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THE USES AND MISUSES OF IN VITRO FERTILIZATION IN ISRAEL: SOME SOCIOLOGICAL AND ETHICAL CONSIDERATIONS

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Israeli society has the highest rates of Assisted Reproductive Technologies (ART) intervention in the world, as well as the highest per capita consumption rate of infertility therapy, with In Vitro Fertilization (IVF) at its center. This situation is sustained by an unprecedented public health policy, posing hardly any restrictions on the eligibility of Israeli citizens for infertility treatments within the National Health Insurance (NHI) system. Given the health risks as well as the emotional and financial costs involved in the excessive use of IVF, this pattern of regulation and consumption calls for a careful sociological and ethical consideration of its origins and implications.

The paper is based on an analysis of key processes and events that took place in the Israeli regulatory and legal arena between 1994 (when the Israeli National Health Insurance Law was enacted) and 2003 (when the last attempt thus far to de-insure IVF was made). Processes and events that took place within that decade include legal actions taken by consumers in matters concerning IVF, court verdicts on IVF usage, parliamentary discussions on IVF regulation and failed attempts to restrict NHI coverage of IVF.

We argue that existing policies and utilization patterns of IVF in Israel are embedded within several frameworks: Israel's pro-natalist culture and "pro-family" values (both of which are contextualized within the Jewish state), a political discourse of demographic threats and rights, organizational changes stemming from the 1994 NHI Law, and the emergence of a "consumer rights" discourse within the public health system. In the concluding section, we discuss the ethical aspects of IVF in Israel, arguing that a reconsideration of priorities in a context of limited economic resources is much needed at this time.

INTRODUCTION: INFERTILITY AND THE RATIONING OF ASSISTED REPRODUCTIVE TECHNOLOGIES

Infertility is not a disease but a condition highly charged by cultural codes, social relations, and emotional responses. It evokes individual and social suffering that work, as suggested by sociological and anthropological evidence, along gendered and national axes. For example, it has been shown that infertile women, more than men, are subject to social stigmatization and that the suffering involved in infertility is intensified in “developing” countries.¹ Indeed, in both “developing” and “developed” countries, the suffering endured by persons denied their wish to bear children is real and concrete, and their pain and struggles are genuine.

However, the suffering endured by “infertile people” is, at least to some extent, mediated by those social institutions, such as religion and the family, within which “infertility” is made into a meaningful human experience. In Jewish tradition, procreation is seen as a positive duty (*mitzvah*) and a sign of prosperity, while barrenness is viewed as a curse. The biblical commandment to “be fruitful and multiply” (Gen. 1:28), the mythological suffering of the barren woman, and theological interpretative discourses according to which, for example, “every person who doesn’t have children is considered dead”² are all part of a Jewish cultural code of in/fertility. This code is part of the contextual ground upon which “barrenness” is made into a concrete and meaningful experience for many people in the Jewish state.

Indeed, nation-states, too, are institutions within which “infertility” gains meaning. The state, via its medical, legal and political establishments, is an active agent in contemporary practices relating to the “infertile body.” In Foucauldian terms, this may be seen as one manifestation of the “bio-political” power of modern surveillance and regulation.³ Medical technologies designed to treat infertility may be viewed in this context as belonging to the social process that give meaning to in/fertility.⁴ The emergence and social management of these technologies—the resources allocated to them and the nature, extent and volume of their utilization—are all part of the regulation of in/fertility and the construction of its meanings. One example if this is the prioritization of Assisted Reproductive Technologies (henceforth: ART)⁵ over other health services. It may be argued that encouraging the intensive use of ART, and downplaying the risks involved, facilitate the construction of biological fertility as compulsory and of infertility as an acute condition.

This paper focuses on the legal and political regulation of ART and its use in Israel. We ask: What social forces and cultural codes coalesce in the regulation of ART in Israel; how do they express themselves in formal policy; and who are the agents involved in shaping these policies? What are the ethical effects of the uses and regulation of ART in Israel? To tackle these questions, we look at one of the key technologies for treating infertility, namely, In Vitro Fertilization (IVF),⁶ and one of the key issues associated with its regulation, namely, its rationing.

The rationing of health services has long been a key issue for policy makers, health economists and medical sociologists.⁷ From a sociological perspective, rationing mechanisms—i.e., the process by which health services are excluded from or included in health insurance programs—are complex social arrangements shaped by economic, political, normative and ethical discourses.⁸ Rationing mechanisms are viewed in this context as dynamic processes influenced by both formal and informal agents, such as experts, legislators, consumers, media reporters, politicians and industry lobbyists.

We use the case of IVF to facilitate a discussion of the sociological and ethical elements involved in rationing health services under the Israeli National Health Insurance Law of 1994 (henceforth: the NHI Law). The Law establishes the provision of comprehensive health care to all persons residing in Israel. Although the NHI Law earmarked taxes for universal health care, the health funds responsible for providing the basic “basket” of services face significant budgetary constraints. In view of the inherent market failures in the health system, questions of priorities and rationing have arisen as a matter of course, becoming central issues in policy-making and a focus of public concern. In this context, one of the major issues to emerge has been the broad scope of public funding for IVF. Rationing decisions in the Israeli health care system usually relate to priorities for adding new treatments to NHI coverage. When dealing with the exclusion of currently funded services, as in the case of IVF, the difficulties inherent in any such decision are compounded.

In what follows, we present some basic facts and figures on ART utilization and public funding in Israel, focusing on IVF. This is followed by a description of key processes and events that took place in Israel’s legal and political arena relating to the regulation of IVF. We analyze these processes and events as embedded in a complex net of values, norms, social relations, organizational frameworks, political trends, professional interests and active choices made

by consumers. Precisely for this reason, the ethics of rationing IVF within the Israeli health services system deserves some careful attention.

FACTS AND FIGURES

Consumption of ART in Israel⁹

Per capita, Israel has the highest rate of ART intervention in the world and the highest number of IVF units (24 in a population of approximately 6.8 million).¹⁰ An international comparison of IVF utilization in 48 countries between 1995 and 1998 revealed that Israel had the highest per annum rates by far—1,657 cycles per million (c.p.m.) population, double the rate for the country in second place, the Netherlands (829 c.p.m.), and almost six times the international average of around 289 c.p.m.¹¹ By 2003, Israeli consumption rates of IVF had increased to 3,350 c.p.m. (see Table 1 and Graph 1).

