusal of the Ministry of Health to publish regulations as to how to properly prepare for and manage the risk of a coronavirus outbreak in Israel's prisons, in spite of its role as the professional body charged with setting policy and determining standards for healthcare in the country during routine times and particularly during a pandemic.

A. The medical system of the IPS prior to the pandemic

Behind the walls of Israel's prisons there is a medical system that remains invisible to the public and the medical community. The medical system of the IPS, which is responsible for treating 14,000 prisoners, operates without oversight, without clear definitions of the services it is required to provide, and without applying the same standards of the Israeli public healthcare system. A report published by PHRI in January 2020 showcases the essential failures and shortcomings in the IPS health system.[55] At the same time, the IPS healthcare system is responsible for the health of one of the most marginalized groups in Israel, who suffer from health problems at significantly higher rates than the general population. Prisoners experience difficulty in advocating for the rights taken from them by the prison authorities, who have absolute control over all aspects of their lives. In theory, inmates are entitled to equal access to health and medical care. In practice, these rights are regularly violated and limited due to the conditions of imprisonment.

The National Health Insurance Law of 1994 grants all residents of Israel the right to healthcare services. The first article of the law determines that health insurance will be based on the principles of justice, equality and mutual aid. Article 3(A) of the law defines the population entitled to health services thus: "Every resident is entitled to health services under this law, unless s/he is entitled to these services under other legislation."

According to the interpretation of the IPS and the Ministry of Health, the Prisons Ordinance[56] constitutes "other legislation," which regulates the right of inmates to health services, and therefore excludes them from the National Health Insurance Law.[57] As a result, the Ministry of Health does not regard itself as responsible for the IPS healthcare system, and the IPS on its part is not obligated to meet the standards of the Ministry of Health. This situation leads to a reality in which medical services for inmates are of inferior quality.

The IPS healthcare system operates clinics inside prisons that provide initial medical care. These services are provided by general practitioners and paramedics, most of whom have only basic training, and are employed directly by the IPS. Specialist treatment is provided to inmates in hospitals or by doctors who come to IPS clinics from hospitals.

Because the National Health Insurance Law does not apply to inmates, the IPS does not regard itself as obligated to supply the basket of health services determined by that law. In addition, the IPS does not regard the accepted standards of the

[55] Niv Michaeli, "Health Remanded to Custody", Physicians for Human Rights, January 2020.
[56] Prisons Ordinance [New Version] 5732-1971.
[57] Letter from IPS Deputy Legal Adviser Adv. Nava Maimon to PHRI, dated Oct. 23, 2001.

public healthcare system in Israel applicable to its internal conduct. The medical services of the IPS are not subject to oversight of a professional medical body, and the rules of its healthcare system are not transparent and have not been published in full.

The morbidity rate amongst the incarcerated population is high relative to the general population, due both to the lifestyle and socioeconomic backgrounds of inmates prior to their incarceration, and to the conditions of incarceration and the quality of medical care offered by the IPS. It is estimated that some 40% of inmates suffer from chronic illness.[58] Some 73% of criminal inmates were referred to psychiatric evaluation or treatment, as compared to 1-1.5% of the general population.[59] The high rates of illness among inmates, and the insufficient medical services provided by the IPS which rely on non-medical specialists and paramedics with minimal training, exacerbate the dependence of the system on external medical specialists.

While in the past the incarcerated population was generally considered young, in recent years there has been a rise in the number of older prisoners. The aging of the population and changes in sentencing policy have led to an increase in the number of prisoners aged 55 and above. Experts and professionals on the subject of prisons in Israel and around the world tend to categorize inmates above the age of 55 as elderly, because their medical situation is typically comparable to those at least a decade older than them outside of prison.

The significance of such a state of affairs led to is that health services for inmates are of inferior quality and availability to those for the general population. This inequality grew during the outbreak of COVID-19 in Israel.

B. Managing the COVID-19 outbreak: Severe infringement on rights and access to health services

When the COVID-19 outbreak reached Israel, the alarm was raised about the risk of the disease entering the prison system, as has occurred in other countries. Incarceration facilities are especially vulnerable to the virus due to conditions that enable rapid transmission. These conditions include highly crowded cells, public areas, and frequent transportation. In addition, prisons are not truly isolated from the general population. Some 10,000 people enter and exit prisons every day – workers who come and go every day, moving between cells, wings, and sometimes between different prisons. There is also a daily changeover of inmates

[58] IPS response from Jan. 1, 2019 to a PHRI Freedom of Information Request.
[59] "The IPS Health Care System", State Comptroller Annual Report p.65, 2015 [Hebrew].

who are newly imprisoned or released, allowed out on leave, who must appear in court, or undergo medical treatment in public hospitals.[60]

The medical condition of many inmates places them at risk for significant and potentially life-threatening complications if they are infected with COVID-19. Most inmates smoke and many suffer from chronic illnesses which increases the risks of complications from the disease.[61] In light of this, in late February as the coronavirus arrived in Israel, the IPS clearly understood the risks of infection in prisons, and immediately implemented measures to prevent an infection. These measures became more drastic as the number of COVID-19 patients in Israel rose.

This chapter will discuss the measures used by relevant parties – the IPS, the Ministry of Public Security and the Ministry of Health to prevent infection in prisons. Our discussion of these measures is based on official IPS publications, information we received from prisoners, and IPS's responses to PHRI inquiries, as well as petitions filed by PHRI and other organizations. It should be noted that the Ministry of Health has not responded to PHRI's appeals urging it to immediately publish instructions to the IPS, in order to prepare for the possibility of a coronavirus outbreak among inmates.

IPS preparations for managing the coronavirus in prisons

The IPS began preparing to combat the coronavirus during the month of February, when it published a ban on all staff members leaving Israel, and required all persons entering prisons to sign a health declaration.[62] Likewise, arrangements were made to enable quarantining each wing, and if necessary an entire facility; entire wings were adjusted in each of the three IPS districts to handle the intake of inmates suspected to be ill.[63] It was later decided to evacuate all detainees, some 200 people, from the Saharonim detention facility to allow the detention of inmates infected by the coronavirus.[64]

At the same time, regulations were issued seeking to reduce the risk of infection spreading within prisons: new detainees entering the IPS system would remain in a holding wing for 14 days prior to entering a regular wing in order to confirm that they are not carrying the virus; movement of inmates was limited within prisons, including time in courtyards, trips and other public areas. Additional

[60] Remarks by IPS Chief Medical Officer Dr. Liav Goldstein during a webinar of the Israel Association of Public Health Physicians, "Special populations coping with the coronavirus outbreak", May 14, 2020 [Hebrew].
[61] To illustrate: 1579 inmates suffer from high blood pressure, 1191 from diabetes, 347 from Chronic Obstructive Pulmonary Disease (COPD), 895 from asthma, and 385 from heart disease. From an IPS response to a PHR Freedom of Information Request, Jan. 1, 2019.
[62] Based on responses by IPS to petitions, and an update by the IPS Spokesperson: "All IPS staff forbidden from leaving the country", March 10, 2020 [Hebrew].
[63] IPS Spokesperson. "Israel Prison Service continues preparations for preventing coronavirus infections in prison facilities", March 4, 2020 [Hebrew].
[64] See: IPS Spokesperson statement, March 4, 2020.

activities in which inmates normally participate were reduced or cancelled. Such activities give structure and sometimes even purpose to life behind bars, improve the conditions of incarceration and provide a meager income (in the case of employment), and assist in coping with the difficulties of life in prison. These activities include education, rehabilitation, therapy meetings, employment, and religious activities.

Likewise, additional measures were taken to maintain hygiene within prisons. Cleaning and sanitation supplies were purchased and distributed; inmates were shown explanatory videos in multiple languages; signs were hung and additional explanatory materials distributed emphasizing the need to maintain hygiene; staff were trained regarding the new rules of behavior and the necessity of accommodating inmates' needs even more during this period; and prison guards were instructed to wear masks and gloves in the wings and public areas of the prisons.

In order to reduce crowding in prisons and reduce the risk of infection amongst prisoners and inmates, the Minister of Public Security decided on March 20 that criminal inmates who were not dangerous and who had a month left until the end of their prison sentence would be released on special leave under condition of complete house arrest. As of May 31, 694 criminal prisoners had been released on leave by virtue of this decision.[65] On the other hand, individual requests filed by defense attorneys to release to temporary leave inmates defined as at high health risk under the Emergency Regulations,[66] and to temporary release on parole for medical reasons,[67] were denied almost without exception based on the IPS claim that there have not been any cases of infection in prisons and therefore there is no health risk. However, the IPS claim is only valid for as long as prisons remain infection free. A case in which one inmate is infected significantly raises the risk of infection for all those held in the same facility due to the conditions of incarceration and puts those in at-risk groups in clear and significant danger.

Although it is true that as of early June infection of inmates in prisons has been prevented, there is concern that the measures used by the IPS are insufficient for what is required. This concern is exacerbated by the absence of a public statement by the Ministry of Health on this matter and the fact that the measures used were not balanced by other measures to mitigate the harm to the lives of inmates.

[65] IPS Spokesperson, "All spokesperson statements regarding prevention of coronavirus penetration into IPS facilities", May 31, 2020 [Hebrew].
[66] Emergency Regulations (Novel Coronavirus) (Special Prisoner Leave), 5780-2020.
[67] Release on Parole Law, 5761-2001, Section 7: Release on Parole for Medical Reasons, subsection B.


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Preventing contact between inmates and people on the outside

One of the measures implemented in early March with the aim of preventing the virus from entering prisons was the cancellation of all prisoner leave and conjugal visits. It was also decided that family and lawyer visits would be held through a divider. Movement of inmates between prisons was reduced as much as possible, as well as entry by civilians for nonessential purposes. Intake of new detainees from the police and the military began to require special coordination in accordance with instructions from medical staff. Later on, family visits were reduced to visits by two immediate family members only, once a month for prisoners, and once every two weeks for detainees.

The regulations were tightened on March 15 when government Emergency Regulations were approved, under which family and lawyer visits to prisons were not permitted at all. Likewise, it was determined that hearings on extensions of detention would be held via videoconference and that detainees would be able to hold consultations with their attorneys by phone. After the regulations were implemented, any person other than prison guards and incoming detainees was forbidden. Prison guards responsible for security began working week-long shifts.

At the end of March, the acting IPS Commissioner issued special regulations restricting prison visits to official visitors and Red Cross representatives. These regulations required such visits to be coordinated at least one week in advance and limited the length of visits to one hour. Normally, such visitors could enter prisons without advance notice, and there were no restrictions on visit length. It is worth noting that visits by official visitors are one of the most important tools for oversight of the IPS and safeguarding inmate rights, and they are particularly essential during a time when other external visitors are forbidden.[68]

Inmates were not immune to the uncertainty and anxiety that gripped the Israeli public. It seems that the IPS recognized the need to maintain calm and took some steps to provide alternatives to the rights and benefits normally offered to inmates which were revoked due to COVID-19, and which usually make life in prison more tolerable. The IPS updated policies and explained new regulations to inmates. For example, after attorney and family visits were cancelled, the IPS announced that it was exploring technological options for allowing closer connections between

[68] Official visitors are appointed by the Ministry of Public Security, in accordance with Article 71 of the Prisons Ordinance [New Version] 5732-1971. Despite the importance granted official visits to prisons by the law, the frequency of such visits is not specified and this matter is left to the judgment of the visitor or the body on behalf of which s/he is visiting. In addition, it should be emphasized that a substantial portion of these visitors are acting on behalf of the Israel Bar Association on a pro bono basis, and visitors acting on behalf of government authorities do so alongside many other tasks for which they are responsible. On April 26, 2020 PHRI and additional organizations submitted an inquiry to the Deputy Attorney General, the Minister of Public Security and the acting Commissioner of the IPS in which we noted that the number of visitors allowed to visit during this time should be reviewed and if needed additional persons could be appointed to do so, that inmates who wish to do so should be allowed to meet official visitors and that this possibility should be made known to inmates.

inmates and their families. In early April, criminal inmates began conducting video calls with their family members. Prior to the Passover, Ramadan and Easter holidays, the IPS announced that each prisoner and criminal detainee eligible for visits would now get a five-minute video call with their immediate family members in accordance with their visitation rights: once a week for detainees, once a month for convicted prisoners. It was also noted that women and minors had already begun speaking with their children or parents via video call two weeks prior.[69]

However, this is a partial solution which does not make up for the cancelled physical visits. Firstly, the frequency of video calls is determined by the minimum visitation rights in the Commissioner's Directive and not by the frequency of visits which took place in practice. For many criminal prisoners, family visits took place once every two weeks prior to the imposition of the Emergency Regulations, so the decision to hold video calls once a month reduced visit frequency to half of what it had been in practice.[70] It remains unclear why it was decided to allocate video calls for each prisoner calculated based on the minimum number of visits to which inmates are entitled by law and not based on the actual number of visits that were allowed prior to the virus outbreak. Secondly, PHRI received reports to the effect that in most cases the video calls were 5-10 minutes long, and that some inmates did not receive any video calls at all. From conversations with inmates in different prisons, we assume that the number of devices for video calling available to the IPS is much smaller than what is needed during COVID-19; it also seems that in addition to inmate conversations with family the same devices were used for court hearings and medical consultations, making them less available for family conversations.

The harm to visitation rights also befell prisoners convicted of security offenses. Although some security prisoners are not entitled to family visits due to various restrictions imposed by the Israeli authorities, a substantial number of them do receive regular periodic visits. In spite of the fact that the ban on phone use disconnected Palestinian inmates entirely from the world outside the prison, the IPS did not publish any actions taken aimed at assisting them in coping with the crisis. It should be noted that after petitions to the High Court of Justice were submitted by HaMoked: Center for the Defense of the Individual, PHRI, Al Mezan Center for Human Rights, the Association for Civil Rights in Israel, the Committee

[69] IPS Spokesperson, "Ahead of the holidays, the IPS will hold video calls between criminal prisoners and their family members", April 7, 2020 [Hebrew].

[70] According to the Prisons Commission Directive 04.42.00 "Visits to Prisoners", A convicted prisoner may be allowed visits within sight and hearing range of a prison guard starting from 30 days after his imprisonment and afterwards every two months. The frequency of visits to convicted prisoners may be increased as a benefit to him/her to up to one visit every 14 days, even if three months have not yet passed since s/he was imprisoned."

