The Hebrew University of Jerusalem

The Strength of Institutions and Ideas:

Immigrant Access to Public Health Insurance

Thesis for Master's Degree in Public Policy
Under the Supervision of Professor Johnny Gal

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Table of Contents

1. Abstract

As international migration increases worldwide, attention has turned to the link between immigration and social policy and more specifically the level of access to welfare services granted to immigrants. Comparative social policy research indicates that policy outcomes regulating immigrant access between different countries varies widely. This study focuses on immigrant access to public health insurance in order to determine the variables that impact these policy outcomes.

In order to answer this question a qualitative comparative methodology is employed here. The study compares immigrant access to public health insurance in the United States, Canada and Israel. These countries were selected based on a most similar research design because they are all classified as settler nations with liberal welfare states and thus both their immigration policy and health policy can be compared. Following the examination of primary and secondary resources highlighting the historical development of immigration and health policy in each country, as well as current policy in both spheres, an analytical framework is applied in order to systematically compare current policy between the countries.

Variations in immigrant access to public health insurance policy emanate from differences in health insurance institutions coupled with divergent ideas impacting immigration policy. Historical institutionalism and the impact of ideas are critical to explaining the divergent policy outcomes between the United States, Canada and Israel specifically in terms of immigrant access to public health insurance. Moreover, this study reinforces the capacity of these theories to explain variations in social policy outcomes in general.

2. Introduction

The growth of international migration to Western democracies in recent years has prompted increased interest in the relationship between immigration and social policy. This field of research has focused on the impact of immigration on the social expenditures of welfare states, while less attention has been given to explaining the level of legal access immigrants have to social services in welfare states (Freeman, 1986; Borjas & Hilton, 1996; Ryner, 2000; Collado, M.D., et al, 2004). In an effort to fill this gap, this research will assess policy determining immigrant access to public health insurance in three settler nations – the United States of America, Canada and Israel – and attempt to explain the differences in policy outcomes between these cases.

The United States of American, Canada and Israel were chosen as the subjects of this study because they are all defined as settler nations with liberal welfare states. Joppke (1999: 13) defines immigration in settler nations as a "willed, recurrent event." Thus, immigration policy in these nations is unique as it was encouraged from the outset and their citizen populations are composed to a large degree of immigrants. In addition, these countries are all classified as liberal welfare states (Esping-Andersen, 1999; Gal, 2004) and have been compared in past studies (Fix & Laglagaron, 2002).

A qualitative comparative methodology will be employed in this study (Ragin, 1987, 1994). Country selection rests on most similar research design, (Lijphart, 1971; Kallenberg, 1966; Peters, 1998; Ragin, 1987) which allows the control of variables such as welfare state typology and historical relationship to immigration, and the ability to isolate the variable investigated here – access to public health insurance. Diversity in health policy for immigrants depends on the type of immigration policy as well as the country's welfare regime (Mladovsky, 2007). A common analytical framework will apply to each of the three countries so that a number of indicators of access can be cross-nationally compared. These indicators include: citizenship, length of residence, means tested need and participation in the work force. Through this analytical framework, the research will explore the diversity in immigrant access to health care in three liberal welfare regime settler nations in an attempt to determine factors contributing to divergent policy outcomes.

The study begins with a section on "Research Methods" which situates the research within the field of Comparative Social Policy and outlines the methods used

to compare policy outcomes in the United States, Canada and Israel in terms of immigrant access to public health insurance. Next, the "Theoretical Framework" section reviews prevailing theory regarding policy outcomes, focusing on theories of historical institutionalism and the impact of ideas. The following section, "Country Studies," outlines the historical development of both public health insurance policy and immigration policy, and outlines current policy establishing immigrant access to health care, in each of the three countries. The "Discussion" section will employ an analytical framework to define indicators[1] of immigrant access, enabling a systematic comparison of current policy in each country. This section will then focus on explaining divergences in current policy between countries, employing the theoretical framework provided by historical institutionalism and the impact of ideas. Finally "Conclusions" will be made regarding divergent policy regulating immigrant access to public health insurance in an attempt to contribute to the understanding of policy outcomes in comparative social policy.

3. Research Methods

3.1 Comparative Social Policy

As an academic field, social policy is defined as the study of "publicly provided, or regulated, core programs such as income maintenance (or social security), housing, health and social services," (Clasen, 2004: 91). Since it's founding over half a century ago by the British scholar Richard Titmuss, this field has engaged primarily in evaluating systems of social welfare of single nations (Mishra, 2002). More recently, with the growth of information technology and the subsequent access to information and data regarding the social welfare system of countries throughout the world, the sub-field of comparative social policy has grown significantly (Hantrais & Mangen, 1996; Clasen, 1999; Ginsburg, 2000; Mishra, 2002; Burau & Blank, 2006). In addition, economic and welfare crises throughout the world have encouraged the study of shared social policy challenges (Burau & Blank, 2006). Thus, the distinct sub-field of comparative social policy, engaged in 'the complex task of examining the welfare order in different countries," (May, 1998: 22) emerged (Clasen, 1999). Mabbett and Bolderson succinctly summarize the methods and aims of the sub-discipline of comparative social policy, noting that, "cross-national social policy

[1] Indicators of access included in this study are: citizenship, length of residence, means tested need and participation in the work force

oriented studies describe, analyze and map different countries' welfare configurations, specific policies or responses to common issues. These studies are used to test/develop theories or hypotheses, construct models, to conduct evaluations, to show more clearly the contours of one country's arrangements, to promote 'peripatetic learning' (Goodman & Peng 1996) or borrowing of policies or practices," (Mabbett & Bolderson, 1999: 54). This study, comparing social policies (specifically health policies) related to immigrants in three different countries, falls into the field of comparative social policy.