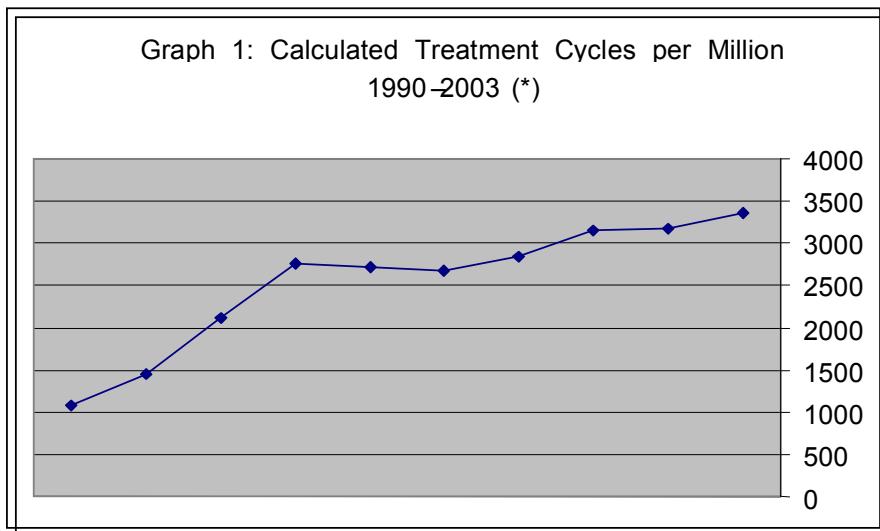
Table 1
Calculated IVF Treatment Cycles per Annum 1990–2003

	1990	1994	1996	1997	1998	1999	2000	2001	2002	2003
treatment cycles*	5169	7908	12172	16220	16396	16536	18011	20512	20886	22449
population (1,000s)**	4821.7	5471.5	5757.9	5900	6041.4	6209.1	6369.3	6508.8	6631.1	6748.4
cycles per million	1072	1445	2116	2749	2714	2667	2831	3155	3164	3350

*Department of Health Information, Israel Ministry of Health, 2003

**Israel Central Bureau of Statistics

As Table 1 and Graph 1 demonstrate, the number of treatment cycles grew more than threefold between 1990 and 2003. A factor in this increase may be the introduction, in 1995, of ICSI,¹² an IVF technique designed specifically for treating male infertility. In 1994, the number of women in whom embryos were successfully implanted was 5,735; a year later, coinciding with the introduction of ICSI, the number reached 10,888.¹³



Public Funding of IVF

Before 1994, when the NHI Law came into effect, health coverage was provided to most Israelis by a system of HMOs known as the “health funds.” IVF services provided by the funds on the eve of the enactment of the Law were as follows:

Table 2
IVF Services by Health Fund, 1994¹⁴

	Klalit	Leumit	Meuhedet	Maccabi
number of treatment cycles	no limitation	6	6 ¹⁵	7
maximum age	no limitation	40	43	47
additional treatments, by approval of an exceptions committee	egg donation in public hospitals	age # cycles 40–42 3 42–44 2 44 1 egg donation	over 43 with egg and sperm donations	egg donation

Table 2 shows that three of the four health funds imposed limits on the number of treatment cycles. The basis for this was “statistical data according to which if 7–8 attempts have failed, the probability of success in treatment decreases drastically, while over the age of 42 the number of successes is minuscule.”¹⁶

With the enactment of the NHI Law, the four health funds became legally responsible for providing the basic basket of health services, as defined by the statute, to all Israeli residents, while the government was charged with financing the costs of the basic health basket out of revenues from an earmarked income-based health tax. The basic basket, as specified in an addendum to the Law, includes “infertility diagnosis and therapy” and “artificial fertilization . . . for the purpose of bearing a first and second child—for couples who do not have children from their current marriage, and also for a childless woman who wishes to establish a single-parent family.”¹⁷ This level of public funding is unparalleled worldwide. In other countries¹⁸ there may be restrictions on the number of funded treatment cycles (usually three or four), or upper age limits for the women undergoing treatment (e.g., 35 in England and Scotland), and publicly funded treatment may be accessible only to married couples. Of particular note in Israel is the funding of treatment for a second child, even for couples whose partners may have children from previous relationships. In other countries, the existence of such children may be a criterion for denial of public funding of ART.¹⁹

Costs and Risks

IVF success rates in Israel are comparable to those in other countries. In 1994, the rate of clinical pregnancies per treatment cycle was 14.5%, and the rate of deliveries 10%.²⁰ Success rates decrease significantly in women over the age of 40. In 1996, the percentage of pregnancies in this group—16% of those who underwent IVF in that year—was only 6%, and the percentage of live births only 5%.²¹ It is estimated that the *direct* cost of treatment per live birth in Israel averages around \$19,000, similar to other countries with public health systems.²² However, this does not include *indirect* costs—most significantly, those ensuing from premature births and associated neonatal complications, which are “the most significant downstream costs” of IVF.²³

According to a 2001 World Health Organization report, there is a “20-fold increased risk of multiple pregnancy following ART compared with the general population.”²⁴ Infants from multiple gestations are much more likely than singleton infants to be born pre-term and with very low birth weight, with the attendant costs of neonatal intensive care. National data for 2001 indicates that approximately one in five births following IVF results in very low birth weight infants.²⁵ Pre-term and very low birth weight infants also carry an increased risk of perinatal death and permanent disability (cerebral palsy, blindness, learning and behavioral disorders and more). It has even been suggested that the increased health risk for children born of ART “challenges the responsible practice of medicine.”²⁶ Certainly, multiple siblings and disabled children place a heavy burden on caring and parenting. Other costs borne by women undergoing fertility therapy include those of work absenteeism. Current social security regulations in Israel provide only partial and arguably inadequate compensation, so that women now carry most of the derivative economic burden and career costs of therapy.

ART also has implications for the woman’s health. IVF is an invasive procedure and entails various medical risks, including ovarian hyperstimulation syndrome, which can be life-threatening.²⁷ Multiple pregnancy is debilitating and sometimes dangerous, and parenting multiple-birth children, even when they are healthy, is associated with long-term domestic and emotional stress. Thus, the costs of ART impose a heavy economic burden on the health system in both the short and the long term.

KEY PROCESSES AND EVENTS IN THE REGULATION OF IVF IN ISRAEL

The Legal Arena

Existing health care policies are always part of a dynamic process; they are subject to change through negotiation and reflect the different (and changing) interests and attitudes of the social agents involved in their formulation. In looking at the dynamic process that have shaped Israeli policy regarding ART in general and IVF in particular, we focus on some of the key events and processes that have taken place since 1994, with the introduction of the NHI Law.