Against Torture, Parents Against Child Detention,[71] and Adalah[72] a temporary addition was added to the Commissioner's Directive of Feb. 3, 2000 according to which Palestinian minors would be permitted to speak by phone with their families once every two weeks during the emergency period.[73] During a hearing on these petitions (which have been merged) on May 27, the IPS announced that during the COVID-19 outbreak it allowed Palestinian women and sick Palestinian prisoners to make phone calls.

In summary, the harm to inmates caused by the ban on family and attorney visits is severe, especially for Palestinian prisoners. Visitations by families offer important comfort for inmates, particularly given the anxiety and emotional distress caused by the pandemic. Visitations are also a key means for prisoners to report on infringements of their rights in prison, including the right to medical care.

Limited access to medical treatment

As previously mentioned, clinics within prisons are capable of providing basic health services only and the IPS healthcare system relies heavily on external medical specialists –requiring transporting inmates out of prison into hospitals, or bringing medical specialists from hospitals into prison. The isolation of prisons due to the coronavirus outbreak put a near-total suspension for nearly two months on specialist health services and all medical tests and procedures carried out outside of prison clinics.

For example, in a case which was made known to PHRI, a private attorney requested a clarification from the IPS as to whether specialist clinics which are normally held in the Eshel Prison were cancelled and specifically whether a visit by a surgeon who had been scheduled to examine this attorney's client was cancelled. The IPS responded that in light of the situation caused by COVID-19 the hospital would not authorize its doctors to conduct examinations in external clinics, and that as of the time of the response no date had been scheduled for a surgical clinic. PHRI's inquiry to the Deputy Director of the Ministry of Health, requesting clarification about who is responsible for suspending medical specialists' visits to prisons, has not been answered.[74]

This state of affairs causes concern that many inmates have been prevented from attaining essential medical treatment. The IPS did announce in early March that it was making medical preparations, including purchasing additional medical

[71] HCJ 2280/20
[72] HCJ 2282/20
[73] See: "Temporary order: Prisons Commission Directive 03.02.00 rules regarding security prisoners – supervised phone calls for minors during the emergency period", Office of the Prisons Commissioner, IPS, April 1, 2020 [Hebrew].
[74] See: PHRI inquiry to Deputy Director General of the Ministry of Health, March 18, 2020.

and protective equipment, and later announced that medical and therapeutic professionals will continue treatment in full cooperation with the Ministry of Health. However, the total absence of any statement by the Ministry of Health regarding preparations necessary in prisons, which constitute an environment at high risk for infection, raises doubts about whether the arrangements made by IPS are sufficient, while at the same time causing concern that the harsh restrictions imposed on inmates are disproportionate and unnecessary. As mentioned above, PHRI inquiries to the Ministry of Health from late February onwards to release instructions for arrangements required of the IPS have gone unanswered.

PHRI contacted the Ministry of Health and the IPS several times with a request to clarify what steps the IPS has taken in order to ensure that secondary medical services are available to prisoners during the pandemic, what criteria are used for making these services available and whether there is in fact an instruction to cease work by medical specialists from hospitals in IPS clinics. The IPS response did not answer any of these questions, but merely claimed that it works closely with the Ministry of Health, follows its instructions at all times and that inmates' health needs are being met with technological means and telemedicine.[75] This response included no explanation of how telemedicine is adequately meeting treatment needs, what criteria is used to determine who receives treatment, or what is the volume of such treatment in practice.

The response was expanded upon somewhat in the reply to a PHRI petition on the matter, in which the IPS claimed that "**... the proper balance must be found between maintaining the health (in the conventional sense) of prisoners and staff, and maintaining their health in the sense of reducing their chance of infection by the coronavirus. It was thus decided that consultations with medical specialists will only be given in cases where this is truly necessary, with the approval of the district doctor**."[76] This reply gave cause for concern that referrals to medical specialists should perhaps not be left in the hands of an IPS doctor – a generalist with a base of knowledge not comparable to that of family doctors – does not constitute a sufficient answer and may put the health of inmates at risk during the COVID-19 outbreak.

Mental health services were also harmed during the outbreak, precisely at a time when emotional distress among the general public and among inmates is rising dramatically. Inmates specifically are held in conditions of near total isolation, which will puts them at greater risk emotional distress. In the IPS's reply to PHRI's petition it clarified that psychiatric treatment will be provided only in cases of

[75] See: IPS response, March 24, 2020.
[76] HCJ 2279/20 PHRI v. IPS.

THE RESPONSE WAS EXPANDED UPON SOMEWHAT IN THE REPLY TO A PHRI PETITION ON THE MATTER, IN WHICH THE IPS CLAIMED THAT "... THE PROPER BALANCE MUST BE FOUND BETWEEN MAINTAINING THE HEALTH (IN THE CONVENTIONAL SENSE) OF PRISONERS AND STAFF, AND MAINTAINING THEIR HEALTH IN THE SENSE OF REDUCING THEIR CHANCE OF INFECTION BY THE CORONAVIRUS. IT WAS THUS DECIDED THAT CONSULTATIONS WITH MEDICAL SPECIALISTS WILL ONLY BE GIVEN IN CASES WHERE THIS IS TRULY NECESSARY, WITH THE APPROVAL OF THE DISTRICT DOCTOR.

first aid, on the one hand. On the other hand it was stated that "**In regards to mental health, psychiatric doctors are continuing to visit prisons and provide treatment in their field as needed. Likewise, they have the possibility of offering treatment via tele-psychiatry, in which the prisoner remains in the prison and the psychiatrist offers treatment from afar, while meeting visually.**" These two clauses contradict one another and it is unclear whether psychiatric treatment is only given in cases of first aid, or as needed; and if it is only offered in cases of first aid what is the alternative for patients who receive ongoing mental health treatment. While it is true that mental health treatments among the non-prison population were also given from afar during the COVID-19 outbreak, the IPS reply does not sufficiently clarify the scope of psychiatric treatments it can make available in this way, and therefore there is concern that not all prisoners requiring such treatment will indeed receive it.

In addition to treatment by psychiatrists, an initial response to inmate mental health crises is typically offered by IPS social workers. In this field the IPS also promised that "**it is making efforts to maintain the service offered to inmates as much as possible. Activities are offered to calm and comfort inmates, on an individual or small group basis, the mood is assessed and visits to all wings take place several times a day. At the same time special emphasis is placed on maintaining treatment for special groups: minors, the elderly, women, and the mentally ill**."[77] Here as well, the reply contradicts reports from inmates in different prisons according to which they have not seen social workers in prison wings at all, since the prisons were shut to outsiders.

In summary, specialist medical care and mental health services were drastically reduced, and no suitable alternatives were provided precisely at a time when stress, uncertainty and infringement of rights reached their peak. PHRI inquiries to the IPS and the Ministry of Health went unanswered and when they were answered, their content did not reassure us that the measures being implemented provide a sufficient response to the actual need. Furthermore, the Ministry of Health's almost complete disregard for its responsibility to set standards must be rectified in the long term, given the severe consequences of this disregard on inmate health.

[77] In response to the same petition.

Lack of transparency regarding the COVID-19 situation in prisons

A central component of a government's effective management of the pandemic is gaining the public's trust; this trust is highly dependent on the transparency of decision-makers and institutions. The level of transparency exhibited by the IPS during this crisis was far from satisfactory. Some topics (such as medical treatment, as will be described below) have not been mentioned whatsoever in IPS publications, and on other topics only general information was published, or information was provided only after inquiries were directed at the IPS.

For example, the conditions of quarantine for inmates who are ill or suspected of having contracted the virus were not published and were only released to PHRI after an inquiry was made on the subject. The IPS conditions of quarantine are not comparable to quarantine at home, in a hospital or a hotel, and there is concern that the quarantining inmates' rights may be violated. Being held in a cell alone for longer than 15 days can have severe health consequences, and international rules define holding persons in this way for over 15 days a form of illegal torture.[78] Most of PHRI's requests for information about additional aspects of the IPS's arrangements were not answered, while others were only partially answered.[79]

In mid-March, the IPS Spokesperson began publishing updates about staff members and inmates who were suspected of having been infected with COVID-19, or who were confirmed as infected. Later it also occasionally published coronavirus test results and updates about the fact that as of that stage no inmates had been diagnosed with the virus. In certain cases, the IPS announced that an epidemiological investigation was being conducted in collaboration with the Ministry of Health to locate additional contacts. In many cases these updates were published by the IPS Spokesperson several days after the information had been spread, not always accurately, by inmates and sometimes even published in the media. Thus, while the general population in Israel could find out in almost real time how many Israelis were suspected of infection, how many were ill, in quarantine and how many had died, inmates and their families had to rely on rumors. This situation increased their fear, anxiety and distrust in the prison system.

Unfortunately, the Ministry of Health also made no statement throughout this period about the numbers of suspected or confirmed COVID-19 patients among

[78] United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules).

[79] Among other things, we asked about the measures being implemented to reduce the risk of coronavirus infection among at-risk groups in the inmate population, including the elderly and those with chronic illnesses; criteria and situations in which coronavirus tests would be carried out; the possibility of reducing movement within prisons by offering self-administered medical treatment in cells rather than in clinics, and the possibility of allowing prisoners to hold their own nebulizers, glucose monitors, insulin syringes and larger quantities of medicines; clear parameters for the distribution of personal protective equipment, hygiene and so forth and the quantities of equipment distributed; and the existence of a plan for reinforcing the IPS staff (medical and otherwise) in order to prevent infection and allow normal life as far as possible while preparing to ensure functioning in a scenario in which a significant number of staff members are infected.

IPS staff or inmates. IPS statements about collaboration with the Ministry of Health were not echoed by ministry statements. Actions taken by the IPS in prisons did not always fulfil the instructions of the Ministry of Health for the general population. The only time the ministry referred to prisons in the context of COVID-19 was in recommendations published in late March by an advisory team for locating COVID-19 infections in Israel, which included a recommendation to conduct sample tests in prisons. Even this recommendation was only implemented by the IPS after a delay of two weeks. In light of this, PHRI and other organizations contacted the Minister of Public Security and the acting Commissioner of the IPS to demand that they publish morbidity statistics and arrangements for managing COVID-19 in prisons. This demand was not answered.[80]

The contrast between the daily updates about the morbidity rates in the population at large, and instructions for behavior published by the Ministry of Health on an ongoing basis, and the partial and out-of-date information published by the IPS, illustrate the gap between a healthcare system committed to transparency that shares information with the public it serves, and a closed system that lacks transparency.

C. Chapter Summary

As of early June, according to IPS publications, no inmate had been infected with COVID-19, and fewer than ten staff members have been infected. This is significant, particularly considering inmate and staff infections in prisons in many countries around the world. However, this success must be examined in relation to the damage which may have been caused to the physical and mental health of inmates over the past few months. The measures implemented by the IPS to prevent an outbreak of the pandemic included significant infringements on inmate rights. These included limitations on access to secondary medical care and mental health support, harsher conditions of incarceration, revoking of activities and banning visitation and leave. These are significant infringements which will probably have long-term consequences.

In light of the fact that the danger of infection in prison has not passed, and the IPS will continue to work under these restrictions for a long time, the state must meet the needs of inmates and IPS staff, and continue providing services during the pandemic which were offered prior to COVID-19.

[80] See PHRI and other organizations' inquiry to the Minister of Internal Security and the Acting IPS Commissioner, April 26, 2020.

Firstly, the IPS must examine the ramifications of limiting inmates' access to medical services. The IPS must systematically examine whether closing off prisons and limiting specialist health services impacted the health of mentally and physically ill inmates. It must consult the Ministry of Health in order to decide about closing off prisons, in a manner comparable to the advisory role played by the ministry in all other fields since the pandemic reached Israel. This is particularly important in light of the uncertainty regarding morbidity rates in the near future in Israel, and the fact that the state is planning to continue limiting entries by outside visitors into prisons.

Secondly, transparency about IPS's activities and the conditions of inmates must be improved. The harsh restrictions imposed on entries into prisons, the lack of information being transmitted by the IPS, the lack of media attention about the COVID-19 situation in Israeli prisons – these all contributed to increased fears of inmates and their families, and their lack of trust in the incarceration system. This is particularly true in light of the inexplicable gap between the transparency of the Ministry of Health and the IPS.

Thirdly, the Ministry of Health must play an active and transparent part. The absence of any statement by the Ministry of Health about the necessary arrangements and conduct for prisons led to concrete harm to the sole means of oversight of prisons during the outbreak of the pandemic, visitation by official visitors. It seems that the harsh limitations imposed on entries into prisons, alongside the lack of information from the IPS, the partial publications by media in Israel and overseas about prisons, and the absence of instructions from the Ministry of Health led visitors not only to fear spreading the virus to prisoners during visits, but to fear themselves becoming infected. An additional cause of the delay in such visits taking place was the uncertainty about what protective measures these visitors must use during visitation. PHRI inquired with various Ministry of Health representatives but has not received a definitive answer.

Furthermore, the severe harm to inmates' access to medical services was not accompanied by oversight or by clear Ministry of Health criteria, in spite of the high rates of chronic illness among inmates, the emotional pressure and the severe harm to prison life as of prior to the outbreak. The ministry has repeatedly claimed that it does not have "the authority or the tools to intervene in the medical system for inmates",[81] but reality has proven time and again that inmates are part of society, whether they are healthy or sick.[82]

[81] Ministry of Health response to PHRI. Niv Michaeli. "Health Remanded to Custody", PHRI, January 2020.

[82] In cases which related to the health of the general public, the Ministry of Health has been compelled many times to relate to medical treatment in prisons, such as for example regarding locating and treating hepatitis C and tuberculosis patients. The Israel Association of Public Health Physicians has already stated that inmates are a part of society in all matters of health and the chairperson of the Association, Prof. Hagai Levine, spoke out on Twitter about the coronavirus and noted that prisons are particularly vulnerable to infection and that the IPS must prepare and strengthen its medical and public health system.

A report by the Knesset Coronavirus Committee, which summarizes conclusions and recommendations for the future, relates to inmates as one of the populations at risk of particular harm in the event of infection.[83] The report reinforces the position of PHRI, which also appeared before the committee, and states that some of the measures used to prevent mass infection among inmates required limitations which significantly infringed on inmate rights, and that the appropriate balance must be determined in advance in order to prevent future infringements.

[83] Knesset Coronavirus Committee report, the Knesset, May 14, 2020 [Hebrew].