A variety of theoretical approaches and methodological tools are used in the field of comparative social policy. Studies aiming to advance general theories of welfare state development most often employ large scale regression analysis of macro-economic and social indicators of many countries (Mabbett & Bolderson, 1999; Wilensky, 1975, 1990; Castles, 1982; Korpi, 1980). On the other end of the spectrum, the case study approach examines particular policies in a limited number of welfare states (as few as two), and thus takes into account institutional, historical and political factors impacting these policies, which are difficult to consider in larger studies. Due to the limited scope of the case study approach, this method does not allow for grand theorizing. However, whereas implementing a large scale regression analysis requires the researcher to pre-select data items to be included in the investigation, the case study method often employs a historical analysis of policy development facilitating an open perspective of the factors and links included in the analysis, (Mabbett & Bolderson, 1999). Heclo (1974) pioneered this type of methodology in his study of the policy processes involved in the development of income maintenance provisions in Britain and Sweden. Like in other studies of this type (Pierson, 1994; Bolderson & Mabbett, 1997), instead of testing a hypothesis, Heclo generalized from the observation of primary and secondary sources and developed supporting theory inductively (Heclo, 1974; Mabbett & Bolderson, 1999).

3.2 Research Design

The study undertaken here employs a case study based comparative social policy methodology. Through the study of primary and secondary sources, the study will first assess policy determining immigrant access to public health insurance in three different welfare states, by exploring the historical development of both public health insurance policy and immigration policy. It will then outline current policy in these

two areas – public health insurance and immigration. Only then, based on existing theory explaining policy outcomes, will it attempt to answer the central question of this study – how can differences in immigrant access to public health insurance between the United States, Canada and Israel be explained? Like Heclo (1974) instead of testing a specific hypothesis, this study will generalize from observation, in an attempt to facilitate an open perspective on the factors that lead to divergent policy outcomes.

In order to do this, the study employs an analytical framework, defining indicators of access. The indicators of access to be examined include: citizenship, length of residence, means tested need and participation in the work force. Thus, in addition to the examination of the historical development of public health insurance policy and immigration policy, this analytical framework allows a systematic comparison of current policy determining immigrant access to public health insurance. In turn, the research is designed to be both open and systematic (Mabbett & Bolderson, 1999).

Case study selection for this study is guided by most similar research design and facilitated by the concept of the settler nation as well as welfare regime typology. All three countries investigated here, the United States, Canada and Israel, are classified as "settler nations" where the historical goal of their colonialist founders was to settle territory and remain there, not to merely use the territory for labor and goods like in India or China (Moran, 2002). In these three counties the colonialist powers replaced the indigenous culture with a Western culture and created a new cultural and national narrative which includes a discourse of rebirth and newness on the basis of immigration (Moran, 2002). Furthermore, settler nations are not only defined based on historical characteristics, but are unique in that they still encourage immigration for the purpose of permanent settlement on a relatively large scale (Bauer et al, 2000).

Since immigration coincided with nation-building and is thus well-entrenched and institutionalized, immigration policy in settler nations has historically been uniquely open in comparison to European nations (Freeman, 1995). Joppke (1999: 13) defines immigration in settler nations as a "willed, recurrent event." He thus concludes that immigration policy in settler nations is influenced by their self-definition as a nation of immigrants and the integration of these immigrants contributes to increasingly more liberal immigration policies.

Despite the comparative openness to immigration in settler nations, the United States and Canada have both experienced increasingly restricted immigration policies.[2] In the case of the United States, major restrictions on immigration were first introduced by the Quota Acts of 1921 and 1925 (Lynch & Simon, 1999). Canada first implemented restrictions on immigration later with an immigrant point system in 1967 (Lynch & Simon, 1999; Bauer et al, 2000). Immigration policy in Canada originally favored immigrants from specific countries of origin but over time has changed to favor individuals with specific skills reflecting labor market demand. United States immigration policy historically gave preference to family reunification while also promoting immigrants with skills reflecting American labor demands. (Bauer et al, 2000).

Immigration policy in Israel is quite different than in the other two countries investigated. Israel was founded in 1948 as a Jewish State with the goal to serve as a safe haven for Jewish people of all origins. While Israeli immigration policy is quite exclusive in terms of non-Jews, its definition of "who is a Jew" is quite broad; elderly Jews and those with limited labor skills are eligible like any other Jew for citizenship (Gal, 2007). Thus, both the basis of immigration policy and the demographics of those immigrating to Israel are different then the other two settler nations investigated here. The historical development of immigration policy and its current manifestation in all three countries will be elaborated upon in the country study section of this research.