ART is regulated in Israeli law mainly within the framework of the Public Health Ordinance. There are two sets of regulations, one relating to artificial insemination and the other to IVF. Regulations published in 1979 require accreditation of sperm banks,²⁸ while later Ministry of Health administrative directives on the “performance of artificial insemination” include rules regarding personnel, record-keeping, informed consent, confidentiality and anonymity.²⁹

When IVF was first introduced in Israel in 1982, it came within the purview of the national “Helsinki Committee,” under regulations for approving medical experiments on human subjects.³⁰ In 1987, the Minister of Health issued public health regulations that addressed, *inter alia*, the accreditation of clinics, access to IVF, egg donations, embryo storage and disposal, as well as informed consent.³¹

Throughout the years, attempts to restrict access to ART were legally challenged by consumers. On more than one occasion, the Israel Supreme Court, invoking rights to privacy and to parenthood, has declared restrictions on access to treatment invalid. For example, in the case of *Zabro v. Minister of Health* (1995),³² a number of infertile couples filed a petition challenging the validity of two provisions in the IVF regulations that doctors construed as preventing them from taking part in surrogacy arrangements. The Ministry of Health, as respondent, conceded that the challenged provisions were *ultra vires*—that is, in excess of its statutory authority in their infringement of fundamental rights, and agreed that they should be voided of legal effect. Subsequently, the Knesset passed the Surrogacy Law (1996). Another petition was filed with the Supreme Court on behalf of single women seeking either sperm donations or IVF treatments. Under a Ministry regulation, they were subjected to a screening procedure consisting of evaluation by a psychiatrist and a social worker to determine their “fitness” for motherhood, though no such procedure was demanded of married women. In 1996, the Association for Civil Rights in Israel petitioned the court demanding cancellation of this regulation. The Court ruled that discrimination against unmarried women, whether gay or heterosexual, regarding access to artificial insemination or IVF is unlawful, as it restricts their reproductive freedom and right to parenthood. The court ordered the Minister of Health to publish new regulations guaranteeing that the procedures be performed “in an equitable manner.”³³

At the end of 1998, two further cases came before the Labor Court, whose jurisdiction extends to implementation of the NHI law. They challenged a

health fund policy restricting coverage to seven IVF treatment cycles (for each of two children). One case was settled, and the other, the *Stolvov* case, was dismissed³⁴ on the technical ground that it was brought during an interim period in which the health fund was not yet legally obligated to provide unlimited cycles of treatment, as appeared to be the entitlement within the basic basket provided under the Law. Shortly thereafter, the Minister of Health made it clear that at the end of the interim period, there would be no administrative restrictions on the number of IVF cycles, up to the birth of two children.³⁵

Another case that gained much public attention and visibility was that of Ruth and Dani Nahmani, which stretched across some fifteen years and had two major legal phases. In the first phase, in the early 1990s (*Nahmani I*),³⁶ the couple petitioned the Supreme Court against the refusal of the Ministry of Health to permit fertilization of their eggs and sperm for the purpose of implantation in a surrogate mother. There was no express provision in Israeli law at the time either affirming or negating the legality of surrogacy agreements, but they were not actually practiced or facilitated by medical practitioners. Accordingly, the Nahmanis were seeking to enter a surrogacy agreement outside Israel, but they wanted to perform the fertilization in Israel because of the significant difference this would make to their costs. The case ended in an out-of-court settlement in which the Ministry of Health conceded that the IVF regulation upon which it had relied in its refusal would not withstand judicial review, and the couple was allowed to perform the medical fertilization in Israel.

In the wake of this case, the Minister of Justice and the Minister of Health appointed a professional public commission, known as the Aloni Commission, to examine the matter of IVF in all its aspects. The Commission's 1994 report³⁷ covered many issues, including rights of access, the definition of parenthood, rights of children to information, and regulation of surrogacy arrangements. The Commission emphasized the constitutional rights of individuals to privacy and autonomy in decisions regarding family and parenthood.³⁸ However, it declined to take a stand on whether these rights are positive in nature (that is, whether they impose a correlative duty on the state to assist in their realization) and did not make any recommendations regarding public funding for reproductive technologies. Following the Commission's report and the *Zabro* case, the Knesset passed the Surrogacy Law (1996),³⁹ making Israel the first country in the world to have legislation that gives positive effect to surrogacy agreements.

Several years later, the Nahmani case emerged again (*Nahmani II*).⁴⁰ The same couple had become estranged, and the man, Dani, was now living with a new partner with whom he had two children. The woman, Ruth, wanted to use their frozen embryos in a surrogacy arrangement, but the hospital would not give them to her without Dani's consent, and he refused. The question facing the court was how to balance the relative weight of rights to motherhood and to non-fatherhood. After a long process of litigation, the Supreme Court finally ruled by a majority in favor of motherhood.⁴¹ In other words, the Court recognized that the right to motherhood is a positive right, in the sense that it imposes a correlative duty on the father to refrain from obstructing its realization. Whether or not the "right to parenthood" also constrains the power of the state to restrict funding of ART remains an open question that has become a focal point of many regulative debates in Israel.

The Organizational and Political Arena

According to the NHI Ombuds report for 1998–1999, IVF was the single subject that received the highest proportion of complaints in the three years following the enactment of the NHI Law—343 (45%) out of a total of 761 complaints on 22 different issues.⁴² The complaints concerned health fund limitations on the number of treatment cycles and on the age of the patient. For example, one case concerned a 28-year-old woman suffering from an ovulatory disorder. Her physician had recommended one cycle of IVF with her own eggs and one more with a donor egg, but in fact she underwent two cycles with her own eggs, both of which were unsuccessful. The health fund had given prior approval for only one such cycle, on the basis of the physician's recommendation, and refused to refund the cost of the second cycle. Henceforth it would fund only treatments with donor eggs. However, the physician was now recommending that attempts to use the complainant's own eggs be continued, and she sought funding for these treatments.

The Ombuds found the complaint justified, since the health fund had not given due consideration to the change in the "expert recommendation." She also cited section 3(d) of the Law, which states: "the services included in the basket of health services shall be given in Israel according to *medical judgment*" (emphasis added). As a result of the Ombuds' intervention, the case

was referred to an exceptions committee, which concluded by approving two further cycles of treatment with the complainant's own eggs before attempting treatment with donor eggs.⁴³

Subsequently, in 1998, the Minister of Health appointed a committee of medical experts to propose clinical guidelines for public funding of ART within the NHI basic basket of services.⁴⁴ The committee comprised physicians (including five leading gynecologists), senior Ministry of Health officials and health fund medical officers. Its mandate was to address risks and benefits of ART, indications and counter-indications for treatment, and matters relating to the frequency of treatment cycles and the age of patients.

In the *Stolvov* case, the health fund had relied on a scientific paper⁴⁵ summing up an Israel-based study which had shown that after three treatment cycles, the effectiveness of IVF decreases per cycle, and that the cumulative pregnancy rate increases through six treatment cycles but then levels off, with a very low chance of success. The health fund had interpreted this as indicating that there was no clinical sense in offering further treatments, given the cost and the limitation of economic resources. However, the expert committee appointed by the Minister of Health gave the same study a different interpretation, namely, that the leveling off of success rates after six treatment cycles means that the same chance of pregnancy exists in each of any subsequent treatment cycles, and so there were no medical grounds for determining a cut-off. This left the economic cost-benefit consideration unresolved, as the expert committee considered this an ethical rather than a medical question and did not want to take a position on it.