"From Exclusion to Inclusion": Status-less people in the Shadow of the COVID-19 Crisis

"For lack of choice, when it comes to the epidemic, we will see them as an inseparable part of the epidemiological region"[84]

Abstract

The COVID-19 outbreak in Israel exposed the population of status-less people to increased distress and risk even compared to other groups in Israel, in no small part due to the policy of exclusion, neglect, and maltreatment that Israeli governments have maintained for many years. This policy, especially the lack of access to public health services, led to a situation where many had nowhere to turn when the crisis struck. Furthermore, the severe economic situation and harsh living conditions of status-less people, in particular asylum-seekers, were greatly exacerbated by the onset of the crisis as many were laid off, and unlike Israelis, they are not entitled to unemployment benefits and other assistance. The economic distress and the lack of access to health services raised concerns that many among the status-less communities would not be able to adhere to the government's regulations on lockdowns and social distancing, which would increase the risk of spreading the virus.

The responsibility for coping with this situation was placed on the Ministry of

[84] Noa Landau, Bar Peleg and Lee Yaron, "Official NSC Document: For Lack of Choice, We Will Treat Asylum Seekers as Citizens", Haaretz, March 28, 2020.

Health. After years of exclusion and renouncing its responsibility, the ministry was left without an operational system, infrastructure, mechanisms and knowledge to address the ongoing health needs of these communities, in particular with regard to COVID-19. While the Ministry of Health's decision to make COVID-19 medical treatment accessible to status-less people without insurance was a step in the right direction, without an institutional infrastructure and awareness of their needs, characteristics and life circumstances, many difficulties arose on the ground level. These in turn prevented some from accessing treatment and denied them monitoring and follow-ups. To overcome these difficulties, a rare cooperation developed between the Ministry of Health and civil society organizations, which facilitated the connections between the Ministry of Health and the status-less communities. Civil society organizations continued to assist in making information accessible provided timely humanitarian responses.

A. The situation before the outbreak of the epidemic: status-less persons in the exclusion trap

According to Population and Immigration Authority estimates over 200,000 "status-less people," migrants, and asylum seekers live in Israel. Most have stayed in Israel for many years, but the majority of whom are not eligible for residency status.[85] This group includes about 101,000 migrant workers who entered Israel legally and have work permits; about 17,000 migrant workers who have remained in Israel after their work permits expired; about 58,000 people who entered Israel as tourists and stayed here after their tourist visas expired; about 31,000 asylum-seekers, the majority of whom are from Eritrea and Sudan, whose asylum requests have been either denied or have not yet been processed by Israel, who nonetheless grants them protection from expulsion to their countries of origin; and about 20,000 Palestinians who live in Israel by virtue of family reunifications or face threats and concerns for their safety in the territories of the Palestinian Authority.[86] This is a very heterogeneous population whose members differ from one another by country of origin, ways and reasons for coming to Israel, and the legality of their presence in Israel. What they all have in common for the

[85] See: "Data on Foreigners in Israel – First Quarter 2020", Population and Immigration Authority, Department of Policy Planning and Strategy, June 8, 2020.

[86] We estimate that over half of status-less persons currently living in Israel are in Israel legally, whether as migrant laborers who were invited to work in Israel in areas in which there is a shortage of workers, such as construction, agriculture, or caregiving, or as part of renewing permits that they receive due to the State of Israel's recognition of the danger to their lives in their countries of origin. Such is the case of asylum seekers from Eritrea and Sudan who have temporary group protection against expulsion from Israel and who currently receive permits that are renewed every year or six months, or the case of Palestinians who receive renewing permits to remain in Israel due to recognition of them being threatened in the PA territories due to suspicion of collaboration or due to persecution based on sexual orientation. Others are partners of an Israeli citizen or resident and are in proceedings to settle their status but these take several years during which they are not eligible for the rights granted to residents of the state.

purposes of the present discussion is that because they are not recognized as residents according to the National Insurance Law, they are also excluded from the National Health Insurance Law (1994), and are not eligible for the public health services that it provides for.[87]

Despite the fact that these are people who live in Israel for extended periods and even though many of them have strong ties with Israel, so far, the State of Israel has refrained from formulating a comprehensive health and welfare policy regarding this population. Instead, it has institutionalized the exclusion of status-less people through additional acts of privatization and segregation: the Ministry of Health has transferred the burden of responsibility for their health to the private sector – to employers and private insurance companies that offer limited insurance policies that are only available to those among them who are legally employed.[88] This policy has led to the status-less population's increasing dependence on solutions from the nonprofit sector – civil society organizations, including Physicians for Human Rights – Israel's Open Clinic, which has limited resources for offering support, aid and treatment.

In recent years, due to the tenacious work of civil society organizations and criticism by the State Comptroller,[89] the Ministry of Health has begun to gradually and hesitatingly offer a handful of medical services, including designated clinics, for some of these.[90] Still, the range of medical services for status-less people living in Israel has remained partial, decentralized and limited – in the scope of the services as well as their geographical accessibility. These steps, while noteworthy, are far from providing an adequate response to all the medical needs of the groups in question. In effect, they still maintain the exclusion from the public health system. As the years go by, without access to welfare and health services, the medical needs of status-less persons have increased, as has their distress.

[87] Except for a group of about 8,000 Palestinians who have permits to stay in Israel by virtue of family reunification. These people are prevented from upgrading their status and receiving residency due to the Citizenship and Entry into Israel Law (Temporary Order). Following a High Court of Justice petition by the Association for Civil Rights in Israel, Kayan and PHRI (HCJ 2649/09) starting in August 2016, the Minister of Health used his authority by virtue of Article 56 (A)(1)(D) of the National Health Insurance Law and applied designated ordinances to this group that provide them with eligibility for services under the National Health Insurance Law, despite the fact that they are not Israeli residents.

[88] See: Article D(A) of the Foreign Workers Law. It should be emphasized that we are not claiming that private insurance does not enable access to medical treatment in the community at all. In fact, many migrants receive proper treatment through private insurance companies, despite the limitations on these poliices. However, these insurance policies are not appropriate for those who have had serious illnesses, or for the living and employment patterns of those who live in Israel for long durations of time or of those who came here to seek protection from persecution in their homecountries. See: "Painful Exclusion: The costs of denying asylum seekers access to healthcare services in Israel, and a proposal for a remedy", Physicians for Human Rights Israel, September 2017 [English].

[89] See: State Comptroller's Report on Foreigners That Cannot Be Deported from Israel (64c 5774) [Hebrew].

[90] Starting in 2001, the Ministry of Health has offered a subsidized insurance arrangement for status-less minors; in 2013, the Ministry of Health began to fund emergency medical services for refugees that are operated by Terem at a clinic located at the Central Bus Station in Tel Aviv, and a year later a clinic was established that provides mental health services for them, which recently began operating at the Terem clinic. In addition, starting in 2008, the Ministry of Health, in cooperation with the Israel Lung Association, has made tuberculosis treatments available to all status-less people lacking medical insurance; and in 2014, after years of tenacious struggle, the Ministry of Health took upon itself the responsibility for treating HIV-positive people who are status-less and lack insurance, and began to provide services to them in the framework of the AIDS clinics at hospitals.

Without adequate services in the community, many status-less persons are forced to wait for a dangerous deterioration in their condition to the point of reaching life-threatening situations, as only then are they entitled to life-saving medical treatment. This is by virtue of the Patient's Rights Law (1996), which states that in the case of a medical emergency, any person whose life is at risk or faces irreversible damage to one of his organs is entitled to urgent medical treatment without prior conditions.[91] This is how the "method" of treating status-less people has developed over the years in Israel: instead of national health insurance that enables regular care in the community, one article of the Patient's Rights Law has become the main pillar on which the access of many groups to medical treatment relies. There is no denying that the lives of many people have been saved thanks to the Patient's Rights Law and the treatment provided in emergency rooms. However, the current "method" takes a heavy toll on the health and quality of life of status-less individuals. Once their condition has stabilized, they are released from hospital without any follow-up and treatment in the community, often also without the ability to continue taking medication, which leads to a break in the continuity of care, and to them needing to wait once again for a dangerous deterioration of their condition in order to receive urgent care in an emergency room.

This 'ethos' also takes an ethical-professional toll on the medical staff who have to provide aid, often with their hands tied behind their backs, while needing to find creative and expansive interpretations of the urgent care necessary in emergency situations in order to provide proper medical care for patients. Sometimes this creates a conflict with the hospital administration and posits them in a state of 'dual loyalties' – to the medical institution and the system on the one hand, and to the patient and their professional commitment on the other hand.[92] In addition, there is a significant economic cost when the health system is forced to cover the expenses of emergency treatment for status-less people without insurance, in the form of bad debts.[93]

The exclusion of status-less people from public health services has extensive consequences for public health. As demonstrated with the outbreak of the COVID-19 epidemic in Israel starting at the end of February 2020, the creation of enclaves or 'bubbles' of populations that do not have regular access to health services has put status-less people as well as the general public at greater risk in the case of an infectious disease or epidemic. It has also created difficulties for the

[91] According to the Patient's Rights Law (1996), Chapter 3, Section 3(b), "In an emergency medical situation, a person is entitled to receive urgent medical treatment without conditions." The law interprets an emergency medical situation as "circumstances in which a person's life is in immediate danger or there is an immediate danger of irreversible disability if urgent medical treatment is not given."

[92] "Social Workers at the Forefront – on the Complexity of Treating Status-less people in the Public Health System", Position Paper, Physicians for Human Rights, January 2020 [Hebrew].

[93] See: Painful Exclusion, Physicians for Human Rights, November 2017.

health authorities' abilities to manage the situation: to create effective prevention and containment strategies.

B. Status-less people in the shadow of COVID-19: between exclusion and inclusion

In examining the three months from March to May 2020, which constituted the 'first wave' of coping with the COVID-19 crisis in Israel, we can identify two main themes through which we can understand the impact of the crisis on communities of migrants and asylum-seekers in Israel. The first theme regards the crisis not only as a health crisis but also (and perhaps, so far, principally) as an economic crisis, and it relates to the scale of the crisis's impact on determinants of health, the economic situation of status-less people, as well as to the connection between these elements and placing them at greater risk of morbidity; the second theme discusses the sharp transition of the Ministry of Health's policy, from exclusion of status-less people in regular times, to their inclusion during the crisis.

Determinants of health: the loss of livelihood and housing distress

While as of the time of writing, the rates of COVID-19 among status-less persons living in Israel were not high,[94] being communities that are more vulnerable and weaker even in regular times, migrants and asylum seekers were among the first groups to be affected by the economic crisis, sometimes in ways that posed unique barriers, both to their access to health services and to their ability to uphold the social distancing and quarantine regulations.

The wave of layoffs throughout the Israeli economy severely affected asylum seekers, many of whom were employed in the hospitality and services industries. According to reports, over 10,000 asylum seekers were laid off in March in the restaurant industry alone, and it is estimated that the unemployment rate is over

[94] As of April 26, 2020, 62 active COVID-19 cases had been confirmed among people without residency status. Out of the 62 status-less persons confirmed as infected: 30 are foreign workers, 21 are asylum seekers, 6 have tourist status, and there are 5 whose status was not listed in the Ministry of Health's records. 80% lived in the center of the country, 13% in the north, and the rest in the south. Out of the 62 confirmed cases – 32 were hospitalized or at COVID-19 quarantine hotels. The location of the rest was not known by the Ministry of Health. As of the date of this report – 28 of them had already recovered. In addition, 160 status-less persons were required to be in quarantine because they had come in contact with confirmed cases. Of them, 68 were reported as in quarantine at home or moved to the designated quarantine centers; as for the other 92 cases who needed to be in quarantine – there is no documentation or follow-up. There were no records of deaths among status-less persons with COVID-19.
See: Nurit Yachimovich-Cohen. "Coping with the Spread of the Coronavirus Among Foreign Populations: A Comparative Perspective", Knesset Research and Information Center, May 13, 2020 [Hebrew]. Towards the end of May, rumors spread of a renewed outbreak among migrant communities, which also fed accusations towards the migrants among groups hostile to them in Israeli society. At the same time, from figures provided by the Tel Aviv District Health Bureau at the beginning of June 2020, while there was indeed a certain increase in morbidity among status-less persons tested at the designated testing facilities in Tel Aviv at the end of May, the rate of infected people was at an average of about 6%, and according to experts does not constitute a "dramatic" outbreak. See: Bar Peleg, Shira Kadari-Ovadia, Noa Landau, Ido Efrati. "Ministry of Health Figures: 98 New COVID-19 Cases Diagnosed in the Past Day", Haaretz, June 1, 2020 [Hebrew].

70% among asylum seekers.[95] Unlike Israelis, asylum seekers are not entitled to unemployment benefits or allowances, including furloughs, which has led to an exacerbation of the poverty and severe economic distress that this group already experienced before the crisis.[96]

The most vulnerable asylum seekers, those who suffer from serious or chronic illnesses and until the crisis had been assisted by fellow members of their community, found themselves without the ability to continue to receive assistance from their caretakers and communities, found themselves without the ability to continue to receive assistance. With the onset of the COVID-19 crisis, economic anxiety and in particular the issue of food security and the fear of homelessness have become the main problem faced by thousands of asylum seekers, the majority of whom still face the risk of homelessness. The economic crisis has thus led to deteriorating living conditions, with many unable to meet the burden of rent payments and facing a real danger of being forced onto the streets or living in overcrowded conditions with fellow community members that make maintaining social distancing and, if necessary, upholding quarantine orders, impossible.

Migrant workers who work as caregivers have found themselves in an especially sensitive position: because they care for a population at high risk – elderly people and people with disabilities – and because they live in the home of their employers, many of them have suffered severe restrictions on their freedom of movement, ostensibly for reasons related to the safety of those they care for. For example, many of the workers have been prevented from going to the apartments that they usually share with their friends on their weekly day of rest, and they are forced to remain at the home of the employer, thus limiting their ability to exercise their right to a day of rest and to freedom of movement and privacy.[97] In some

[95] See: Lee Yaron, Asylum Seekers in Israel Forced to Fend for Themselves During Coronavirus Crisis", Haaretz, March 24, 2020. Oren Ziv, "No Pay, No Unemployment Insurance, Asylum Seekers on the Brink of Catastrophe", Sicha Mekomit, March 17, 2020 [Hebrew].
Sivan Klingbail and Jenya Volinsky, "Mass Coronavirus Layoffs Leaving Tens of Thousands Without Jobless Benefits", Haaretz, March 21, 2020.