The United States, Canada and Israel are also similar in terms of welfare regime typology, a theory that emerged in the field of social policy as an attempt to classify welfare states into distinct categories based on prominent policy configurations and interactions (Clasen, 1999). The welfare state, both as a theoretical concept and as it is implemented, has a variety of manifestations. First of all, there is no absolute definition of the welfare state as welfare states in different countries manifest themselves differently (Flora & Heidenheimer, 1981). Many scholars agree that the purpose of the welfare state is to enhance human welfare (Gough, 1979) and some attest that any state with the "intention" to realize the welfare aspirations of its citizens can be considered a welfare state (Pierson, 1998). Other scholars attempt to define the welfare state more specifically. Pierson (1998) sets out three sets of criteria that must be fulfilled before a state can be considered a welfare state: 1) social

[2] The case of Israel is different and will be explored below.

insurance system; 2) growth of social expenditure and; 3) public welfare extended beyond relief of destitution and maintenance of public order and given as a right of citizens which binds the state and its citizens through an exchange of rights and duties. Gough (1979) identifies two specific sets of state activities that can included in the generally accepted definition of the welfare state: 1) state provision of social services including social security, health, social welfare, education, training and housing which are provided through cash and in kind services and; 2) state regulation of private activities which affect the immediate welfare of individuals and groups.

Furthermore, in addition to attempts to define the concept of the welfare state, starting with Richard Titmuss (1958) a number of classification systems, attempting to divide welfare states into categories according to specific criteria, have developed over the past half century. Gosta Esping-Anderson (1990), one of the foremost scholars in the field of comparative social policy, distinguishes three major "welfare regime typologies" – liberal, conservative and social democratic. Welfare states are classified as one of these three regimes based on their level of decommodification,[3] as well as stratification,[4] (Mabbett & Bolderson, 1999). Welfare states classified as part of the liberal regime are differentiated from other regimes by their narrow definition of social risks (residual) and their encouragement of free markets (Esping-Andersen, 1999). Esping-Andersen (1999) classifies the United States and Canada as liberal welfare states.

It is less clear where Israel fits into the Esping-Andersen regime typology (Gal, 2004; Lewin-Epstein et al, 2004). Historically Israel was found to be most similar to the social democratic model of the welfare state (Zambon et al, 2006). While Israel is occasionally still classified as such (Menachem 1999, Mandel & Semyonov, 2006), due to economic and ideological forces over the past twenty years, Israel's welfare state has been marginalized and now more clearly reflects the liberal regime (Doron, 2001; Zambon et al, 2006). Still others even classify Israel as a conservative welfare state (Stier et al, 2001; Okun et al, 2007). However this classification has been countered by the existence of social welfare safety nets providing direct cash transfers to mothers and state support of women's employment and compensation for unpaid child support (Gal & Ben Arieh, 2002; Okun et al,

[3] The degree to which social policy enables citizens to be independent of the market.
[4] The degree to which social policy differentiates between different groups of citizens. Stratification is juxtaposed with solidarity, which indicates that social policy offers the same benefits to all citizens.

2007). Thus, while Israel is clearly a hybrid case exhibiting characteristics of all three welfare regimes, in its current form it most reflects the liberal model like the other two countries to be examined in this study.

Thus, based on their similarities as settler nations and liberal welfare states, the historical relationship to immigration as well as welfare regime typology can be controlled for the United States, Canada and Israel, the foci of this study. This design allows the isolation of the variable examined here – immigrant access to public health insurance. Through historical analysis of the development of public health insurance policy and immigration policy in each country, coupled with the assessment of indicators of current access to public health insurance, based on primary and secondary resources, this study aims to explain divergences in immigrant access between the three countries.

4. Theoretical Framework

Diverse theoretical approaches exist in an attempt to explain policy outcomes, as well as policy divergences between countries. Historical institutionalism and the impact of ideas are two predominant approaches to variation in policy outcomes. They will be examined here in order to provide a theoretical basis by which divergences between the immigrant access to public health insurance in the United States, Canada and Israel can be explained.

4.1 Historical Institutionalism

The historical institutionalist approach to studying politics focuses on the way institutions structure and shape political behavior and policy outcomes and uses history as an analytical tool. According to historical institutionalists, institutions are formal organizations and rules as well as the informal norms and procedures that govern conduct (Thelen & Steinmo, 1992). Political scientist Peter Hall coined the widely accepted definition of institutions as: "the formal rules, compliance procedures, and standard operating practices that structure the relationship between individuals in various units of the polity and economy," (Hall, 1986). Historical instutionalists focus on specific empirical cases in an attempt to understand real outcomes, instead of constructing general political theories that explain many incidents.