Similarly, one of the health funds proposed to restrict funding to only one child,⁴⁶ but the expert committee considered the proposal unfounded on medical grounds, since the main obstacles lie in achieving a first pregnancy, and once the infertility barrier is broken, the chances of achieving a second pregnancy improve. Here, too, the committee shirked the ethical issues concerning the allocation of public funds. It did not address the social question of whether IVF for a second child can be considered treatment of "infertility." Nor did it deal with the justifications for inclusion of treatment for a second child within NHI coverage, considering the economic constraints and the need to set priorities for the provision of publicly funded health services.

In conclusion, the expert committee recommended the following clinical guidelines:

- The age limit for women undergoing IVF with their own eggs should be set at 45.
- The age limit for women undergoing IVF with donor eggs should be set at 51.
- In cases of failure of ovarian function, treatment using the woman's own eggs would be counter-indicated.
- Where three consecutive treatment cycles fail to produce eggs or sperm for fertilization, or fail to result in fertilization, further treatment would be counter-indicated. In such cases, couples should be entitled to at least one additional treatment cycle in another IVF unit.
- The maximum number of treatment cycles per year should not exceed six, and the interval between two successive egg retrievals should not be less than 45 days. These restrictions would not apply to implantation of frozen pre-embryos.

The committee noted that these were general criteria, while treatment might be indicated in individual cases even outside the guidelines. So long as treatment was given after thorough consideration of the risks and benefits in the particular case, it would be within the bounds of reasonable standards of practice. To sum up, the clinical guidelines were now clear: Couples who do not exhibit counter-indications or fall outside the age limits are entitled to unlimited IVF treatment cycles for up to two children. The same rules apply to the public funding of treatment within the NHI basic basket of services.

IVF in the Parliament: A Sociological Case Study

The overall tendency evident in Israel's legal, organizational and political frameworks regarding regulation of IVF has thus been remarkably inclusive. Attempts have also been made in Israel's Knesset to stretch the existing borders of IVF regulation. In 2001, a private member's bill was placed on the Knesset agenda, proposing that the wording of the Law be changed to the effect that there would be no limits on the number of IVF cycles "for the purpose of delivering *two live births*," rather than "two children" in the existing formulation.⁴⁷ Since IVF often results in multiple gestation, it is quite likely for a single IVF birth to produce two (or more) children. Thus, the proposed revision was meant to extend the already unparalleled, inclusive criteria of

the Law to allow women to give birth to even more children. This proposal was warmly supported by the Knesset plenary. For example, MK Langental, a member of the National Religious Party, declared that he intended to submit a bill of his own “to finance fertility treatments for the third child, so it goes without saying that I do not object to [the proposal].”⁴⁸ The bill was referred to the relevant committee for further preparation and was discussed again, four months later, at a joint meeting of two parliamentary committees, the Committee on the Status of Women and the Labor, Welfare and Health Committee. The participants in that meeting expressed almost unreserved support of the proposal. As MK Nissim Ze’ev of the ultra-Orthodox Shas party put it:

[As] I understand, there is no dispute with regard to the principle itself, and everyone agrees on as many children [as possible] in two pregnancies. Therefore, I think we have to keep our eyes on the goal, not on the means. The means is the pregnancy. . . . But we are talking about the goal, which is the child.⁴⁹

Along the same lines, Rabbi Dr. Mordechai Halperin, then in charge of the medical ethics committee at the Ministry of Health, said: “in principle there is no argument. In principle we all want to get there [to approve the proposal], but I understand that there is an implementation problem due to [the timing of] budget reductions.”⁵⁰ This analysis, according to which there was a consensus in principle but a strategic problem with the timing, was accepted by most of the session’s participants. A single reservation was voiced by the committee’s legal advisor, who asked her colleagues to take notice of the values reflected in the proposal and the ethical problems that might arise if it were approved:

The question we are dealing with is one of values. Do we want, within the framework of the health basket, to prefer what is requested here over other proposed amendments? That is, is it justifiable to take the money—this is how the Ministry of Finance will probably put it—that is meant for the health basket and channel it and dedicate it for the purpose of [IVF treatments]? This is a question of values, which the committee will have to thoroughly consider and resolve.⁵¹

None of the meeting’s participants referred back to this challenge throughout the remainder of the session, and they seem to have faded within a discussion

that revolved mainly around the formulation of the law, while reiterating the “agreed principles” and disregarding potential ethical repercussions.

Yael Dayan, a member of the Labor Party, a declared feminist and head of the Committee on the Status of Women, stated: “of course, for me, support of this bill is absolute. . . . We agree as to the result to which we all aspire. . . . I understand that there is an agreement in principle, and the problem is about formulation.”⁵² In the same spirit, the legal advisor to the Ministry of Health assured committee members: “The Minister of Health will support [this bill]. There is no doubt that the Ministry of health also believes, in principle, that bearing children is a blessed [cause].”⁵³

The bill itself did not progress through the legislative process and probably expired naturally with the dispersion of the Knesset prior to elections. However, in the unusual alliance it created across a wide spectrum of political identifications—feminist, nationalist, religious, and also representatives of the Arab parties—it illustrates well the consensus that tends to form around initiatives to expand the limits of IVF in Israel.

While this and most other efforts to alter existing public IVF funding policies had aspired to extend its scope, there was one notable exception. In 2003, as part of the discussion of the annual budget for the 2004 financial year, the Ministry of Finance formally proposed drastic cuts in public funding for IVF treatments, so that the basic “health basket” would cover at most five treatment cycles, and only for one child. This proposal sparked an uproar both inside and outside the Knesset.⁵⁴

The NHI Law had provided for the possibility of subtracting services from the basic basket to make room for the inclusion of new technologies at no added overall cost, and the notion of restricting public funding for infertility treatments had been suggested in inner government circles. Yet, while the subject of including new health technologies in the NHI basic basket had been on the public agenda for several years, this was the first time that the question of excluding hitherto funded services had actually been raised for public debate. The matter provoked a heated public discussion on the right to parenthood, the right to happiness through parenthood, the suffering involved in “childlessness,” and the Jewish state’s obligation to reduce emotional suffering and enhance happiness.⁵⁵ Although some critical views on existing policies were voiced (mainly by media agents), most reactions by politicians, consumers, physicians and media agents criticized the attempt to alter existing policies.

One reaction to the proposed de-insuring of IVF was the creation of a self-organized group of consumers, who formed a lobby under the title of “The Right to Parenthood” for the purpose of pressuring politicians to reject the proposed change. They appeared in the media, participated as observers in the parliamentary committee discussions and issued a heart-rending, emotional statement portraying the proposed cuts as tantamount to a death sentence. A letter sent by a member of the group to Prime Minister Ariel Sharon declared that the writer, a man in his early thirties, would refuse to fulfill his “civil duties” as an army reservist as long as he was being denied his “civil rights” to be treated with IVF. Another member, a woman in her late twenties, testified at the Committee on the Status of Women that apart from her own suffering as an unfulfilled potential mother, she had a profound emotional duty, as the only granddaughter of a Holocaust survivor, to enable her grandmother “to see continuity and have grandchildren of her own.”