[96] The severe economic crisis that has affected the population of asylum workers should be understood against the backdrop of the ongoing damage caused by the Deposit Law. This law came into effect in May 2017 and required employers of asylum seekers from Eritrea and Sudan to deduct one fifth of their monthly salary towards a designated deposit fund whose contents would be returned to the workers only upon their departure from Israel. The Deposit Law led to a substantial deterioration of the economic situation of the community of asylum seekers and led to hunger for many. For some of the asylum seekers, the current wave of layoffs was the last straw, leading to the complete economic collapse of many. On April 23, 2020, at the height of the COVID-19 crisis, the High Court of Justice made a ruling as part of a petition by the Worker's Hotline and other organizations, including PHRI, against the law (HCJ 2239/17) and overturned it immediately, while requiring the state to return the accumulated money to the workers. Since then and over the past few weeks, asylum seekers have begun receiving the deposit money, in a way that has enabled some of them to start to rehabilitate their situation. However, the return of the deposit money is not a sustainable solution for all asylum seekers as a means for extricating themselves from the economic crisis.

[97] It is important to note that while the Ministry of Labor published regulations that prohibit excluding caregivers from the Ministry of Health's regulations and that they must be allowed to leave the patients' home while observing the regulations, the Population and Immigration Authority has issued a regulation that prohibits caregivers from going to the apartments that they share with other workers on their day of rest, as is the case during regular times. See regulations by the Supervisor of the Rights of Foreign Workers at the Ministry of Labor, Social Affairs and Social Services from May 6, 2020, "The COVID-19 Crisis – Announcement to Foreign Workers Who Work as Caregivers and Their Employers." See letter from Director of Foreign Workers Administration at the Population and Immigration Authority to permit holders in the personal care aid industry and authorized private bureaus in the personal care aid industry from May 8, 2020.

cases, caregivers in assisted living residences have even been forbidden from leaving the facility at all, in a manner that prevented some of them from receiving medical treatment for diseases that are not COVID-19.[98]

Migrant workers in the agriculture and construction industries face increased risks given their crowded living conditions. For example, many workers in the agriculture industry live in shipping containers, sometimes without proper heating, air conditioning or ventilation, in a way that prevents them from upholding the rules of social distancing. Without effective enforcement on employers and without government aid for employers to carry out the necessary adjustments, there is an ongoing concern that during the epidemic it will not be possible to prevent massive infection among these workers.

Access to health services: from exclusion to inclusion

Underlying much of the distress of status-less communities during the current health crisis is their ongoing exclusion from the public health system, that the Ministry of Health has implemented for many years. This policy led to a situation whereby upon the onset of the crisis, the Ministry of Health was without an operational system that would address the ongoing health needs of the population of status-less persons and the coronavirus in particular. The main defects will be presented below.

The loss of insurance. In addition to severe economic distress, the COVID-19 crisis and the wave of layoffs that followed it led to the loss of health insurance policies among asylum seekers, because such insurance is conditional upon employment: when workers are laid off, the insurance policies are cancelled. The loss of insurance means the loss of access to medical care including for chronic illness and serious diseases, in a way that could pose a real danger to patients' health, at exactly the hardest moment for the Israeli healthcare system. The access to health services for status-less children – who number approximately 10,000 children, the majority of whom were born in Israel – also began to be undermined due to the crisis. The economic crisis harmed the ability of parents whose children are insured in the administrative arrangement through the Meuhedet health fund to continue to pay the insurance premiums on time. Cessation of payment could lead to insurance being discontinued and to the accumulation of debts starting in the coming months.[99]

[98] Galit Edut, "Restrictions only on Filipinas: The Workers at Ahuzat Tzahala Have Been in Lockdown for Six Weeks», Hamakom Hachi Ham Begehenom, May 10, 2020 [Hebrew].

[99] See PHRI letters to the Director of the Capital Market, Insurance and Savings Authority on March 19, 2020, as well as on April 26, 2020 and May 12, 2020; see PHRI letter to the Ministry of Health and Meuhedet Health Fund on March 22, 2020, and Ministry of Health's response on March 29, 2020, in which it was stated that the services will not be discontinued even upon cessation of insurance payments during the COVID-19 crisis. However, the cessation of insurance payments leads to the accumulation of debts that place the continuation of insurance in question.

The COVID-19 crisis has further exposed the problematic nature of relying on the 'method' for treating status-less persons without insurance, by overly relying on the Patient's Rights Law as well as on a handful of designated services. Throughout the crisis, many status-less people refrained from visiting emergency rooms due to concerns of being exposed to the virus and infected, and thus remained without medical care. Complaints received by PHRI show that in some cases policies regarding accepting status-less people in emergency rooms have become stricter due to the COVID-19 crisis. On the other hand, migrants without health insurance have found it even more difficult than usual to rely on the handful of designated clinics operated by volunteers or partially subsidized by the Ministry of Health. In light of the massive recruitment of medical staff to hospitals and Health Funds clinics, PHRI and Terem's clinics have had difficulties operating regularly and have needed to make special adjustments in order to ensure, with great difficulty, the regular provision of medicine and follow-up care for patients who suffer from chronic problems such as diabetes, high blood pressure, epilepsy or asthma, as well as ongoing women's health services.

The COVID-19 crisis also has consequences for the mental health of migrants and asylum-seekers. Spending time in the company of elderly people who have gotten sick from the virus has impacted the mental condition of their migrant caregivers, some of whom experienced anxiety for two reasons – concern for the welfare of the elderly person, and fear of getting infected with the virus. In some cases, this was compounded by anxiety about their continued employment in Israel and the loss of their place of residence, upon the death of the employer. In addition, for many asylum-seekers the COVID-19 crisis has intensified the post-traumatic symptoms that they suffer from due to difficult events that they experienced in their countries of origin and on the way to Israel,[100] and which have increased the need for mental health services.[101]

However, even in regular times, the private insurance policies offered to foreign workers exclude mental health services, and the only clinic that offers such services to asylum seekers, the Ruth Clinic, is underfunded in a way that limits its ability to provide mental health aid to only about 250 people per year. The COVID-19 crisis has further limited its activity and the budget for medicines has been delayed, leaving many asylum seekers suffering from mental illness untreated. During April and May, there were two suicide incidents among the asylum-seeker community, and there were reports of several more suicide attempts, including by parents who have children.

[100] See: "Victims of Torture in Sinai: Towards a Solution", position paper, forum of refugee and asylum-seeker organizations in Israel, August 2017 [Hebrew].
[101] See: Zoe Gutzeit, "Not Passive Victims: Towards the Rehabilitation of the Sinai Torture Survivors in Israel", Physician for Human Rights in Israel, August 2016.

Information gaps. On the eve of the epidemic, a few days before the first case in Israel was confirmed, the Ministry of Health published the existing regulations and information in Hebrew and English, ignoring the need to make the regulations accessible in other languages. Following protests from the Arabic-speaking sector, a system of making the information accessible and translating it into Arabic began to operate, but there was still a lack of information and regulations in various languages, including Amharic, Russian, French, Spanish, Tigrinya and Thai. Following a PHRI request demanding that the Ministry of Health make the information and regulations accessible to the communities of migrants and asylum seekers, the Ministry of Health started to translate and publish the regulations in various languages.[102] Later, the Ministry began operations to translate the constantly-updating regulations into a variety of languages, but there were still delays in their publication. Meanwhile, PHRI took it upon itself to translate the Ministry of Health's regulations into Tigrinya and to distribute them among asylum seekers from Eritrea in an organized fashion soon after their publication in Hebrew.[103]

While over time the Ministry of Health has made notable efforts in the field of the linguistic accessibility of written information, access to aid services at MDA and Ministry of Health call centers has been inadequate. While the Ministry of Health has claimed that these centers were provided for all people in Israel regardless of their legal status in Israel, in practice they have remained inaccessible for the majority of status-less people: **first**, due to language barriers, and despite all of the assurances, services were not available in various languages; **second**, in light of the requirement of identification via ID card, a requirement that led some status-less people to hang up the calls; and **third**, as has been brought to our attention, due to the explicit refusal of call center agents in some cases to help those who are not residents of the state.

In light of the fact that MDA's and the Ministry of Health's call centers served as the first stop for handling those who believed they had been exposed to the virus or had developed symptoms and were in need of consultation or a test, the lack of effective linguistic accessibility in itself is a significant barrier to the accessibility of information and services that the state has offered during the crisis. The lack of services in various languages could be taken as a symptom of the ongoing disregard of the needs of status-less people and their broader institutional exclusion from the welfare and healthcare systems.

Access to medical treatment during the epidemic. About two weeks into the crisis, in March, the Ministry of Health took heed of our warnings and decided to

[102] See correspondence between PHRI and the Ministry of Health starting on February 24, 2020.
[103] Later, gradually, the Ministry of Health also tried to provide translation into Tigrinya, but this was only done partially and inconsistently.

make medical treatment for COVID-19 accessible to status-less persons without insurance. In a letter sent by Dr. Vered Ezra to MDA and to the hospitals on March 16, the Head of Medical Management at the Ministry of Health made it clear that **"... on March 15, 2020, the Ministry of Health held a meeting with a variety of aid organizations for populations without legal status in Israel and marginalized populations [...] we would like to draw your attention to the fact that all of the necessary services must be provided to all people, for all reasons, with an emphasis on people who have come to emergency rooms with symptoms that could indicate being infected. In addition, MDA teams must provide services for this population as part of calls to the COVID-19 call center, as with any resident."**[104]

However, this act of ad-hoc inclusion in the COVID-19 treatment system was carried out without the prior development of infrastructure and mechanisms to enable its effective implementation in practice. During the weeks that have passed since this welcome step by the Ministry of Health, it has become clear how the lack of awareness of the unique characteristics and life circumstances of status-less populations, the lack of preparedness of those providing treatment in the field for making the services accessible, and the lack of access to family doctors through the health funds, have placed real barriers to receiving the services, despite the Ministry of Health's regulations, and despite its efforts and the dedicated work of representatives of the district health bureau.

Complaints that have reached PHRI show that in practice, MDA has refused to accept requests from status-less people without insurance to be tested, which has required additional letters to the Ministry of Health to clarify the regulations and update those at MDA and keep updating them. On April 13, about a month after the Ministry of Health's first declaration, and in response to our request to clarify the issue of payment for the costs of treatment, the Ministry of Health provided an additional clarification, in which it emphasized that "...**it is of the utmost importance to treat confirmed COVID-19 patients and those exposed, regardless of their legal status in Israel. If a person suspected or confirmed of having COVID-19 comes to a medical institution for treatment or contacts MDA to receive its services, s/he must be accepted for treatment without any payment conditions. If the payment can be collected from the patient through any medical insurance policy, it should be activated and the payment should be collected in that way. If the patient does not have medical insurance, treatment must be provided without any payment conditions."**

[104] See also Dr. Shlomit Avni's letter on behalf of the Ministry of Health on March 24 on this issue.

Afterwards too, those who received tests were sometimes required to wait for many days for an answer due to irregularities at labs, the loss of information, and difficulty transferring information to the health bureau due to the lack of a proper ID number. Later, in the absence of a family doctor at the health fund to transfer the test results and to monitor the patients and decide whether to keep them in home quarantine or to order their hospitalization, there was a clear lack of follow-up and monitoring. In some cases, district health bureau physicians needed to personally carry out follow-up of status-less people without insurance. In addition, there was a shortage of quarantine facilities for those who cannot carry out the regulations for home quarantine due to crowded living spaces. Without adequate solutions, the Ministry of Health was forced to hospitalize status-less persons confirmed to have COVID-19 even when their health condition does not require doing so, only because of the lack of quarantine solutions.

Only at the end of April was an attempt made to create mechanisms that "circumvent the health funds" for status-less people, and a specific procedure was formulated for "medical follow-up for COVID-19 patients without medical insurance in the community ("status-less people")".[105] These mechanisms required that the Ministry of Health collaborate with private companies to provide alternatives to the health funds' physicians for carrying out monitoring and follow-up. Even given these mechanisms, there is a reasonable concern of cases falling between the cracks due to the large number of bodies involved in the treatment chain. It is clear that if the Ministry of Health had made sure to include status-less people in the public healthcare system in the first place, beyond the clear health and economic benefits in regular times, it would have spared the need for designated regulations.

The transition from equality to equity. The Ministry of Health's declaration on making services accessible to status-less people purported to equalize and regulate status-less people's access to treatment during the COVID-19 crisis, but this did not occur. Years of exclusion, discrimination and hostility on the part of the authorities led to a lack of trust and fears among migrant communities, which were suspicious of the declaration that they would suddenly receive COVID-19 treatment and that the costs of the treatment and hospitalization would not be imposed on them. Among portions of the status-less population, conspiracy theories even spread that the authorities were trying to infect them in order to blame them for the spread of the disease. At the same time, many status-less people, and in particular those groups facing deportation, were afraid of going to receive help because of the need for means of identification and submitting

[105] See: appendices to regulations for coping with novel coronavirus disease update 16. Appendix 29.

information as to their residential address, out of concern that this information would be passed on to the Immigration Authority and be used to identify and arrest them. Even though PHRI wrote to the Immigration Authority and the Ministry of Health about this issue, and even though the Director-General of the Immigration Authority confirmed that the information collected as part of the struggle against COVID-19 would not be misused – the failure to make a public declaration on the issue left many status-less people with serious concerns.[106]

As part of the learning process that the Ministry of Health and other authorities went through during the crisis, it was understood that in order to promote equality in access to services and their consumption, it is necessary to relate to the unique characteristics of the status-less population, including the institutional barriers as well as the concerns and lack of trust described above. This understanding led, among other things, to the establishment of a designated testing facility for migrants in South Tel Aviv that was opened and operated by Ichilov Hospital, the Tel Aviv Municipality and MDA, in recognition of the inability of status-less people to receive tests through the Health Funds and their reservations about contacting MDA.

Later on, a meeting was also held between the Tel Aviv District of the Ministry of Health and leaders of the Eritrean and Sudanese asylum-seeker communities in order to bring up the difficulties and create cooperation and communication between them and the health authorities. This meeting led to the appointment of one of the members of the community who is employed at the Ministry of Health as a "treatment coordinator" who is responsible for connecting the asylum-seekers with the health authorities and addressing needs related to COVID-19 treatment. The meeting also led to the participation and involvement of translators and cultural mediators at the testing facility and transferred them the responsibility for providing answers to those whose COVID-19 tests came out negative. The meeting gave expression to the health authorities' recognition, albeit partial and one-time, of the need for sensitivity to the special needs of asylum seekers and of creating designated solutions for them. It also opened a dialogue between the communities and the Ministry of Health and contributed to the visibility of status-less people to the authorities.