While the term "historical institutionalism" was conceived in the last thirty years the general approach – the use of institutions to understand political behavior – has been used since Plato and Aristotle began to study politics[5] (Steinmo, 2008). Jean-Jacques Rousseau established the basis for the institutional approach in his notion that individual preferences or behavior are products of the norms and institutions of society. In the same vain, political decisions, just like individual behavior, are products of the institutional settings in which they exist, (Immergut, 1998). With the emergence of the modern academic discipline of the social sciences in the late 1800s and early 1900s political scientists focused on the interaction between constitutional design (the basis for institutional design) and political behavior. Known now as "old institutionalism," political scientists examined the formal institutions of governments and states, both comparatively and within specific countries, mapping the legal and administrative arrangements of governments and the public sector (Bell, 2002). However, following World War II and the collapse of democratic institutions at the hands of dictatorship and autocracy, institutions were disregarded in their ability to determine political outcomes. Instead, institutions were viewed as "the vessels in which politics took place," (Steinmo, 2008: 119). Thus, political theorizing focused on approaches such as behavioralism, Marxism, functionalism, systems theory, modernization theory and rational choice theory, instead of institutionalism (Steinmo, 2008).

During the late 1970s and early 1980s a number of political theorists began to focus on empirical outcomes, instead of theoretical variables, by asking "why do real world outcomes vary in the ways that they do?" (Steinmo, 2008: 123). For many scholars, the widespread behavioralist approach, which used observable behavior to explain political phenomena, did not adequately answer this question (Immergut, 1998). With the increasing number, size and complexity of social, political and economic institutions, as well as widespread institutional restructuring following the economic unrest of the 1970s, institutions, as well as behavior in the context of institutions, repeatedly emerged as an answer to this question (Bell, 2002). Theda Skocpol (1979) was one of the forerunners of this trend in political theory. Her study of revolutions in France, Russia and China concluded that state institutions in these

[5] In *The Republic*, Plato compares different forms of government in an attempt to understand the impact of institutions on political behavior. In *Politics,* Aristotle focuses on political institutions and the way they shape political incentives and normative values.

three countries prior to revolution had a significant impact on the outcome of each revolution, (Skocpol, 1979). Following Skocpol's example, disciplines throughout the social sciences including, political science, economics and sociology, began to compare specific outcomes in different countries and institutions frequently emerged as a defining factor in these outcomes (Bell, 2002). This trend is known as "new institutionism" and distinguishes itself from "old institutionalism" in that instead of merely describing institutional structures, "new institutionalists" employ institutions to explain outcomes and develop theory (Bell, 2002).

In addition to the stream of historical institutionalism, two other streams of institutionalism emerged as part of "new institutionalism" – rational choice institutionalism and sociological institutionalism (Hall & Taylor, 1996). While all three schools view institutions as rules that structure human behavior and examine the role of institutions in determining social and political outcome, what differentiates these schools is the understanding of the nature of human behavior, (Hall & Taylor, 1996; Steinmo, 2008). Rational choice institutionalists hold that humans are rational beings that use cost-benefit calculations in order to make decisions that maximize their own benefit. In this vain, institutions serve to structure individuals' strategic behavior, (Bell, 2002). Sociological institutionalists, on the other hand, view humans as first and foremost social beings who act habitually, instead of rationally. In this case, institutions serve as social norms, structuring the very way individuals view the world and therefore the way they act within the world, (Steinmo, 2008).

Historical institutionalism holds that humans are both norm-abiding as well as self-interested rational actors. Thus, neither social norms, nor rational choices can be exclusively examined in order to understand specific outcomes. Both social norms and rational choice must be considered, in collaboration with structural constraints, to understand outcomes (Pierson, 1993). In addition, in the pursuit to understand a political outcome, its historical context must be examined in order to determine the impact of social norms and rational decisions (Pierson, 1993; Steinmo, 2008). Furthermore, when investigating outcomes, in this stream, emphasis is placed on the asymmetric distribution of power by institutions as well as the tendency of institutions to be persistent or path dependent[6] (Hall & Taylor, 1996). Power and interest are

[6] Path dependence is a model borrowed from economics which views policy outcomes as the result of seemingly marginal, multi-stage changes to already established institutions, (Pierson 2000; Esping-Anderson 1999).

central to the historical institutionalist analysis of outcomes (Immergut, 1998). Finally, historical institutionalists hold that comparative case study research design is effective in understanding political and social outcomes (Pierson, 1993). A number of examples of the historical institutionalist approach will serve to further illuminate this approach.

In an attempt to understand the underlying reasons why some nations have implemented comprehensive health care systems, while others have not, Immergut (1992) investigated health care systems in three countries in Western Europe – Switzerland, France and Sweden. In all three of these countries, national health insurance had been proposed, but policy results differed; Switzerland rejected national health insurance, France introduced a compulsory public health insurance program that pays for treatment by private doctors and includes limited controls on doctors' fees while Sweden not only accepted national health insurance but subsequently converted its health system into a national health service that provides treatment directly to Swedish citizens through publically employed doctors and public hospitals. Despite these divergent programs, Immergut holds that these policy outcomes cannot be attributed to differences in policy makers' ideas, political partisanship or the preferences and organization of interest groups. She posits instead, that the differences in policy outcomes can be attributed to differing political institutions in each country. Differing institutional rules in each country, which regulate the decision making process in each respective country, created distinct constraints on executive power and interest-group influence. Therefore, institutions ultimately determine what type of health system was implemented in each country.