These narratives emphasized the national and civil codes accompanying fertility treatments in Israel. Similar narratives were invoked by members of nationalistic parties, but they were also, less obviously, invoked by medical experts. For example, a prominent fertility expert declared that denying patients their right to more than five treatment cycles was equivalent to a death sentence for all the children that would have been born had access to therapy not been denied:

We are talking about at least 2,000 children that [will not] be brought into this world because of this decree. . . . It is almost impossible to achieve pregnancies with five treatment cycles. . . . [If the de-insuring policy is approved], 50% of the parents who would have been able to bear children will not be able to do so under the present conditions, not to mention the second child, whom you have canceled altogether. Do you know what you are doing here and what kind of a proposal this is? It is like sitting down and shooting around 1,000 or 1,500 children.⁵⁶

And indeed, after five months of public debate and negotiations among parliamentarians, again resulting in a wall-to-wall consensus regardless of political identification, the Ministry of Finance withdrew from its initial intentions. Public funding for IVF in Israel remained intact and seemingly unrestrictable.

SOCIAL AND CULTURAL FORCES AT WORK
IN THE REGULATION OF IVF IN ISRAEL

The high utilization of ART in Israel should be viewed in its specific cultural context, as expressed in both formal and common-sensian settings. Israel's official pro-natalist population policy⁵⁷ is demonstrated in the budgets allocated to support families "blessed with children."⁵⁸ Moreover, while pregnancy and birth-related expenses have always been covered in Israel by the public health system and by social security, coverage for contraception and legal abortion is only partial.⁵⁹ It seems there is provision for women's special reproductive health needs only to the extent that their role as mothers is reinforced.⁶⁰ Israel's highly generous policy of public funding for ART is consistent with this approach.

This pro-natalist tendency can be associated with several overlapping cultural codes in Israeli society. First, there is the politics of the "demographic competition" embedded in the Jewish-Arab conflict. This national narrative of a Jewish collective struggling to survive in a hostile environment is reinforced by the collective memory of the annihilation of six million Jews in the Holocaust, making the bearing of children not only a "survival necessity" but also a "moral necessity." As expressed by a leading IVF medical expert: "there is no doubt that the Holocaust is one of the reasons that children are so important in Israel."⁶¹ As early as the 1940s, when the news of the Holocaust in Europe first reached the Jewish community in Palestine, David Ben Gurion began speaking of a "demographic duty" to the nation and warning that Jewish existence was at stake. The popular phrase "making children for Ben Gurion" signified the nationalization of childbearing and motherhood in the Jewish nation-state. The symbolic significance of the "demographic competition" was also expressed in a 1967 government resolution to establish a "Center for Demography." As the resolution stated, "the government finds it necessary to act systematically to realize a demographic policy that is directed to creating an atmosphere which encourages birth, taking into consideration that it is vital to the future of the Jewish people."⁶²

As in other national discourses, this policy accords with religious concerns for promoting the value of the family. The above-mentioned religious duty to "be fruitful and multiply" is observed not only by Orthodox Jews but also as a general societal value. Conversely, the suffering associated with female barrenness is a consistent and profound theme in the Bible and in Jewish

tradition. Rachel's words to Jacob, "give me children or else I die" (Gen. 30:1), reverberate in Israeli culture. The deep symbolic and psychological significance of in/fertility for Israeli women is documented in the valuable, if scant, sociological accounts of ART experiences in Israel.⁶³ These reveal that the experience of infertility is central in the making of gendered identities and that the stigma of infertility is a powerful symbolic mechanism, sometimes leading women to pursue treatments for many years, at any cost.

Indeed, "pro-natalist values" cannot be analyzed separately from "family values." The family in Israel is a central social institution, and voluntary childlessness is virtually non-existent. It is within this pro-natalist and pro-family culture that we suggest decoding the scope of public funding allocated to assisted reproduction in Israel. However, a pro-natalist culture does not exist "in itself" but, rather, is maintained and re-created via the active interpretation and practices of the social agents involved in its making. Moreover, it is not only via formal discourses but also through everyday practices and knowledge that pro-natalism is sustained. Thus, what sociologists refer to as "common-sensian" knowledge—the knowledge of what it is (and, no less important, how it feels and what it means) to "have a family," to "be a parent," to experience "the joy of children"—plays an important role in the informal context within which pro-natalism is sustained and IVF is prioritized. The common-sensian notion that "a family" is a biological unit consisting of "at least" two children is informal—yet crucial—cultural knowledge, shaping the regulation of ART in Israel. As one of the lobbyists objecting to the 2003 attempt to de-insure IVF declared:

We must not touch this issue—not in the State of Israel, and not as human beings. [Publicly funding treatments for the purpose of bearing two children] is not arbitrary; [it is a result of our] understanding that one child is not enough [to constitute a] family.⁶⁴

DISCUSSION: ETHICAL AND SOCIAL ASPECTS OF RATIONING IVF

It is evident, then, that sociological factors such as pro-natalist values, religious commitments, national-demographic politics and pro-family cultural codes are channeled into the rationing of IVF in Israel. Rationing policies are not only an effect, as we have seen, of a complex net of values, norms, social

relations, organizational arrangements, political trends, professional interests and active choices made by consumers; they are also saturated with power relations—between women and men, therapists and consumers, Jews and Arabs, and so on. We have argued that these elements mandate scrutiny of the ethics of rationing within the health service system. In the previous section, we focused on decoding the mechanisms through which rationing is maintained within Israel's specific socio-cultural context. We conclude by suggesting a reflexive reconsideration of existing policies.

The case of ART appears to be particularly amenable to rationing restrictions for several reasons. One ethical principle used in determining the just and fair allocation of healthcare resources is that of “improving health as a primary goal.”⁶⁵ The question of whether infertility should be perceived as a “disease” and its treatment as a “cure” depends on social and cultural factors. It has been argued, for example, that childlessness in a pro-natalist society, and particularly in traditional cultures, produces “social suffering” that threatens the well-being of the women and men involved.⁶⁶ Nevertheless, infertility clearly does not involve any threat to the life or physical health of the “infertile” woman or man. Non-treatment does not increase the morbidity of the population and does not entail risks to public health (as would non-treatment of an infectious disease).

Explicit rationing of ART is possible and indeed practiced in other countries on the basis of quantifiable criteria, such as the number of treatment cycles, age, marital status of the candidates, and number of existing children. This brings to the fore the normative, cultural and political contexts within which rationing policies are embedded. These are the factors that color the debate as to whether Israeli practices represent an “over-use” of IVF. One might argue that a critical and/or comparative evaluation indicates that the extent of its use is excessive and should be re-considered; or, alternatively, that it represents “abundant use”—that is, that the Israeli model is inclusive and enabling and should be emulated in other countries.