[106] See: PHRI correspondence with Prof. Shlomo Mor-Yosef, Director-General of the Population and Immigration Authority, on March 12, 2020.

THE MINISTRY OF HEALTH'S DECLARATION ON MAKING SERVICES ACCESSIBLE TO STATUS-LESS PEOPLE PURPORTED TO EQUALIZE AND REGULATE STATUS-LESS PEOPLE'S ACCESS TO TREATMENT DURING THE COVID-19 CRISIS, BUT THIS DID NOT OCCUR. YEARS OF EXCLUSION, DISCRIMINATION AND HOSTILITY ON THE PART OF THE AUTHORITIES LED TO A LACK OF TRUST AND FEARS AMONG MIGRANT COMMUNITIES, WHICH WERE SUSPICIOUS OF THE DECLARATION THAT THEY WOULD SUDDENLY RECEIVE COVID-19 TREATMENT AND THAT THE COSTS OF THE TREATMENT AND HOSPITALIZATION WOULD NOT BE IMPOSED ON THEM

C. Chapter summary

The COVID-19 epidemic publicly exposed the risks inherent in excluding status-less people from health insurance arrangements. We estimate that out of the more than 200,000 people living in Israel without residency status, on the eve of the COVID-19 crisis only about half of them had private insurance that enabled access, even if limited, to health services in the community through the Health Funds. All the rest remained without services in the case of exposure to the virus or the development of symptoms.

To a great extent, the COVID-19 crisis has served as a watershed not only for the Israeli government but also for the community and civil society organizations in general, and Physicians for Human Rights Israel in particular. Regarding health services, the crisis has revealed that while responses developed during times of emergency help cope with problems, because they are temporary, they lack organizational infrastructure and an ongoing connection with the community and do not enable the accumulation of knowledge and the creation of trust with the community of patients. These barriers were present during the crisis and delayed quick and effective responses. To overcome these difficulties, a relatively rare state of cooperation has developed between the Ministry of Health and civil society organizations, including Physicians for Human Rights Israel.

The COVID-19 crisis forced the migrants department at PHRI to significantly adapt our activity: including by operating the Open Clinic in a protected manner preventing infection of staff and patients, establishing a hotline to provide insurance assistance, and operating a transportation assistance system for dialysis patients who needed help getting to treatment due to limitations on public transportation. At the same time, the department worked with the authorities on identifying and fixing lapses in the accessibility of treatment and information for the community on the COVID-19 crisis. The department transitioned from an approach based mainly on critiquing the authorities and petitioning them to apply their responsibility to an approach characterized by cooperation and joining forces for the good of the communities in whose name we work. For example, along with demanding the Ministry of Health to provide linguistic accessibility of information, we worked to convey the regulations to migrant populations and translated some of them ourselves. On one occasion, when it was necessary to find a translator for the municipal testing facility, PHRI funded his work. The Ministry of Health for its part relied on the information that the department provided regarding the distress reported on the ground and agreed to try to resolve it. Unlike the disregard that we face many times before the crisis, the channels of communication with

representatives of the Ministry of Health remained open, and there was a clear willingness for greater attentiveness to the needs raised.[107]

Among other government ministries too, as well as on the part of the Tel Aviv Municipality, there was a clear desire to listen, share and think together in order to provide responses and solutions that would advance the condition of status-less people during the epidemic.[108] We have no illusions that this attention and willingness will persist and continue after the crisis is over. However, it is to be hoped that the lessons and insights reached over the past few months will in the future be translated into practices of inclusion and of advancing equity in the health of status-less people. **The past few months have shown that things can be different.**

[107] For example, on Passover eve, we wrote to the Ministry of Health regarding the distress of status-less dialysis patients who were in needed of assistance with transportation. In response, the Ministry of Health shared with us a list of volunteers who agreed to help Israeli patients in similar contexts, and we received their assistance.

[108] For example, aside from the continuous communication with the Ministry of Health, we were invited to take part in a roundtable group with the government ministries, in meetings with the Ministry of Justice, the Ministry of Health, and the Tel Aviv Municipality.

Healthcare in the occupied Palestinian territories during COVID-19

Abstract

The COVID-19 crisis struck a Palestinian healthcare system that was already weak and unprepared to handle an epidemic. After decades of Israeli occupation and its severe restrictions on freedom of movement, the Palestinian public health system has been left seriously lacking in both funding and in manpower. In light of this severe lack of resources – including ICU beds, ventilators, basic protection for medical staff, sanitary supplies and more – the decision was made to implement severe restrictions in order to prevent the virus from spreading. The West Bank was placed under an external lockdown (by Israel) and an internal lockdown by the Palestinian Authority. The Gaza Strip self-imposed an almost air-tight isolation on itself in addition to a freeze on movement enforced by Israel. All these measures involved serious impairment to Palestinians' rights, in particular their right to health. Despite its responsibility for the dismal situation of the Palestinian healthcare system as the controlling power of all areas of life in these territories, the State of Israel has not upheld its legal and moral responsibility to provide the necessary responses and to ensure that all relevant Palestinian authorities have all the tools and support they need in dealing with the outbreak. Even worse, many seriously ill patients, including cancer patients, are being blocked from receiving essential treatment (sometimes even life-saving treatment) because of the restrictions on travel between Palestinian areas and Israel.

A. The state of the Palestinian health system before the pandemic

Some five million Palestinians live in the territories, roughly three million in the West Bank (including 337,000 in East Jerusalem)[109] and some two million in the Gaza Strip. The Palestinian healthcare system is divided into three areas (the West Bank, the Gaza Strip and East Jerusalem). Along with its restrictions on movement, Israel has prevented the proper development of the Palestinian healthcare system from the time of the Oslo Accords until today. Prior to the Oslo Accords, Palestinian life in the territories was managed by the military and then the civil administration. Both of these, for various factors (including the desire to ensure continued dependence on Israel) blocked the establishment of an independent, autonomous healthcare system.

Even after the Oslo Accords, Israel continued to control the passage between various Palestinian areas, both in terms of people and goods, including medical personnel, patients and medicine, as well as maintaining control on determinants of health such as water, land and more. The lack of progress in negotiations created a reality in which Israel has security control in all Palestinian territories. Further, Israel has expanded settlement constructions, created enclaves by dividing the West Bank into different regions, separated East Jerusalem and other areas from the rest of the West Bank via a separation wall, and has avoided implementing its commitment to building a secure passage between Gaza and the West Bank. This has created facts on the ground which entrenched Israeli control over Palestinian life and movement and the fragmentation of the Palestinian healthcare system, which has forced the Palestinians to establish multiple infrastructures and makes long term planning difficult.

Impairing the ability to manage a Palestinian healthcare budget. Serious restrictions on the Palestinian economy, along with high levels of unemployment and poverty, hamper the Palestinian Authority's ability to tax its residents. The PA is also dependent on Israel for customs and import taxes, which delays the transfer of funds based on various grounds. The PA's budget, and in particular its healthcare budget, are dependent on donations – a fact which seriously restricts long-term planning. In addition, the budget is heavily burdened by needing to purchase health services not available in the Gaza Strip or the West Bank from Israel and other foreign countries.

Restrictions on the freedom of movement. Because Israel controls all passage within Palestinian territories as well as between the territories and Israel via its

[109] Michal Korach and Maya Hoshen. "The population of Jerusalem, by age, religion and geographic distribution", Jerusalem Institute for Policy Research, 2019 [Hebrew].

A SENIOR OFFICIAL IN THE GAZA WELFARE MINISTRY DECLARED THAT THE ISOLATION AND HERMETIC SEALING OF GAZA WERE A POWERFUL PREEMPTIVE DEFENSE. “FROM THE FIRST MOMENT WE KNEW THAT IF THERE WOULD BE AN OUTBREAK, THE HEALTHCARE SYSTEM WOULD COLLAPSE, AND THEREFORE IMMEDIATELY QUARANTINING EVERYONE WHO ENTERED THE GAZA STRIP WAS THE BEST POSSIBLE METHOD

permit system, Palestinians in need of treatment that is unavailable in their area of residence are forced to contend with the Israeli mechanisms for issuing permits. This is a long and elaborate process which requires getting a referral from the relevant Palestinian bodies (Hamas or the PA, depending on the area) and paying fees to the PA before an individual can submit a request to the Israeli District Coordination and Liaison, which will then decide on permitting an individual to enter Israel or pass through it. The permit policy changes often, and permits are frequently refused or delayed in a way that seriously impairs the access of patients to essential treatment.[110] Moreover, Israel often uses the desperate situations of sick Palestinians seeking permits for its political or security advantage.[111]

Alongside the restrictions on movement for patients, the movement of medical professionals is also restricted, whether it be between different Palestinian areas, to Israel, to Jordan or abroad. Palestinian hospitals in East Jerusalem depend primarily on healthcare workers who come from the West Bank and Gaza, but their arrival to these hospitals is dependent on receiving permits from Israel's District Coordination and Liaison. In addition, since the blockade was imposed on the Gaza Strip, medical personnel from Gaza have been cut off and are blocked from participating in professional conventions and training sessions through which they can gain exposure to new technologies and medical developments. Therefore, there is a serious lack of expertise in Gaza in particular.

The Palestinian Healthcare System. The most important laws regarding the provision of public health services in the occupied territories are the Palestinian constitution (2003) and the Public Health Law (2004),[112] which confer on the Palestinian Authority the authority to regulate and provide medical services to its population. In practice, health services are provided by a variety of healthcare providers including the Ministry of Health, NGOs, private organizations, the United Nations Relief and Works Agency (UNRWA) and military medical services.[113] Some 78% of the Palestinian population in the West Bank and Gaza are covered by some sort of health insurance. The principal providers are UNRWA and governmental healthcare, alongside private providers which are responsible for upwards of 90% of the insurance coverage which is provided, including referrals to specialists that are not available in the Palestinian public healthcare institutions.[114]

Some of the problems which characterize this system stem from the lack of investment from the Palestinian Authority in an integrated public healthcare

[110] Danny Zaken, "The Palestinian plan for disengagement from the Israeli health system", Globes, 10 May 2019 [Hebrew].
[111] See: Mahmoud Abu-Arisha, "Denied: Harassment of Palestinian patients applying for exist permits", Physicians for Human Rights, June 2015.
[112] "Palestine's Constitution of 2003 with Amendments through 2005", Constitute Project.
[113] Palestinian Legislative Council, Public Health Law, No. (20), April 23, 2005.
[114] "Occupied Palestinian territory: Right to Health 2018", World Health Organization.


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system and the inclusion of all the relevant players into this system.[115] The Palestinian Health Ministry is the main provider of health services in the territories, and is responsible for 43% of the hospital beds in the West Bank and 73% of those in the Gaza Strip. Non-governmental parties are responsible for 46% of the beds in the West Bank and 22% of those in Gaza. The rest of all healthcare services is provided by private organizations, from the military[116] and from UNRWA.[117]

Health services in the occupied territories. The number of beds per 1,000 people stands between 1.3-1.7 in both the West Bank and Gaza (a number significantly lower than in Israel – 2.2 as of 2018). The Palestinian Health Ministry grapples with a serious lack of human resources, and struggles to answer the needs of its population. As of 2015 there were 1.3 doctors per 1,000 civilians, as opposed to 3.1 in Israel. The number of specialists in the territories is one-eighth the number in Israel relative to population size; 0.22 per 1,000 vs. 1.76 per 1,000 in Israel. The number of nurses is 1.9 per 1,000, whilst in Israel it is 5 per 1,000.[118]

Gaps in key health indicators. Despite its control over so many facets of life, Israel has never acknowledged its obligation and responsibility for the health of the Palestinian population.[119] This explains why there are massive gaps between the Israeli population and the Palestinians in most health indicators. The infant mortality rate in the West Bank stands at 12.8 per 1000 and in Gaza at 14.9 per 1000 while in Israel that number is only 3.3.[120] Life expectancy in the territories (74.9 in Gaza and 75.9 in the West Bank) is significantly lower than in Israel (83).[121] In addition, the prevalence of infectious diseases is higher in the territories than in Israel. Some of the vaccines that are provided in Israel are not provided in the occupied territories: hepatitis A, chickenpox, pneumonia, rotavirus and the human papillomavirus.

Alongside all these factors, it is important to note that there are also health gaps which directly stem from the occupation. Most living space in the occupied territories is under Israeli control, which creates a housing shortage in the West Bank. Moreover, the lack of building permits combined with Israel's security needs leads to the fact that Israel frequently conducts demolitions of Palestinian homes.[122] Similarly, Palestinian civilians deal with a serious lack of access to water sources

[115] For more information, see: Reem Abuiyada and Ra'ed Abdulkarim. "Non-Governmental Health Organizations in Palestine from Israeli Occupation to Palestinian Authority", October 2016, Asian Social Science 12(12):29.
[116] The Military Medical Services of Palestine (MMS) were established in order to provide healthcare for Palestinian military personnel and their families.
[117] Health Annual Report Palestine 2018", State of Palestine, Ministry of Health, July 2019.
[118] See: Mor Efrat, "Divide and conquer: inequality in health", Physicians for Human Rights, January 2015.
[119] See: Hadas Ziv, "A Legacy of Injustice: A Critique of Israeli Approaches to the Right to Health of Palestinians in the Occupied Territories", Physicians for Human Rights, Nov. 2002.
[120] The infant mortality rate in the West Bank stands at 12.8 per 100,000 and in Gaza at 14.9 per 100,000.
[121] These statistics are taken from the CIA World Factbook with regards to Israel, the Gaza Strip, and the West Bank.
[122] "Statistics on demolition of houses built without permits in the West Bank (Not including East Jerusalem)", Btselem, updated July 8, 2020.

because of restrictions that Israel imposes on entry into areas defined as closed military areas, in part in order to protect roads designated for settlers.[123] This exists alongside other restrictions, such as arbitrary arrests, restrictions on freedom of movement, and restrictions on fishing areas.[124] This combination of factors created a reality in which the Palestinian governmental authorities' preparedness for dealing with a pandemic were severely impaired.