Another example of the historical institutionalist approach is research done by Béland and Lecours (2005) on the promotion of the decentralization of Belgium social insurance schemes (Social Security) by Flemish nationalists. In this case, existing institutional structures and interests caused by previous policy prevented the decentralization that Flemish nationalists endorsed. Through this example, Béland and Lecours argue that nationalism is not merely a societal force, but also a political construction influenced by institutional arrangements and policy legacies.

A significant amount of literature has focused on the impact of institutions on welfare states and more specifically on welfare state retrenchment (Starke, 2006). Paul Pierson's (2001) extensive study of welfare state retrenchment concluded that financial curtailment of welfare states is politically difficult to achieve. Despite its

unpopularity, scholars have investigated the institutional circumstances that lead to successful retrenchment. One research direction focuses on the level of fragmentation as opposed to centralization of political systems. Retrenchment has been found to be less likely in countries with significantly fragmented political power due to the fact that more parties hold veto power and thus can block reductions to the welfare state, (Tsebelis, 2002; Huber & Stephen, 2001). Conversely, however, the institutional concentration of power has also been found to deter retrenchment due to the fact that in these political systems accountability is also concentrated on specific political actors. In fragmented systems, political actors can avoid blame or share blame with other actors, thus increasing the likelihood that these actors would risk unpopular support of retrenchment, (Pierson, 1994; Pal & Weaver, 2003). Therefore, both the institutional concentration of power and concentration of accountability must be taken into consideration when investigating welfare state retrenchment.

Other scholars have investigated the impact of existing welfare institutions on the success of welfare state retrenchment (Starke, 2006). While it may be reasonable to assume that welfare state retrenchment would be more likely in countries with more extensive welfare states, and thus more provisions vulnerable to financial cuts, this has not be found to be true (Korpi & Palme, 2003). In fact, in some cases retrenchment has been found to be more difficult in these larger welfare states which are typically are supported by cross-class coalitions. The involvement of the middle-class has been found to lower success of welfare state retrenchment (Esping-Anderson, 1990; Korpi & Palme, 2003).

Finally, other scholars have found that specific welfare state structures, or policy legacies, have a direct impact on the extent and type of retrenchment possible in that welfare state (Pierson, 1994; Starke, 2006). One clear example of the impact of path dependence is evident in the example of the attempt to change pay-as-you-go pension systems into funded pension systems. In a pay-as-you-go system, contributions from current workers pay the pension benefits of current retirees. Thus current workers are dependent on future workers to fund their pension benefits. In a funded pension system, current workers pay into a pension account that accumulates assets to be given to them as pension benefits when they retire in the future. While there are many advantages to funded systems, especially in light of the increasing number of retirees as compared to workers, pay-as-you-go systems by definition are difficult to change. In order to entirely change a pay-as-you-go system to a funded

system, current workers would have to simultaneously pay into the existing system to support current retirees, as well as contribute capital to their own funded pension. Thus because of the necessity for double payment, the institutional structure set up by pay-as-you-go systems prevents complete conversion to a funded system. Retrenchment in this case is dependent on policy decisions that came before it and the institutions and structures that were subsequently put into place (Myles & Pierson, 2001).

As elucidated by these examples, institutions are critical to the understanding of political outcomes as they shape and influence the behavior, power and policy preferences of political actors (Bell, 2002) as well as determine the extent to which existing policy can be altered (Starke, 2006).

4.2 The Impact of Ideas

Recently, the role of ideas in determining policy outcomes, and the interaction between ideas and institutions, has developed as a focus within the field of historical institutionalism (Steinmo, 2008). In many cases ideas are viewed as complementary to institutions in explaining outcomes (Starke, 2006). Although academics only began focusing on the impact of ideas on public policy outcomes in the 1990s (Thelen & Steinmo, 1992) the centrality of ideas to political and social outcomes was noted by the sociologist and political economist Max Weber (1946) in his view that ideas profoundly impact the course of events in that they guide interest-based action towards an outcome.

While a broad concept in general, when referring to the impact of ideas on policy outcomes, cognitive paradigms, world views, norms, values, ideologies, identities, principled beliefs and frames are all considered types of ideas (Campbell, 2002). Specific world views and cognitive paradigms serve as "road maps" (Goldstein & Keohane, 1993: 12) for policy makers, restricting the alternatives considered and thus directly affecting policy outcomes (Campbell, 2002). Moreover, in comparing similar policy issues in different countries, it has become evident that cognitive paradigms differ significantly from country to country, thus leading to divergent policy outcomes in response to similar policy problems. This is evident in Esping-Anderson's (1999) investigation of the development of the European welfare state after World War II. While in Southern European nations, with primarily Catholic populations, policy makers operated under the assumption that family members have

responsibility for childcare, in Scandinavian countries, no assumption about the family role in childcare existed among policy makers. Thus, the Scandinavian welfare state implemented extensive childcare programs and support, while these programs were absent in Southern European countries. In this case, a Catholic world view or paradigm, directly impacted the type of welfare policy implemented.