As we have seen, in the debate on rationing ART in Israel, the voice of the consumer—expressed through complaints to the NHI Ombuds, challenges to health fund policy in the courts and public protests—has been a leading factor in resistance to administrative restrictions based on economic considerations. The health funds, medical experts, political decision-makers and the courts have all ultimately converged in acquiescing to consumer pressure.

At the individual level, bioethical discourse acknowledges patient autonomy and considers clinical decision-making a matter of the patient–doctor partnership. Indeed, the intensive use of ART in Israel is often attributed to patient demand, resulting from a national-religious-gendered cultural expectation that women must become mothers and establish families at any cost.

However, doctors might also be overly proactive in prescribing intervention, so that the market becomes supply-driven. Indeed, it is not at all clear that most patients are aware of the health risks and costs of IVF and of alternatives to treatment. The principle of informed consent to medical treatment is well grounded in Israeli law, imposing a duty of disclosure upon the physician.⁶⁷ However, the manner in which success and failure rates and the risks of treatment are presented to the patient might be motivated by the physician's ambition to be a pioneer in a cutting edge area of rapid technological innovation,⁶⁸ or by financial interest in a lucrative area of medical practice.

The medical profession in Israel also objects to administrative restrictions on clinical discretion. In the general rationing debate, it takes a stance of commitment to the needs of the individual patient, invoking the ethical duty to heal. In the context of ART, this appears to inspire a position of giving the best and most advanced care to as many patients as possible. On one occasion, as we have seen, a committee of medical experts resisted the attempt to use clinical guidelines as a camouflage for a rationing policy motivated by economic considerations. On another occasion, medical experts, testifying in parliament committees when de-insuring was at stake, strongly and almost unanimously rejected it as an option, explicitly basing their objection on Israel's pro-natalist culture, on the one hand, and on claims of economic inefficiency, on the other. Some of them argued, for example, that the de-insuring scheme would pressure consumers to embrace intensified hormonal therapy, which might result in costly multiple-embryo pregnancies.⁶⁹ However, they overlooked the ethical implications of health experts submitting to such consumer pressures. The final result seems to be a refusal to take social responsibility for difficult choices in allocating scarce resources.

Courts of law do not have the tools to answer rationing dilemmas. Judges decide individual cases, and it is difficult to resist the human drama of persons in need. On the other hand, administrative restrictions on the scope of funded services, whether based on evidence-based clinical guidelines or even on strictly economic considerations, are likely to withstand judicial review.⁷⁰

Israeli courts in general do not intervene in matters of policy and economic priorities.⁷¹ Despite the bias in favor of reproductive autonomy and privacy, it is unlikely that courts would intervene in reasoned restrictions on public funding for ART. This leaves rationing decisions to political decision-makers, such as the Minister of Health, who has the legal authority to set limitations to the scope of funding for ART. However, s/he also has to contend with consumer pressure and activism. Politicians are reluctant to take the lead in promoting unpopular policies that might alienate voters.

The coinciding, in the Israeli case, of consumer activism with professional and political interests on the one hand, and with a formal and “common-sensian” pro-natalist culture on the other, has silenced debate on rationing ART, leaving many unresolved questions pertaining to its ethical and social aspects. Is there a positive right to parenthood that imposes a duty on the state to assist in its realization? Is there a constitutional right to the public funding of medical treatment for infertility? If such a right is indeed acknowledged, what are its limits? What degree of statistical ineffectiveness might justify denial of public funding? Should public funding be limited because of the health risks and costs of ART to women and children? Is public demand a relevant factor in rationing ART? Does the Israeli “pro-natalist culture,” and the social suffering that seems to result from “childlessness” in this context, justify an intense and unparalleled usage of ART? Who should decide, and through what process?

Rationing decisions are always difficult and involve hard ethical choices. The magnitude of ART usage in Israel, as compared to other countries, remains a matter of concern in terms of financial and other health-related costs, and would seem to be an easy target for rationing. Nonetheless it seems that an accumulation of social and cultural forces make any decision to subtract ART services from the NHI basic basket almost impossible. This leaves the debate in the public arena. Public education on the risks and costs of ART is clearly indicated, combined with various forms of public involvement in the debate on setting priorities for the provision of health services in conditions of limited economic resources.

Notes:

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1. For a discussion of suffering pursuant to infertility in gendered and cross-national contexts see, e.g., Abdallah S. Daar and Merali Zara, “Infertility and Social Suffering: The Case of ART in Developing Countries,” in Effy Vayena, et al. (eds.), *Current Practices and Controversies in Assisted Reproduction* (Geneva: World Health Organization, 2002), pp. 15–21; Marcia C. Inhorn, “Global Infertility and the Globalization of New Reproductive Technologies: Illustrations From Egypt,” *Social Science and Medicine*, 56 (2003), pp. 1837–1851; and Ruth Macklin, “Reproductive Technologies in Developing Countries,” *Bioethics*, 9 (1995), pp. 276–282.
2. Saying attributed to R. Yehoshua b. Levi, BT *Nedarim* 64b, quoted in Sara Wiseman-Stein, “*Kol Akara*: The Voice of the Barren Woman,” in *Women and Judaism: Contemporary Writings* (http://www.utoronto.ca/wjudaism/contemporary/articles/a_stein1.html).
3. As described by Michel Foucault in *The History of Sexuality*, I (New York: Vintage Books, 1981).
4. On the cultural dialectics of infertility/fertility in relation to ART see Faye D. Ginsburg and Rayna Rapp, “Introduction: Conceiving the New World Order,” in idem (eds.), *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley: University Press of California, 1995). See also Marcia C. Inhorn, *Local Babies, Global Science: Gender, Religion and In-Vitro-Fertilization In Egypt* (New York: Routledge, 2003).
5. All explanations of medical terms in this article are taken from E. Vayena., P.J. Rowe and P.D Griffin (eds.), *Current Practices and Controversies in Assisted Reproduction* (Geneva: World Health Organization, 2002). “Assisted Reproductive Technologies” are all treatments or procedures that include the *in vitro* handling of human oocytes and sperm or embryos for the purpose of establishing a pregnancy.
6. In Vitro Fertilization is an ART procedure that involves extracorporeal fertilization.
7. For the discussion of “priority setting” and “resource allocation” of health services see, e.g., Malcolm Ashmore, Michael Mulkay and Trevor Pinch, *Health and Efficiency: A Sociology of Health Economists* (Milton Keynes: Open University Press, 1990).
8. See, e.g., Ashmore et al., *Health and Efficiency* (above, note 7); Denny Vaero, “Health Inequalities as Policy Issues—Reflections on Ethics, Policy and Public Health,” *Sociology of Health and Illness*, 17/1 (1995), pp 1–19; P. Menzel, *Strong Medicine: The Ethical Rationing of Health Care* (New York–Oxford: Oxford University Press, 1990); and Ann Rogers, Alison Chapples and Michelle Sergison, “‘If a Patient is Too Costly They Tend to Get Rid of You’: The Impact of People’s