B. Health services in the territories during the COVID-19 crisis

Preparedness for COVID-19 and the occupation

The COVID-19 crisis emerged amid a serious economic crisis that was already underway in the West Bank and Gaza. Prior to the pandemic there were already some 1.5 million unemployed Palestinians in the territories, and following the outbreak of the virus, several hundred thousand more joined their ranks.[125] One of the reasons for the severe economic crisis is the fact that many Palestinians work in Israeli settlements or on the Israeli side of the Green Line.[126] Additionally, even before the COVID-19 crisis, the Palestinian healthcare system was weak and largely dependent upon donations from international agencies, and upon medical services and supplies from Israel and other countries. Consequently, the Palestinian establishment ill-prepared for the pandemic due to lack of trained personnel as well as lack of key resources, including ICU beds, ventilators, masks and protective suits for medical staff. On March 5, concerns became a reality when the first cases of COVID-19 were discovered within the areas controlled by the Palestinian Authority.[127] In response, the PA declared a state of emergency and took a number of steps, including a lockdown in Bethlehem and later a closure restricting all movement in the West Bank, aside from trips to buy food and medical supplies.[128]

Severe restrictions were also put in place in Gaza by the Hamas government. The Gaza Strip had been in economic turmoil for several years already and was severely lacking in medical supplies. To put things in perspective, prior to the pandemic there were only 63 respirators in Gaza and just 70 ICU beds in total. In addition, electricity is supplied only eight hours a day in the Gaza Strip.[129] On March 15, following the first confirmed cases of the disease in Gaza, the Hamas

[123] "The Occupation of Water", Amnesty International. November 29, 2017.
[124] "Israel and occupied Palestinian territories 2019", Amnesty International.
[125] Suha Arraf and Meron Rapaport, "In Israel they want Palestinian workers, but the PA prefer that they stay at home", Sicha mekomit, April 8, 2020 [Hebrew].
[126] Adnan Abu Amer, "Coronavirus reveals Palestinian economic dependence on Israel", Al Monitor, April 24, 2020.
[127] Suha Arraf, "The Palestinian Authority is fighting COVID-19, Israel is fighting the Palestinian Authority", Sicha mekomit, 28 May, 2020 [Hebrew].
[128] Amit Waldman, "A tightened siege or too few restrictions: how Gaza and the West Bank are experiencing the COVID-19 crisis differently," Mako, April 10, 2020.
[129] Elior Levi, "The Palestinians are trying to manufacture ventilators: 'It's a humanitarian project'", Ynet, 2 April, 2020 [Hebrew].

security apparatus published guidelines forbidding all gatherings, including in shopping areas, restaurants and cafes, as well as at weddings, mourning tents and in mosques.[130] In an attempt to prevent an outbreak of the virus, they set up 32 quarantine centers throughout the Gaza Strip as well as a field hospital by the Rafah border crossing to prevent potentially contagious people returning from abroad from infecting the rest of the population. A senior official in the Gaza Welfare Ministry declared that the isolation and hermetic sealing of Gaza were a powerful preemptive defense. "**From the first moment we knew that if there would be an outbreak, the healthcare system would collapse, and therefore immediately quarantining everyone who entered the Gaza Strip was the best possible method.**"[131]

Eyewitness accounts brought attention to the fact that the quarantine facilities in Gaza were not providing adequate solutions for the medical and hygiene needs of COVID-19 patients. The quarantine centers in Gaza were uncomfortable and lacking in basic furnishings, such as food, sanitation supplies and more. It was also reported that those in quarantine were treated poorly and were forbidden from leisure activities. The hours in which they were allowed outdoors were limited in a way that ensured they would primarily spend time in overcrowded rooms – with some five to a room. Staff at these facilities were not equipped to deal with the psychological and social effects of quarantine in such conditions. This was made all the more difficult by the lack of testing available, which meant that the time spent in quarantine needed to be longer than usual.[132] Following a severe lack of critical equipment, the Health Ministry in Gaza asked the WHO and the international community for as much vital equipment and supplies as possible, including ventilators, COVID-19 tests, protective gear for medical personnel and sanitation materials.[133]

This low level of preparedness was evident in East Jerusalem as well. In the three Palestinian general hospitals in East Jerusalem (Makassed, Augusta Victoria and Saint Joseph's) there were only 22 ventilators and 62 beds dedicated to COVID-19 patients.[134] Although Palestinian residents of Jerusalem have permanent residency status in Israel and therefore frequently receive treatment in Israeli hospitals (they are covered by Israeli Health Funds), the distress experienced by the Palestinian

[130] Jack Khouri, "Doctors Warn of Gaza Strip's Collapse After First Coronavirus Cases Surface", Haaretz, 23 March, 2020.
[131] Jack Khouri, "With coronavirus in check, Gaza worries about economic fallout", Haaretz, May 7, 2020.
[132] "How is Gaza dealing with COVID-19?", Al Monitor, March 31, 2020. "No sanitizers, fresh food or distance in some of Gaza's quarantine centers" AL Monitor, April 9, 2020.
[133] Jack Khouri, "On the Brink of Its Own Coronavirus Crisis, Gaza Appeals to Israel and the World for Help", Haaretz, March 24, 2020.
[134] Twelve of the ventilators are reserved for immunocompromised patients at Augusta Victoria Hospital. At Makassed Hospital there is a COVID-19 ward with 22 patient beds, and at St. Joseph's Hospital in Sheikh Jarrah there is a special COVID-19 unit with 28 beds. See: Judith Sudilovsky, "East Jerusalem scrambles to prevent COVID-19 outbreak before Ramadan", +972 Magazine, April 26, 2020.


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hospitals there affects access to medical treatment, especially for West Bank residents who are dependent upon them.

The decision of the Palestinian administrations to impose a full lockdown on the Occupied Territories was motivated in large part by the deeply depleted Palestinian healthcare system, which has not been allowed to develop properly under the Israeli occupation. Even though the number of infected persons was relatively low compared to many other countries (largely because of the lockdown), the social and economic consequences were unbearable, as were the infringements on the rights of Palestinians.

Israel's responsibility for the Palestinian healthcare system during the COVID-19 crisis

The low level of preparedness in Gaza for dealing with the COVID-19 outbreak is in large part due to the long lasting blockade which Israel has imposed, as well as Israeli control of border crossings, which undermines the Palestinians' ability to conduct free trade and create their own monetary policy. These steps prevent the Palestinian administrations from developing the local economy in a way that allows them to properly collect taxes and fund social services. Largely because of this – in addition to internal factors – the quality of health services offered to Palestinian civilians is quite low. From the standpoint of international law, as well as from universal human ethics, Israel has the responsibility to ensure that the Palestinian administrations are adequately equipped to handle the pandemic.[135]

Following the announcement of the first two COVID-19 patients in Gaza on March 22, all outpatient clinics in hospitals throughout the Gaza Strip were shut down. The lockdown in Gaza forced PHRI to freeze its field activities in the territory. PHRI appealed to the Coordinator of Government Activities in the Territories and the Israeli Ministry of Health to demand that they provide for the healthcare system in Gaza the necessary means at its disposal, and that they work to fill the gaps in medical supplies created due to the blockade and the dependence of Gaza on Israel with regards to the movement of goods[136] and people,[137] as well as the supply of electricity.[138] Despite this, Israeli policy with regards to assisting the Occupied Territories confront the pandemic was entirely lacking in transparency, and our request did not receive any response from COGAT or from the Ministry of Health. Thus, on April 23 PHRI filed a petition to the Supreme Court to demand

[135] "Occupied Palestinian territory: Right to Health 2018", World Health Organization.
[136] Hagar Shezaf, "In Trade War Between Israel and Palestinians, Losers on Both Sides", Haaretz, February 16, 2020.
[137] Danny Zaken, "The Uprising That Wasn't: Dependence on Israel Prevented an Intifada", Globes, December 30, 2020 [Hebrew].
[138] Jack Khouri, "On the Brink of Its Own Coronavirus Crisis, Gaza Appeals to Israel and the World for Help", Haaretz, March 24, 2020.

that the Israeli government publish its plan for assisting the healthcare systems in the West Bank and Gaza. We further demanded that the assistance offered to Gaza include ventilators, medicines, protective gear for healthcare workers and as much medical equipment as possible.[139]

Although the government's response listed a number of steps it had taken to help the authorities in Gaza in eradicating the virus, the government argued that publicly disclosing the provision of aid could harm Israel's foreign relations. It further argued that Israel does not see itself as responsible for the public health situation in the territories even during the COVID-19 pandemic, based on the claim that "**responsibility and authority over healthcare with regards to the Palestinian population in Judea and Samaria and in the Gaza Strip were transferred to the Palestinian Authority**."[140] The judges accepted the government's position, and following the release of parts of the information we had requested, we asked that our petition be revoked.

According to the information released, fearing a potential outbreak of the virus, Israel took a number of steps geared towards helping the Palestinian administrations deal with the pandemic: 5,900 COVID-19 tests were transferred, as were 200 protective suits, 1,500 sanitation kits, and 50,000 protective masks, and Israeli medical teams trained Palestinian medical staff with regards to the virus.[141] On May 11, the Israeli government agreed to transfer NIS 800 million to the Palestinian Authority as an advance on tax payments that Israel collects on its behalf.[142] This aid is inadequate insofar as the Palestinian healthcare system was dealing with a dramatic lack of protective gear, testing kits and medicines, alongside a chronic lack of supplies for all other medical conditions that are not COVID-19.

Cancer patients prevented from leaving the territories for treatment

The COVID-19 pandemic created a situation in which the provision of medical services in the territories was limited to a small number of medical facilities which dealt almost exclusively with emergency treatment.[143] Because of the restrictions set in place by the authorities in Gaza, the West Bank and Israel, there was in practice both an internal and an external lockdown in place from the middle of March 2020. This situation severely impacted patients in Gaza dealing with dangerous and chronic illnesses, because most relevant treatments are unavailable

[139] See HJC 2669/20.
[140] "Following PHRI Petition, Israel Releases Information on the Extent of Assistance to Gaza and the West Bank", Physicians for Human Rights, May 13, 2020.
[141] Amir Buhbut. "Palestinian Authority Warns of COVID-19 Disaster, IDF Prepares for Extreme Scenarios in the West Bank", Walla, March 30, 2020 [Hebrew].
[142] Noa Landau. "Israel Set to Approve $230m Loan to the Palestinian Authority for Its Coronavirus Response", Haaretz, May 11, 2020.
[143] "Daily Report for COVID 19 Virus", Palestinian National Authority Ministry of Health Unit of Information System, May 17, 2020.

there, and therefore require permission to receive treatment in the West Bank or East Jerusalem. Foremost among this group are cancer patients, whose treatments (such as radioactive iodine) are completely unavailable in Gaza.

Even under regular circumstances, cancer patients in Gaza suffer from restricted access to treatment. The Israeli exit permit system forces them to wait for permits from the Israeli District Coordination and Liaison for several weeks, even months, in order to receive a permit which will allow them to leave the Gaza Strip for treatment. Prior to the outbreak of the pandemic, the rate of permits approved for cancer patients was 69%, with 9% rejected and 22% given deferred permits. Despite this, following the lockdown associated with the COVID-19 outbreak, the number of exit permits was severely reduced and included only those in the most extreme emergency situations. While many countries enforced restrictions on movement as a way of preventing the spread of the virus, all such countries (including Israel) did not enforce a lockdown on those in need of medical treatment; in fact, almost every country made a serious effort to ensure that those in need of treatment for cancer and other chronic illnesses were still able to receive all necessary medical treatment.[144] Because of the clear life-threatening nature of cancer and the potential for a rapid decline in patients' health, PHRI sent an exhaustion of remedies letter to COGAT and the Israeli Ministry of Health demanding that they find a solution for all cancer patients from Gaza who were left without life-saving treatment as a result of the newly imposed travel restriction in and out of the occupied territories.

Having to attain the permission of Israel's District Coordination and Liaison to exit Gaza takes a heavy toll on the health and quality of life of cancer patients and those suffering from chronic illnesses; especially those who need treatments and procedures not available in the Gaza Strip. Incessant delays for long periods with regard to exit permits from Gaza often harms their chances of recovery, especially when they are awaiting specific treatments within a larger treatment process.

Not only do the restrictions on exit permits harm these patients, but also the anxiety surrounding the permits as well as the lack of a proper mechanism for ensure their return to reasonable conditions in Gaza hamper the patients' recovery process. PHRI's representatives have reported that patients have often forfeited approved permits, because the travel to hospitals as well as the quarantine period was viewed as potentially damaging to the patient's health. This means that chronically ill patients from Gaza, in particular those with cancer, were forced to choose between two terrible options: giving up on life saving treatment or

[144] AlWaheidi, Shaymaa, Richard Sullivan, and Elizabeth A. Davies. "Additional challenges faced by cancer patients in Gaza due to COVID-19". ecancermedicalscience 14 (2020).

traveling to hospitals in East Jerusalem and the West Bank while facing exposure to COVID-19, which in turn forces them into overcrowded quarantine facilities upon their return to Gaza, which also contains its own risk factors.

Palestinian workers who stayed in Israel during the COVID-19 pandemic

The travel restrictions which the Israeli government and the Palestinian Authority put in place to prevent the spread of COVID-19 also had a significant impact on Palestinian workers who traveled daily to work inside Israel. Because the infection rate was far higher in Israel than in the West Bank, there was concern that those traveling to and from Israel for work would cause to a rise in infections inside the West Bank. And in fact, there were a number of cases wherein Palestinian workers contracted the virus whilst working with Israelis.[145]

With the goal of protecting the specific industries most dependent upon Palestinian labor (construction, agriculture), the Israeli Ministry of Defense issued a regulation enabling Palestinian workers to enter Israel, under the condition that they stay for 30 days (for agriculture workers) or for 60 days (constructions workers) consecutively. The responsibility for enforcing this fell on the Israeli employers.[146] At the same time, government ministries did not bother to publish criteria for employers as to how to financially compensate Palestinian workers for these new restrictions (for instance, by offering room and board), nor did they issue health guidelines. In short, Palestinian workers were left to fend for themselves. In light of the deep financial distress in the occupied territories, many workers preferred to stay employed even if the conditions were unreasonable. One of the reasons that such workers preferred to remain in Israel, despite the fear of infection and the poor conditions (such as sleeping on construction sites or in storage units), was that employers threatened to fire them if they did not continue their work during this period, which meant that they would not be able to return to their jobs even after the crisis and would also lose their work permits.[147]

In light of this reality, Physicians for Human Rights Israel submitted an exhaustion of remedies letter, and together with The Workers' Hotline and The Association for Civil Rights in Israel, petitioned the Supreme Court to establish an arrangement that would ensure health and appropriate housing for Palestinian workers that remained inside Israel (HCJ 2730/20). The petition was filed after a memorandum

[145] Suha Arraf and Meron Rapaport, "In Israel they want Palestinian workers, but the PA prefer that they stay at home", Sicha mekomit, April 8 2020 [Hebrew].