Furthermore, norms, values, ideologies, identities and principled beliefs are also considered ideas that impact policy outcomes. In general, these types of ideas assist people in their perception of reality and enable them to make decisions that lead to actions in an ever-changing world (Cox, 2004). Thus, in terms of social and political outcomes, instead of limiting the policy alternatives considered from the outset, as in the case of paradigms, these types of ideas restrict the alternatives that are deemed acceptable or legitimate and thus some policy options are viewed more favorably then others (Suchman, 1997; Campbell, 2002; Béland, 2009). March and Olsen (1989: 160) refer to this impact of values on the assessment of policy options as a "logic of appropriateness." The Scandinavian welfare state is a prime example of a case in which values impact policy. The values of universalism, solidarity and freedom from the market (decommodification) have served as the basis for welfare policy since its inception in Scandinavian countries (Cox, 2004). While these values serve as a basis for policy, the way they are interpreted and prioritized allows for policy variation. For example, recently in Sweden and Denmark there has been an effort to reform the broad universal social services provided by the state in an attempt to make them more efficient and less costly. Consequently these reforms have limited the universality of the services. Those supporting the reforms argue that they will increase solidarity by provided resources to the most disenfranchised, while those opposing the reforms see them as a direct attack on the value of universalism in welfare state policy. It is evident in this case that the divergent prioritization of values has led to different policy preferences (Cox, 2004). Despite these conflicting views, the basic values that underline the Scandinavian welfare state model consistently serve to create a "logic of appropriateness" that structures the debate surrounding welfare policy decisions. Thus, this type of idea provides a broad guideline in terms of policy outcomes, but does not dictate the specific policy to be implemented.

Finally, some academics have looked at the way in which policy makers use ideas, or more specifically frames, to make some policies more politically acceptable then others. By framing policy alternatives, policy makers legitimize the policies they

prefer (Campbell, 2002). In fact, frames are strategically and deliberately used by policy makers and interest groups to garner public support for specific policy alternatives (Béland, 2005, 2009). Frames not only impact the initial development of policy, but can also be manipulated in an attempt to change existing policy. In this case frames are used to convince the public there is a need for policy change. This is evident in the reframing of United States welfare policy in an attempt to reform it in the 1970s and 1980s. Policy makers reframed means-tested welfare programs as providing financial and in-kind support to primarily African-Americans, while being funded by working-class white Americans through taxation. In effect, this frame divided voters along racial lines and served to garner support for welfare reform among white working-class voters (Quandagno, 1994). Another example of effective framing was British Prime Minister Margaret Thatcher's framing of welfare reform as a way to end the culture of dependency. While Thatcher did not succeed in fully dismantling the British welfare state, significant reforms were made in terms of labor relations and housing policy (Béland, 2005). The potentially significant impact of framing is evident in the comparison between Thatcher's welfare reforms and the neo-liberal attempt at welfare reform in New Zealand. Policy makers in New Zealand did not create a coherent frame for these reforms and thus were less successful then Thatcher (Schmidt, 2002).

It is apparent that ideas, in all their manifestations, have an impact on policy outcomes. In addition, just as institutions create path dependence, impacting the type and scale of reform to already existing policies, so too do ideas create path dependency. Due to the fact that ideas, such as paradigms or values, are commonly deeply held, people are inclined to maintain their ideas even within the context of a constantly changing reality. Rarely are ideas completely abandoned, and thus, similar to the path dependence of institutions, ideas must be refined or redefined, instead of overhauled, in order that they accommodate change (Hall, 1993; Cox, 2004). Ideas have an impact both on the policy alternatives considered and on those considered legitimate and thus provide another approach to accounting for divergent policy outcomes.

It is evident that institutions and ideas have significant influence on policy outcomes in specific countries. Furthermore, they have been used to explain divergences in policy outcomes between countries. Thus, the theoretical framework provided by the large body of research on the impact of institutions and ideas on

policy outcomes will shed light on the divergences in immigrant access to public health insurance in the United States, Canada and Israel.

5. Country Studies – Immigrant Access to Public Health Insurance

In order to understand divergent policy outcomes in three different settler nations with liberal welfare states, this study will examine immigrant access to public health insurance in the United States, Canada and Israel. Foreign-born individuals residing in these nations fall into a variety of different categories. The definition for relevant categories can be found in Appendices A, B and C. This study will relate to legal immigrants, excluding non-immigrants[7] and undocumented or illegal residents. In addition it will relate primarily to policy regulating immigrant access to public health insurance, and not to non-legal barriers to access.

5.1 United States of America

5.1.1 Immigration Policy

Since before the founding of the United States of America as an independent nation, immigration has been one of the nation's defining characteristics. The nation has developed from a cluster of colonies actively encouraging immigration in order to cultivate new land and gain power in relation to their mother countries, to a modern, liberal democracy struggling to balance its desire to main its history as a settler nation while protecting its citizens from foreign labor competition and security threats.