- Perceptions of Rationing on the Use of Primary Care," *Health Care Analysis*, 7/3 (1999), pp. 225—237.
9. The data quoted in this section are based on a report issued by the Department of Health Information, Israel Ministry of Health, 2003.
10. 3.5 units per million population, compared, for example, with 1.31 in the USA, 1.28 in the UK, 2.39 in France, 1.22 in Germany, 1.63 in Ireland and 2.99 in Japan. Source: John A. Collins, "An International Survey of Health Economics of IVF and ICSI," *Human Reproduction*, 8/3 (2002), pp. 265–277.
11. *Ibid.*, p. 268. Denmark had 713 c.p.m. per annum, Sweden 674, Finland 663, and France 610. The last four countries on the list were Kazakhstan (2 c.p.m.), Pakistan (4), Indonesia (4) and China (5). The article distinguishes between IVF and ICSI, but we use the term IVF to refer to all related treatments, including ICSI (see the next note).
12. In ICSI—intracytoplasmatic (intracytoplasmic) sperm injection—a single spermatozoon is injected into the oocyte.
13. *Women's Health In Israel 1999: A Data Book* (Jerusalem: Israel Center for Disease Control—Ministry of Health—Israel Women's Network, 1999), p. 43.
14. *National Health Insurance Ombuds Annual Report No. 1 for 1997* (Jerusalem: Ministry of Health, 1998; henceforth: *NHI Ombuds Report 1997*), p. 62.
15. By 1997, the Meuhedet Health fund had added two more treatment cycles to its basket (*ibid.*).
16. *NHI Ombuds Report 1997* (above, note 14), p. 62. In addition, two of the health funds had a one-year waiting period for new members. It is worth noting that the ombuds considered this to be in violation of section 21(a) of the Law, which prohibits discrimination in the provision of services to health fund members; *ibid.*, pp. 63–64.
17. Paragraph 6(e) of the Second Addendum to the National Health Insurance Law, 1994, S.H. no. 1469, p. 183.
18. Israel Ministry of Health data.
19. See, e.g., A. Plomer, I. Smith and N. Martin-Clement, "Rationing Policies on Access to *In Vitro* Fertilisation in the National Health Service," *Reproductive Health Matters*, 7/14 (1999), pp. 60–70.
20. *Health in Israel 1998* (Jerusalem: Ministry of Health, 1998), p. 160.
21. 1999 Report of the Committee for the National Collection of ART Data.
22. In 2002, the estimated cost per IVF cycle in Israel was US \$3,817 (Collins, "An International Survey" [above, note 10], p. 269). Taking into account an average of five treatment cycles, the direct costs of IVF, including consultation, drugs, laboratory charges, ultrasound, oocyte retrieval and embryo transfer, etc., could be estimated at around \$19,085. For a comparative estimate of cost per IVF cycle in 28 countries see Collins, *loc. cit.*

23. Collins, “An International Survey” (above, note 11), p. 268.
24. Mahmoud F. Fathalla, “Introduction,” in *Current Challenges in Assisted Reproduction* (Geneva: World Health Organization, 2001), p. 4.
25. *Data Base on Very Low Birth Weight Infants—Summary Report for 2001* (Israel Neonatal Network and Gertner Institute, Tel HaShomer, October 2003).
26. R.D. Lambert, “Safety Issues in Assisted Reproduction,” *Human Reproduction*, 17/12 (2002), pp. 3011–3015.
27. Other risks include anesthesia-related complications, intra-abdominal bleeding, pelvic inflammatory disease, laceration of internal organs, and extra-uterine pregnancy. When treating for male infertility factors, in addition to the risks to the woman receiving the treatment, there are also risks to the man in obtaining sperm, including anesthesia-related risks, infection, hematomas, and, in rare cases, hormonal testicular dysfunction. *Medical Guidelines for IVF Treatment: Recommendations of the Insler Committee* (Jerusalem: Ministry of Health, 1998).
28. Public Health (Sperm Bank) Regulations, 1979.
29. Note that the artificial insemination directives are considered to be of dubious validity, since they are not published in the official gazette, as generally required of primary or secondary legislation, and particularly where the legislation affects fundamental rights. CA 449/79 *Salameh v. Salameh* 34 PD (2) 779, at 784.
30. Public Health (Medical Experiments with Human Beings) Regulations, 1980. In 1984 these Regulations were amended to specifically require review by the national “Helsinki Committee” of any experiment relating to “unnatural fertilization of a woman,” as well as any experiment relating to the human genome. The national Helsinki Committee and those of individual hospitals were established to review and approve experiments with human beings in compliance with the Declaration on “Ethical Principles for Medical Research Involving Human Subjects” adopted by the 18th World Medical Association General Assembly in Helsinki, Finland, in June 1964, and revised by the 52nd WMA General Assembly in Edinburgh, Scotland, in October 2000.
31. The Public Health (Extra-Corporeal Fertilization) Regulations, 1987.
32. HC 5087/94 *Zabro et al. v. Minister of Health* (unpublished decision), July 17, 1995.
33. HC 998/96, 2078/96, 2444/96 *Weitz et al. v. Minister of Health* (decision of February 2, 1997). The NHI Law currently covers infertility therapy for both married and unmarried women.
34. Case 141138/98 *Stolvov et al. v. Maccabi Health Services et al.* (Tel Aviv Labor Court, unpublished).
35. Minutes of an internal ministry meeting with the Minister of Health, Yehoshua Matza, November 30, 1998.