[146] Yoav Zeitoun, "Palestinian workers will be able to remain in Israel for two months", Ynet, March 16, 2020.

[147] Suha Arraf and Meron Rapaport, "In Israel they want Palestinian workers, but the PA prefer that they stay at home", Sicha mekomit, April 8, 2020 [Hebrew].

of law was published, but not advanced, according to which employers of Palestinian workers would supply them with health insurance. The petition, which was filed against the Ministries of Health, Labor and Welfare, the Interior, Construction and Housing, and the Minister of Defense, demanded a regulated arrangement for health insurance for the Palestinian workers who stayed in Israel under accommodation permits during the coronavirus pandemic, conditioning employment of these workers on providing appropriate housing as set forth in the Foreign Workers Regulations, and setting a protocol to guarantee enforcement of the health and safety of workers.[148]

Following the petition, the government published emergency regulations that included mandatory medical insurance in Israel for every Palestinian worker with an accommodation permit; it is the employer's obligation to meet the standard of accommodations that would be similar to those of foreign workers, and certification of additional supervisors. Furthermore, the conditioning of an accommodation permit for a worker on the employer committing to holding the worker's ID card was canceled. [149] The situation of Palestinian workers, who do not receive any reasonable social aid is the result of longstanding regulatory weakness that allows and continues to allow employers in Israel to enjoy the fruits of the labors of Palestinian residents of the occupied territories, without having to give them reasonable and fitting working conditions.

C. Chapter summary

In many ways, the COVID-19 pandemic exposed the depth of the crisis in the Palestinian healthcare system both in the West Bank, and in the Gaza Strip. The pandemic also exposed the dependence of Palestinian healthcare on Israel. For all the reasons noted above, the Palestinian Authority lacks both the power and authority that allows an independent state to deal with a humanitarian crisis. While the restrictions on movement aided in slowing the spread of infection, this was achieved through the implementation of a strict lockdown on movement and shuttering the economy – methods that are likely to have far-reaching consequences on the Palestinian economy, which was already in crisis even before the pandemic.

Israel cannot brush off its responsibility for the lives and health of the Palestinians in the occupied territories. Israel's control of movement and so many of the determinants of health in the territories – access to water, land, and livelihood

[148] "Supreme Court petition: Israel must ensure medical insurance to Palestinian workers employed and staying in Israel in the shadow of the coronavirus pandemic", Physicians for Human Rights, April 28, 2020.
[149] "Rights for Palestinian workers in Israel during COVID-19", ACRI [Hebrew].

– coupled with the Palestinian economy's lack of monetary independence, is a significant factor, even if not the only factor, in developing an adequate healthcare system. Israel's claims that various international conventions do not apply to it, and its reliance on the transfer of powers in the Oslo Accords, are insufficient. Thus too, the level of aid that Israel supplied throughout the crisis so far does not compare to the level of its responsibility and control. The argument that Israel is not responsible for the health of the Palestinians will be valid only when the occupation ends.

To deal with a global and humanitarian crisis like the coronavirus crisis, the PA must be autonomous and not dependent on Israel, with an independent and well-developed healthcare system. It clearly would have been impossible to contain the crisis without massive aid from the international community and from foreign countries. However, this does not mean that we should demand any less than that Israel end the occupation and remove the blockade on Gaza to exercise the right to health of Palestinians independently and not reliant on Israel.

Discussion and conclusions

This report discusses and summarizes Israel's policies regarding the COVID-19 pandemic in the first months of the outbreak. As these lines are being written, the Israeli government and the public are preparing for an increase in the number of cases. As we are still far from herd immunity, and a vaccine is still not expected to be available in the coming months, we must accustom ourselves to the current situation. The conclusions that arise from this report are not the final word on the matter and reflect only the handling of the initial months of the pandemic, from March to June. However, because the battle with the coronavirus is expected to continue for some time, it is all the more important to discuss the broad implications of COVID-19, and not take a narrow view of the number of new cases, patients on life support and deaths. Waiting for the crisis to end will not solve the institutional problems that existed before and will continue to exist after the crisis and will continue to impact issues closely connected to the right to health.

A complex picture arises from an analysis of the ways in which various Israeli government systems handled the coronavirus crisis. On the surface, the Israeli government's application of a lockdown achieved its desired results, that is, slowing the spread of the virus, and a low mortality rate relative to other countries in the Western world.[150] At the same time, the damage the crisis has caused is palpable in many different areas — loss of financial security, the harm to mental health exacted by the policies of quarantine and social distancing, feelings of uncertainty and anxiety, all of these have taken and continue to take an unbearable

[150] According Johns Hopkins University's database, the mortality rate from COVID-19 in Israel is 3.35 per 100,000 as of July 10, 2020. This is a very low number as compared to Belgium (84.1), Great Britain (61.18), Spain (58.08), Italy (56.2), Ireland (34.68), and the U.S. (33.92), to name a few countries. See: "How does mortality differ across countries?", Johns Hopkins University.

THIS EXPOSES THE INJUSTICE AND THE INEFFECTIVENESS OF THE LOCKDOWN POLICY AND THE POLICY OF PRIVATIZATION THAT HAS GUIDED THE ISRAELI GOVERNMENT IN RECENT DECADES. IN THE MOMENT OF TRUTH, THE ISRAELI GOVERNMENT INTERNALIZED THAT THE LACK OF EQUAL HEALTHCARE IS NOT JUST A MORAL ISSUE, BUT RATHER AN ACTUAL WEAKNESS IN THE STRUGGLE AGAINST THE PANDEMIC, THAT INDEED, EVERY ONE OF THE GROUPS THAT WAS FOR DECADES EXCLUDED FROM RECEIVING ADEQUATE HEALTHCARE SERVICES BECAME A POTENTIAL SPREADER OF THE VIRUS. THE DECISION MAKERS REALIZED THAT 'EQUAL HEALTHCARE FOR ALL' IS NOT JUST A SLOGAN, BUT ALSO A SIGNIFICANT NATIONAL INTEREST.

toll on individuals, families, and communities. This is in addition to the sense of alienation and mistrust of many regarding the actions of the government, which has also been severely criticized, at home and abroad, for its disproportionately undemocratic measures and lack of transparency in its conduct.

This criticism is not detached from the centralized and opaque manner in which the decisions were made in the exclusive 'kitchen cabinet', limited mainly to Prime Minister Benjamin Netanyahu, Ministry of Health Director General Moshe Bar Siman Tov, Head of Public Health Services Professor Sigal Sadetsky, and National Security Council Chairman Meir Ben-Shabbat. The price of this centralization was the absence of scrutiny and oversight of the approaches taken by the 'kitchen cabinet', a lack of adequate cooperation between professionals from key fields in the fight against the pandemic, and a sweeping policy not suited to the characteristics and needs of those groups who differ from what the decision makers consider the fictional 'average Israeli': poor people living in overcrowded conditions, people with special health needs, people living in institutions and more. Because of the disconnect from the relevant players who are aware of the unique needs of these groups, the government adopted a one-size-fits-all strategy. A state of emergency also requires decentralized system management and operation include the participation of multiple bodies throughout the system and failing to adopt such a course of action has many severe consequences.[151]

Therefore, we must ask, could we have achieved the same results had the lockdown not been combined with such a severe infringement on individual rights, including the right to work and the right to privacy, and if the policy had been accompanied by transparency in the presentation of data, of the key assumptions in the development of models, and as to the manner in which decisions were made, as well as advocacy better suited to different groups and the dynamic nature of the situation? Could the sustained weakness and budgetary erosion of the Israeli healthcare system, which impaired its preparedness for the crisis, have possibly contributed to the decision to take such extreme steps? And what was the price of exclusion of marginalized groups on the level of national preparedness for the pandemic?

This chapter synthesizes the findings arising from the various chapters of the report into conclusions about the major failures and their implications for the lives, well-being, and health of all people under Israel's control.

[151] Amos Harel, "Despite centralization and disorder, Israel can mark a victory over the coronavirus", Haaretz, May, 8, 2020. Carmit Padan, Meir Elran, Einav Levi, Sasson Hadad, Ahaz Ben Ari. "The Corona epidemic: systemic challenges for Israel", The Institute for National Security Studies, Insight No. 1277, March 20, 2020.

A. An insufficient healthcare system meets a pandemic

When the coronavirus pandemic arrived in Israel in early February 2020, the public was exposed to what health professionals have been warning about for quite some time: over the past two decades, the Israeli healthcare system has had its budgets, infrastructure, and manpower gutted, while public and communal health and medical services have been privatized and diminished.[152] In such conditions, there was a serious concern that the healthcare system did not have the necessary resources for dealing with the coronavirus crisis; that is, that the epidemiologic investigation apparatus, laboratories, number of ICU beds, ventilators, medication, manpower, and more would not be sufficient for the number of patients who would need serious care.[153]

Motivated by this concern, the government decided to impose a general lockdown while restricting individual rights and social life, with the goal of preventing a massive outbreak - what became known as 'flattening the curve'. This decision was forced by the sustained neglect and debilitation of public health services, which, with proper resources, could have monitored the spread of the virus, executed epidemiological investigations and laboratory tests more wisely, and would allow for targeted regional lockdowns. The decision that was made – general nationwide lockdown, and the subsequent severe economic damage without fast, effective mechanisms for support or compensation, and a restriction of human rights and liberties, has exacted a heavy price.

Shutdown of the economy. In order to buy time for the healthcare system to adequately prepare for a massive intake of COVID-19 patients, especially those requiring respiratory support, the government shut down the economy. This policy proved itself in preventing an outbreak, but the toll on the economy and its effect on Israeli citizens has been enormous: rising unemployment (1.14 million unemployed as of the middle of April),[154] closing of businesses (an estimated 70 thousand businesses will close as of the end of 2020),[155] general loss of job security, even for those who remain employed. Even if many of the layoffs are currently defined as furloughs, and are eligible for unemployment benefits from National Insurance, the damage isn't only financial, but also takes the form of a sense of loss, depression, loss of self-value, and difficulty in recovering and moving on to the next stage of one's professional life.[156] For young professionals who are just

[152] Nihaya Daoud, Nadav Davidovitch, Hadas Ziv, Rabia Khalaila, Ameed Saabneh, Dani Filc, "An Outline for dealing with the 'pre-existing conditions' of the Israeli healthcare system after the crisis", Crisis Specialists, Health Team, Position Paper 1, April, 2020 [Hebrew].
[153] Gali Weinreb, "Comptroller: Israel's health system not ready for huge pandemic", Globes, March 23, 2020.
[154] Dafna Bramly Golan, "The Secret of the job market: why doesn't anyone know Israel's unemployment rate?", Globes, June 8, 2020 [Hebrew].
[155] Adi Dovrat-Meseritz, "Worst-case scenario: 70 thousand businesses, including 4,000 restaurants and 1,000 clothing stores, will close", The Marker, May 14, 2020. [Hebrew]
[156] Suzy Sofer-Roth, "Endless rejection: how to escape the corona furlough cycle", Calcalist, May, 31, 2020 [Hebrew].

starting their careers, these difficulties could follow them for even longer than those who already constitute part of the workforce.[157] It is worth noting that this damage is not the result of closing the economy so much as the result of the way in which the state dealt with the closing, and the insistence on avoiding the increase of external debt, not raising taxes on the wealthy or on corporations, and not assuming debt – all steps that other countries have taken to prevent furloughing workers, and to compensate employers and small business to prevent their collapse.

Emergency services only. Although medical services continued to be provided, even during the crisis, their quality and availability were seriously limited when hospital wards were instructed to cut back on their services in order to prepare for COVID-19 patients. Outpatient treatments, non-life-saving surgeries, follow-up for patients with chronic conditions, and sometimes even care for patients whose conditions complicated – all these were delayed until after the crisis.[158] The emphasis on preventing the virus from spreading led to instructions to avoid in-person visits to health clinics if possible, and doctors reported that patients were vanishing, or arriving in significantly worse condition as a result of not visiting the clinic in time. Once it understood the danger, the Ministry of Health launched a campaign calling for anyone who was sick to get tested.[159] The true extent of the impact of this policy of emergency management is still unknown to the wider public.

Reduction of social services. While the coronavirus crisis led to a dramatic increase in rates of domestic violence and suicide attempts, the desire to reduce movement of civilians greatly impacted the availability and scope of social services.[160] Thousands of workers who provide essential social services were categorized as nonessential and furloughed.[161] More than ever, in a time of social crisis with deep and far-reaching consequences on the social and mental resilience of Israeli citizens, when they are demanded to shut themselves up in their houses under a cloud of uncertainty and severe financial hardship, they are left with diminished support from a system that even when not in crisis does not provide adequate support. As a result, those who rely on social services – the elderly, people with disabilities, victims of domestic violence, etc. – suffered especially. For this reason, we see, for example, a sharp rise in cases of domestic violence, leading in some cases to suicide.[162]

[157] Sivan Klingbail and Avi Waksman, "Lost generation: 150 thousand young people may get stuck in unemployment", The Marker, April 30, 2020 [Hebrew].
[158] Gali Weinreb, "The delayed appointments, the tests that weren't done: the indirect damage of the coronavirus." Globes, April 22, 2020 [Hebrew].
[159] Linoy Bar Geffen, "'Where have all the patients gone?' Doctors speak out about the silent killer of the coronavirus pandemic", The Hottest Place in Hell, April 5, 2020 [Hebrew].
[160] Lee Yaron, "More Women Die by Suicide as the Coronavirus Crisis Ushers in Rise in Domestic Violence." Haaretz, May 10, 2020.
[161] Michal Cohen, "Cuts to welfare NGOs, just when we need them most", The Marker. April 6, 2020 [Hebrew].
[162] Lee Yaron, "Israel reports four suicides linked to domestic violence since start of coronavirus lockdown." Haaretz, May 3, 2020.


מגן דוד אדום בישראל
MAGEN DAVID ADOM IN ISRAEL

An overview of the situation shows that the preventative actions taken by the Israeli government, including general lockdown and additional limitations, were successful in limiting the spread of COVID-19 and reducing the rate of new infections. At the same time, the reduction of resources and low level of preparedness of the healthcare system for the pandemic led to a situation in which the lockdown policy created many victims and significant damage: from losing economic security to severe impairment of nonemergency health services, to a dangerous reduction of social services essential for the wellbeing of people living in Israel.

B. Health bubbles

Another yardstick for measuring the success of the government's policy is its ability to provide equitable and suitable health services to all people and sectors of the population for which the government is responsible during the coronavirus pandemic. Not just out of concern for equal human rights, but also out of an understanding that in a pandemic, providing such services contributes to the vital mission of stopping the spread of the virus.