5.1.1.1 Historical Development of Immigration Policy

Immigration policy in the United States can be divided into six distinct eras:

The Colonial Period (1609-1775) – During this period the British government promoted the deliberate population of their colonies on the American continent in order to cultivate the land and send raw materials back to the mother country. Thus the goal of immigration during this time period was the recruitment of labor (Bernard, 1998).

[7] For example, foreign students and tourists.

The Open Door Era (1776-1881) – The founding of the independent United States of America in 1776 brought with it a new concept of national identity. The Founders saw themselves as a nation separate from their mother countries; a nation that was unique in its mingling of many different nationalities. This is reflected in the fact that the writers of the US Constitution made foreign born citizens ineligible for only one position, President of the United States. Immigrants were seen as the key to creating a strong nation. Immigration policy was unorganized on the federal level, with the federal government keeping no records until 1820, when they began to count the number of immigrant entrants each year. In practice, states with large ports regulated immigration and maintained records. Shipmasters were required to report immigrant names, occupations, birthplaces, ages and physical conditions. Those who were deemed infirm or destitute could be deported based on their likelihood to become wards of the state (Bernard, 1998).

The Era of Regulation (1882-1916) – In the Supreme Court decision of 1875, Henderson v. Mayor of NY, all existing state laws regulating immigration were deemed unconstitutional because they usurped the power of the Congress to regulate foreign commerce. This decision brought about a series of statutes enacted by Congress which put immigration under the direct control of the federal government and were designed to narrow the range of immigrants who qualified for admission. The Immigration Act of 1891 created the Immigration and Naturalization Service (INS), or the Office of Immigration as it was known at that time, as part of the Department of Treasury.

During this period the origin of immigrants began to change. Until this time the majority of immigrants were from northern and western Europe. Beginning in the 1880s the number of immigrants from southern and eastern Europe began to increase. Native born American citizens saw these immigrants as from alien cultures, as inferior and as racially inassimilable and called for policies that would limit their numbers and facilitate their adjustment. In 1903 the INS (then called the Bureau of Immigration) was transferred to the Department of Commerce and Labor, reflecting the view of immigrants primarily as a source of labor (Bernard, 1998).

The Era of Restriction (1917-1964) – This era was characterized by a series of laws that further limited immigration by factors such as occupation and nationality. The

Immigration Act of 1917 imposed a literacy test on potential immigrants and enacted policy that favored certain nationalities over others. Due to the fact that this legislation did not reduce the overall number of immigrants, the Quota Act of 1921 was enacted in order to put annual quotas on the number of immigrants admissible – 3% of each specific nationality recorded in the 1910 US Census. Immigrants from the Western Hemisphere were not bound by these quotas. In addition, wives, fiancés, parents, siblings and children under 18 years of age of US citizens or persons who had applied for citizenship were given preference within the quota limits. The Immigration Act of 1924 (or the Johnson-Reed Act) further reduced the number of immigrants admissible from each country to 2% of those registered in the 1890 census. After the 1924 Act, wives and dependent children as well as persons belonging to a learned profession or employed as domestic servants were allowed to enter the US as non-quota immigrants. The 1924 Act failed to distinguish between immigrants and refugees and thus limited the entry of Jews fleeing from fascist regimes in Europe. In fact, only in 1950 did the second Displaced Persons Act change the admission laws that discriminated against Jews and Catholics displaced by World War II. As a result of World War II and the view that immigration was an issue of national security, the INS was moved to the Department of Justice. In the shadow of the Cold War the Internal Security Act (1950) was enacted and allowed the exclusion and deportation of Communist party members. Finally in 1952 the Immigration and Nationality Act compiled the many different immigration laws into one unified code (Bernard, 1998).

The Era of Liberalization (1965 – 2001) – As the United States began publicly declaring its role as leader of the free world providing asylum to the oppressed, the previous wave of restrictive immigration policies presented a stark contrast to this desired image. This contradiction was particularly evident during and immediately following World War II. President John F. Kennedy was a strong proponent of a more liberal immigration policy and his initiatives in this area culminated, following his assassination, in the Immigration and Nationality Act of 1965. This Act abolished quotas based on national origins and moved the focus of the source of immigration from Northern and Western Europe to Latin America and Asia (which had been restricted until this point). 290,000 immigrant visas were granted annually, 120,000 to immigrants from the Western Hemisphere and 170,000 from the Eastern Hemisphere,

of which no country could use more then 20,000. As a result of complaints regarding preferential treatment of immigrants from the Eastern Hemisphere, the Western Hemisphere Act of 1976 distributed preferences equally to immigrants from both Hemispheres. Visas for immigration were granted on a first-come-first-serve basis. In addition, family members of US citizens and those applying for citizenship and individuals with particular skills were admitted outside of the allotted quotas (Bernard, 1998). Finally, the Refugee Act of 1980 created comprehensive refugee policy creating a category of immigrants specifically for refugees and asylum seekers (Congress of the United States, 2006).