36. HC 1237/91 *Nahmani v. Minister of Health* (unpublished).
37. *Report of the Public-Professional Commission in the Matter of In Vitro Fertilization* (Jerusalem: Israel Ministry of Justice, July 1994).
38. Indeed, a constitutional right to privacy is guaranteed in the Basic Law: Human Dignity and Liberty, sec. 7, so that it may be restricted only by law, for a proper purpose, and only to the extent necessary. Restrictions to access would, therefore, have to be justified by a weighty societal interest.
39. The Surrogate Mother Agreements (Approval of the Agreement and Status of the Child) Law, 1996. The Law has two main parts. The first deals with approval of the agreement by a statutory committee, and the conditions thereof; the second with the status of the child and the determination of parenthood in his or her respect. While the form of the statute is in accordance with the Aloni Commission's recommendations, its substance differs in principle. The Commission's recommendations were founded on the principle of the privacy and autonomy of the parties to the arrangement—especially of the surrogate mother. The statute, however, was guided by rules of kinship according to Jewish law. See C. Shalev, "Halakha and Patriarchal Motherhood: An Anatomy of the New Israeli Surrogacy Law," *Israel Law Review*, 32 (1998), p. 51.
40. FH 2401/95 *Nahmani v. Nahmani* 50 P.D. (4) 661.
41. Contrast this with the rulings in *Davis v. Davis*, 842 S.W. 2d 588 (1992) (Tennessee), and in *Kass v. Kass*, 91 N.Y. 2d 554 (1998) (New York), which held that decisions regarding the use of frozen embryos must be consensual.
42. These are the calculated figures, based on the issues for which at least four complaints a year were filed with the Ombuds. *NHI Ombuds Report for 1998–1999*, Table 26.
43. *NHI Ombuds Report 1997* (above, note 14), pp. 110–112.
44. Note that the ombuds had also recommended that a professional committee should define the statistical probability of successful IVF treatment, on the basis of medical parameters such as age, the number of treatment cycles, and the medical condition of the couple. *NHI Ombuds Report 1997* (above, note 14), p. 63.
45. J Dor et al., "Cumulative Pregnancy Rate Following In-Vitro Fertilization: The Significance of Age and Infertility Aetiology," *Human Reproduction*, 11/2 (1996), pp. 425–428.
46. Maccabi Health Fund position paper, November 29, 1998.
47. Knesset Protocol, July 4, 2001, bill on "National Health Insurance (Amendment: Entitlement to Aid with IVF)."
48. *Ibid.*
49. Protocol, joint meeting of the Committee on the Status of Women and the Labor, Social Affairs and Health Committee, November 6, 2001.
50. *Ibid.*

51. Halit Barak, *ibid.*
52. *Ibid.*
53. *Ibid.*
54. For a sociological analysis of parliament and media discussions on de-insuring IVF in Israel see Sigal Gooldin, “Technologies of Happiness: Fertility Management in a Pro-Natal Context,” in Adriana Kemp and Yossi Yona (eds.), *Citizenship Gaps: Migration, Fertility and Identity* (Hebrew; Jerusalem–Tel Aviv: Van Leer–Hakibbutz Hameuchad, forthcoming in 2007).
55. *Ibid.*
56. Prof. Shlomo Mashiach, a prominent fertility expert, testifying for the Committee for the Advancement of Women’s Status, (Committee protocol, September 18, 2003).
57. For a discussion of Israel’s formal pro-natalist policy see Susan M. Kahn, *Reproducing Jews: A Cultural Account of Assisted Conception in Israel* (Durham, NC–London: Duke University Press, 2000); and Jacqueline Portugese, *Fertility Policy in Israel: The Politics of Religion, Gender and Nation* (Westport, CT: Praeger, 1998).
58. The Israeli concept of families “blessed with children” (*berukhot yeladim*) refers to families with “many children” and is an emic expression of the identification of large numbers of children with “blessings.” This concept is politically antithetic to the neo-Malthusian notion of “quality over quantity” in reproduction, as expressed in the opposing Israeli concept of families with “many children” (*merubot yeladim*).
59. The costs of contraception (as opposed to counseling) are not covered by the health funds within the NHI, and abortion is funded only for girls under 17, or where “medically indicated” in the strictest sense. (All legal abortions must be approved by a medical committee, so that all are “medically” indicated in the broad legal sense.)
60. On motherhood in Israel as a social and national role see Nitza Berkovitch, “‘Women of Valor’: Women and Citizenship in Israel,” *Israeli Sociology*, 2/1 (1999), pp. 277–317 (Hebrew). The culture of motherhood and family in Israel is so well grounded that most women don’t even question why they have to pay from their pockets for contraception, within a system of publicly funded comprehensive health services. Since this policy has the effect of reinforcing stereotypes of women as mothers and of restricting reproductive autonomy, it should be considered a violation of substantive equality and so a form of gender discrimination. In Israeli jurisprudence, the focus is on discriminatory outcome rather than on intention to discriminate. There is a violation of equality if the conduct in question has a discriminatory effect, or if it reinforces discriminatory stereotypes of women. See Carmel Shalev, “On Equality, Difference and Sex Discrimination,” *Sefer Landau*, 2 (1995), pp. 893 (Hebrew).
61. Prof. Shlomo Mashiach, Knesset Finance Committee (Protocol, December 4, 2003).

62. Lesley Hazleton, *Israeli Women: The Reality Behind the Myth* (Jerusalem: Idanim, 1978), pp. 58–61 (Hebrew).
63. Larissa Remennick, “Childless in the Land of Imperative Motherhood: Stigma and Coping Among Israeli Women,” *Sex Roles*, 47/11–12 ((2000), pp. 821–841; Hilla Haelyon, “Experiences of Israeli Women with the New Reproductive Technologies” (Ph.D. Dissertation, Bar Ilan University, 2004), and see her article in this issue; Orly Benjamin and Hilla Haelyon, “Rewriting Fertilization: Trust, Pain, and Exit Points,” *Women’s Studies International Forum*, 25 (2002), pp. 667–678; and Daphna Birenbaum-Carmeli, “Reproductive Partners: Woman–Doctor Relations in Israeli and Canadian IVF Contexts,” in Nancy Scheper-Hughes and Carolyn Sargent (eds.), *Small Wars: The Cultural Politics of Childhood* (Berkeley: University of California Press, 1998). pp. 75–92.
64. Ofra Balaban, Knesset Financial Committee (Protocol, December 4, 2003).
65. E.J. Emanuel, “Justice and Managed Care: Four Principles for the Just Allocation of Health Care Resources,” *Hastings Center Report*, 30/3 (2000), pp. 8–16.
66. Daar and Merali, “Infertility and Social Suffering” (above, note 1).
67. See, in particular, section 13 of the Patients’ Rights Law, 1996.
68. The issue of informed consent is particularly sensitive in relation to novel treatment methods. It is a matter of record that women were *not* protected as subjects of human experimentation during the initial phases of IVF development, though the fetus was. See Carmel Shalev, *Birth Power—The Case for Surrogacy* (New Haven, CT: Yale University Press, 1989) pp. 105–112.
69. See, for example, the testimony of Dr. Amihai Barash at the Committee for the Advancement of Women’s Status (protocol, September 18, 2003, p. 7).
70. Case 5-7/97 *Medzini v. Klalit Health Fund* (National Labor Court, unreported, August 9, 1998), upholding restriction of the number of physiotherapy treatments for multiple sclerosis patients; Case 0-17/97 *Zeinfeld v. Klalit Health Fund* (Tel Aviv Labor Court, unreported, May 1, 1997)—upholding refusal to fund diapers for incontinent prostate cancer patient; clinical guidelines restricting funding for interferon were upheld in Case 9-205,7-2/97 *Medina Bat-Ami v. Ministry of Health* (National Labor Court, unpublished, July 9, 1997).
71. For example, the Israeli Supreme Court upheld the legitimacy of budgetary considerations as constraints on the provision of public broadcasting services, in HCJ 3471/92 *Brand v. Minister of Communications* 47 P.D. (3) 143.