The data point to gaps in health services that were provided to different groups: between residents of Israel with national health insurance and those who receive health services under other legislative powers; between residents of the State of Israel and residents of the occupied territories; between people in a higher socio-economic cluster and those in lower clusters, etc. We might note the failures in making information about the coronavirus accessible to communities in Israel's geosocial periphery, the unequal distribution of testing stations, the gaps in the monitoring of infections,[163] the enforcement of coronavirus regulations[164] and more.

This exposes the injustice and the ineffectiveness of the lockdown policy and the policy of privatization that has guided the Israeli government in recent decades. In the moment of truth, the Israeli government internalized that the lack of equal healthcare is not just a moral issue, but rather an actual weakness in the struggle against the pandemic, that indeed, every one of the groups that was for decades excluded from receiving adequate healthcare services became a potential spreader of the virus. The decision makers realized that 'equal healthcare for all' is not just a slogan, but also a significant national interest.

This realization forced the authorities to learn the best possible way to reach

[163] Boaz Efrat, "Parliament report: the Ministry of Health is not supervising dozens of status-less persons", Walla, May 14, 2020 [Hebrew].
[164] Muhammad Darawshe, "How do you say 'corona' in Arabic?" Haaretz, March 23, 2020 [Hebrew].

excluded populations in Israel in general, and Palestinian citizens in particular, how to reach status-less groups in Israel, how to work more closely with prison health services, and how to coordinate the battle against COVID-19 with the PA. All these were surveyed in previous sections. In order to do so, the government began to cooperate with civil society organizations to a degree not often seen, as in the case of status-less persons, while at the same time occasionally ignoring cries for help from organizations and NGOs for long periods of time, as in the case of nursing homes.

It is difficult to assess the extent of the tragedy and suffering that would have been caused if those civil society organizations had not filled the vacuum left by the state in addressing the needs of those disadvantaged groups. Civil society organizations, including PHRI, were forced to adapt to a new reality and to new needs, and supplied a wide variety of crucial services – from healthcare services to distributing food and protective gear, to raising awareness and making information accessible, and submitting legal petitions in cases of clear violations of rights. The excessive dependence on civil society organizations demonstrated the dangers of the privatization processes that Israel has gone through in recent decades.

The pronounced reliance on civil society organizations revealed the weaknesses of the healthcare system where professional bodies might have helped – as public health services and the emergency authority depleted their resources and/or did not participate in decision-making processes. After decades of segregation between communities, accelerated privatization of social services and the creation of various health bubbles, the government was forced to improvise, relying on social organizations and associations representing marginalized communities whom the state has been reluctant to listen to previously.

C. A stress test for democracy

"As for our common defense, we reject as false the choice between our safety and our ideals."

(Barack Obama, 2009)[165]

The outbreak of the coronavirus coincided with the crisis in Israeli democracy, which cast a long shadow on the entire decision-making process around managing the consequences of the epidemic. This shadow grew larger as the result of a number of aspects of the government's handling of the coronavirus crisis.

Lack of transparency. It is still too early to determine the toll of the coronavirus on a person's life, on job security and financial security, and on general wellbeing, but it is already clear that the public's right to information was one of the first casualties of the pandemic. The conduct of decision-makers regarding the coronavirus crisis constituted an emblematic example of decision making without public transparency. Thus, for instance, there was no hope for the public, the media, or even public health professionals, to know which factors the government considered when making decisions, as the government refused to disclose the transcripts of its meetings during the coronavirus period. Meeting transcripts are classified for 30 years.[166] This conduct was challenged in a petition by the Freedom of Information Movement and various journalists.[167] The result of the lack of transparency, that is the public's distrust of government decisions, was evident in a survey by the Freedom of Information Movement, which included some 1,250 respondents and found that 73.3% of the public believed that the information received from the government was unsatisfactory.[168]

Curtailing liberties and human rights. The lack of transparency is even more troubling in light of the exceptional scope of emergency regulations, including restricting gatherings and enforcing restrictions through fines using advanced technological means operated by security services in a manner unparalleled in democracies around the world during the crisis.[169] It is important to note that the

[165] Inaugural Address of President Barack Obama, January 20, 2009.
[166] Chen Maanit, "In search of the lost protocols: why didn't the public know how the government decided on lockdown and economic paralysis?", Globes, June 8, 2020 [Hebrew].
[167] Chen Maanit and Tal Shneider, ""Globes" joins petition for disclosure of minutes of government meetings", Globes, April 7, 2020 [Hebrew].
The High Court ordered the deletion of the petition seeking permission to publish the transcripts of government meetings from the period of the Corona plague and in general. The judges ruled that the petitioners must apply for information through the Freedom of Information Act.
[168] Rivki Dabash and Guy Zomer, "Survey: transparency in the coronavirus crisis—a summary of public opinion." The Movement for Freedom of Information, April 23, 2020 [Hebrew].
[169] Gedalia Afterman, Daniel Cohen, Liron Shiloh, Maya Shavi, Ziv Muzar, and Laura Ortega. "Use of technology in the fight against the spread of COVID-19", The Abba Eban Institute for International Diplomacy, May 2020 [Hebrew].

Israel Security Agency (Shin Bet) expressed its displeasure with the use of its capabilities for civilian purposes, and was the first to announce when it felt it was no longer needed while recommending developing civilian capabilities such as the Ministry of Health's protective smartphone application.[170]

The restriction of freedoms was particularly severe for the most vulnerable groups in society: inmates who were denied leave, non-emergency medical treatments and visitations with their families and lawyers; patients in mental health facilities, at-risk youth in boarding schools, hostel residents and residents of nursing homes who were completely prevented from leaving and whose family members' visits were forbidden; Palestinian workers who could not return home for many weeks by decision of the Ministry of Defense; Palestinian patients whose treatment outside the territories was denied by virtue of decisions by Israel and the PA; personal care workers, migrant workers who were prohibited from leaving their patients' homes, etc. The violations of all of their rights was carried out without the publication of transcripts of government meetings, without the oversight of the Knesset, without the presence of opposition representatives in the meetings, and while the courts operated on a limited basis by decision of the acting Minister of Justice.[171]

Tracking and locating. Another right that has fallen victim to the battle against COVID-19 is the right to privacy, as draconian measures have been taken to enforce the quarantine provisions. For the first time since the establishment of the state, the Shin Bet received powers to monitor Israeli citizens in order to fight a health crisis. This power was transferred to the Shin Bet without legislation (and was therefore rejected by the Supreme Court).[172] The use of a covert security service as a tool for monitoring the spread of the virus was also unusual in relation to decisions of other democracies around the world that did not use similar measures. This fact is particularly jarring in light of opposition from health officials, including the Association of Public Health Physicians, who claimed that it was a violation of public trust,[173] and from Shin Bet chief Nadav Argaman, who called for creating a civilian tool for locating individuals.

The method used by the government to restrict, track and monitor the public in Israel also stood out in relation to the restriction of rights in other countries in the world. The severity of the means and the concentrated and opaque manner in which the decisions were made by the 'kitchen cabinet' have led prominent newspapers around the world to declare that the Netanyahu government is

[170] Rafaella Goichman, "The Deadline is midnight: the ISA will stop monitoring citizens tonight", The Marker, June 10, 2020 [Hebrew].
[171] Avishai Grinzvaig, "Courts will operate on an emergency basis: Netanyahu's trial is delayed until May 24", Globes, March 15, 2020 [Hebrew].
[172] Yair Altman, "Supreme court: continuing use of telephone location in the fight against COVID-19 must be legislated", Israel Hayom, April 26, 2020 [Hebrew].
[173] Rafaella Goichman, "Doctors: ISA monitoring is hindering the fight against COVID-19", The Marker, March 25, ,2020 [Hebrew].

taking advantage of the coronavirus crisis to effect regime change.[174] Whether or not this was true, public trust has been severely damaged, precisely while public trust and responsiveness are a key component in the fight against the coronavirus pandemic.

D. What do we do now?

Five-and-a-half months have passed since the arrival of the coronavirus, and most countries in the world are still fighting the virus. Therefore, it is essential that the Israeli government develop smart, population-friendly ways of coping that navigate the right balance that will limit the virus's spread while minimizing the harm to normal life and democratic values.

It is difficult to sum up an event of which we are still in the midst of. However, the insights that emerge from this document point to success, so far, in reducing the morbidity and mortality rates to very low levels compared to many other countries on the one hand, and on the other, failure to preserve vital components of society – non-COVID-19 health services, economic and social needs, and maintaining the normal conduct of democratic life – in light of the consequences of government policies. This goes beyond the question that must be asked whether the same results would not have been achieved more quickly and optimally had the various health organizations been partners in crisis management, and had the public been provided with more accessible information and less enforcement. The deterioration of public cooperation with the announcement of the second wave of the outbreak is a testament to the destructive potential inherent in this loss of confidence.

However, this does not absolve the decision-makers and policymakers, led by the unity government set up to deal with the coronavirus crisis, from taking bold steps to change reality in a way that would make those systematic ailments exposed by the onset of the coronavirus a thing of the past, helping the most vulnerable who were most severely harmed. Although it seems that the Israeli public is too exhausted to carry out significant reforms, history shows that precisely in times of crisis, moves of this magnitude that could not be made at another time become possible. Such steps include:

Increasing investment in public health. As noted innumerably in various reports and research papers, the public healthcare system has been weakened for

[174] Tomer Michelson, "International headlines: with coronavirus as a cover, Netanyahu is staging a coup", The Hottest Place in Hell, June 13, 2020 [Hebrew].
Gershom Gorenberg, "With a pandemic as cover, Netanyahu is carrying out a coup in Israel", The Washington Post, March 19, 2020.
Noga Tarnpnopolsky, "Critics in Israel say Netanyahu using coronavirus as pretext for massive power grab", LA Times, March 18, 2020.


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decades. It is impossible to expect a system that is so underfunded even in regular times to function properly in a crisis.

Rehabilitating public health services. The coronavirus crisis exposed the weakness of public health services that were neglected for decades, including infant care, student healthcare, and more. This severely weakened the system in terms of manpower, in infrastructure (both physical and in data collection, analysis, and distribution), in the quality of services, and of course the reduction to a bare minimum of the ability to conduct epidemiological investigations at the outset of the crisis. The decision of the Ministry of Health to recruit 300 students to help with epidemiological investigations was a step in the right direction, provided that these positions are maintained until the end of the crisis.[175]

Defining social services as essential professions during the pandemic. Periods of quarantine and isolation, especially those that are not limited to a given timeframe, lead to an increase in needs that must be answered by government social services, needs that if neglected will lead to harm to the individual's health and wellbeing. Even in daily life, but especially in times of national crisis, there is a major demand for social services to provide an answer to these needs, while finding ways to maintain social distancing.

Increasing representation of disadvantaged groups in policymaking circles. The first communities to be hit by the crisis were those who from the outset were vulnerable in terms of economic, social, and health-related factors. These groups are for the most part not proportionally represented among decision-makers who are not aware enough of their specific health challenges. Increasing representation of these groups in decision-making forums will help ensure that no community will be left behind.

Establishing a dedicated body for ensuring transparency. Transparency is a key aspect in any modern state, in daily life and even more so in times of pandemic. Transparency allows for public oversight of mistakes in policy and proper allocation of resources; it helps with control and supervision of the government's and other agency's actions and preserving their importance, effectiveness, and fairness; transparency constitutes an essential basis for public trust and response and adherence to instructions from professional bodies; and most importantly, transparency provides a sense of certainty as to the state of affairs. Throughout the crisis, a significant number of freedom of information requests were completely ignored, and it therefore seems that the system is not suited to meet the needs of the public. As such, there must be a more fitting and effective answer. A dedicated body for government transparency can receive and coordinate

[175] Dafna Eisbruch, "A manpower boost for public health services", Davar, June 19, 2020 [Hebrew].

petitions from the public, and collect information from government sources, thus increasing public faith in its institutions.

Emergency economic plan for supporting the unemployed, employees and employers. The only way to ensure wide public support for restricting movement and lockdown, which prevent people from making a living and bring many close to hunger and poverty, is an emergency economic plan that includes relief payments and ensures income that will allow people to abide the regulations and stay at home without having to go into serious debt.

Strengthening local authorities and civil society. The COVID-19 crisis exposed just how essential the contribution of local authorities and civil society organizations were to deal with the crisis. The various actions they initiated and aided in included opening crisis management centers, manning various aid centers, providing support and assistance of all kinds, including health services for migrants and disadvantages communities, distributing food and medicine, and more. The assistance provided by these parties was invaluable. At the same time, due to the absence of any central body to coordinate between the activities of the various NGOs, resources were needlessly wasted, often in the midst of systemic chaos. As such, the state must strengthen its connection with civil society in order to ensure that all needs can be met in an organized way.

Regional cooperation. Another resource of which the government failed to take advantage despite its availability was cooperation with neighboring countries who, like Israel were dealing with the COVID-19 crisis. It is precisely during a crisis, that countries must strengthen connections with their neighbors using various tools such as sharing scarce essential resources, offering loans, coordinating fiscal activity, and sharing strategies for slowing the spread of the virus.

These are difficult steps to take, but the benefits from taking them in this time of crisis will serve the public for years to come. Historically, national crises, including health crises, contributed greatly to building the modern state; these crises forced governments to develop sanitation services and public health services, sewerage systems, vaccines and pasteurization, which today have become the public healthcare system; they forced governments to provide medication, food, and various types of aid to disadvantaged groups, which became the basis for the establishment of the states' welfare and aid system; they forced governments to oversee housing conditions, employment and traffic, and thus became the basis for regulation.[176] The principles applied by those governments are not some outdated trend, but rather principles that can and should be repeated when crises

[176] Mariner, Wendy K., George J. Annas, and Wendy E. Parmet. "Pandemic preparedness: a return to the rule of law." Drexel L. Rev. 1 (2009): 341.

arise that require answers that only the state can offer.

More than anything, the COVID-19 crisis demonstrated the necessity for public engagement and assistance from the state in times of national crisis. Even after years of privatization, commodification and erosion of public trust in values such as solidarity and mutual responsibility in favor of principles of market superiority, it is clear that in times of crisis, the government is the only entity that can provide fundamental answers to the public's needs. The reduction of government-operated aid programs causes indescribable damage to the health and wellbeing of the citizens. It is therefore vital that governments maintain their social services capacities, being that governments remain the primary actors that can adequately respond to large scale crises