Over time, the number of illegal immigrants grew significantly and in the 1980s significant attention was paid to this problem, especially by US workers and taxpayers afraid that low-paid illegal immigrants were taking jobs away from US citizens. As a result the Immigration Reform and Control Act (IRCA) of 1986 was enacted. This Act, aimed at reducing illegal immigration, did three things in practice: it allowed undocumented immigrants who had been in the US illegally since before January 1, 1982, to apply for legal residence; it made it illegal for employers to knowingly hire undocumented workers and; it implemented the Special Agricultural Worker program allowing undocumented agricultural workers to apply for legalization and allowed additional farm workers to be admitted if there was a shortage of farm labor (Calavita, 1998).

In contrast to the IRCA of 1986 which attempted to curb immigration, only four years later, the Immigration Act of 1990 was the most liberal immigration law since the first Quota Act of 1921. This act established three tracks by which people could immigrate to the US: family-sponsored immigrants, employment-based immigrants and diversity-immigrants from countries with low sending rates. This act also created a legal basis for people fleeing from areas of armed conflict or natural disaster to reside in the US for an extended period of time and work under temporary protective status. Following the Oklahoma City bombing in 1995 the Congress passed two laws that affected immigrants. The Anti-Terrorism and Effective Death Penalty Act (AEDPA) of 1996 mandating the detention and removal of criminal and undocumented aliens and those linked to terrorist groups. The Illegal Immigration Reform and Immigrant Responsibility Act (IRIRA) extended AEDPA and revamped the enforcement procedures for undocumented aliens. In addition the Personal Responsibility and Work Opportunity Act (PRWORA) of 1996, also known as

welfare reform, changed immigrant eligibility for federal benefits (see section below on immigrant access to health care) (Lynch & Simon, 1999).

Post-September 11 Era (2001-current) – Prior to September 11, 2001, immigration policy was only minimally concerned with protecting the US from terrorism. Instead the focus was on protecting American jobs from foreign competition. After the terrorist attacks on the United States of September 11, 2001, the US government has used the regulation of immigration as a means to combat terrorism (Chishti et al, 2003). The Patriot Act,[8] which was passed on October 26, 2001 and was renewed in 2006, has had a significant impact on immigration policy. The Patriot Act is not directed at non-citizens or immigrants specifically but provides for non-citizens to be detained for up to seven days and gives the government the ability to hold those who they intend to deport for up to six months (Schain, 2007). In May of 2002 the Enhanced Border Security and Visa Entry Reform Act was enacted which placed a restriction on non-immigrant visas from countries identified by the US as State sponsors of terrorism. In July of the same year the Immigration and Naturalization Service (INS) began to enforce section 265(a) of the Immigration and Nationality Act, which had previously not been enforced, mandating all non-citizens to register address changes within ten days of moving (Cainkar, 2004).

With the signing of the Homeland Security Act in November of 2002, which created the Department of Homeland Security (DHS), immigration policy has been more directly affected. The structural underpinnings of the federal immigration bureaucracy were dismantled to respond to heightened security concerns. In March 2003, The Homeland Security Act transferred INS, once again, from the Department of Justice to the Department of Homeland Security. Historically, the department to which implementation of immigration policy is allocated has provided a symbolic lens on how immigration was viewed at the time. The move from the Department of Justice to the Department of Homeland Security is no exception; from this point forward migration and immigration has been viewed primarily as an issue of national security (Waslin, 2003). Three immigration agencies are included under the Department of Homeland Security: the US Customs and Border Protection (CBP), the US Immigration and Customs Enforcement (ICE) and the US Citizenship and

[8] Full name: Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT Act*)*

Immigration Services (USCIS). The CBP is responsible for border enforcement at and between legal ports of entry and has initiated programs to secure US borders from illegal immigration. The ICE's mission is to "detect and prevent terrorist and criminal acts by targeting the people, money and materials that support terrorist and criminal networks" (US Immigration and Customs Enforcement, 2007) and is responsible for interior enforcement of laws including investigations, detentions and the deportation of unauthorized aliens. The USCIS is responsible for implementing the policies and administering the programs that make the nation's legal immigration system, adjudicates applications for immigrant and non-immigrant admission to the US and administers legal status changes (Meissner & Kerwin, 2009).

Other changes enacted since the September 11 terrorist attacks include additional and more extensive electronic name checks before granting both immigrant and non-immigrant visas (Meissner & Kerwin, 2009), a significant increase in the naturalization fee from $330 until July 2007 to $595 thereafter, and a new emphasis on the civics and history portion of the naturalization test aimed at making it more meaningful and useful to the potential naturalized citizen (Laglagaron & Devani, 2008).

These changes not withstanding, in the two years following the attacks, overall immigration remained steady while the number of temporary visas granted, dropped. Non-immigrant visa applications were the most affected (Cainkar, 2004). This can be attributed to the fact that two-thirds of the people who obtained permanent residence status in these two years were already in the US before September 11th (Migration Policy Unit, 2003).

The development of immigration policy in the US over the past four centuries has been comprised of a series of policy changes in an attempt to straddle the line between the immigrant identity upon which the US was founded and the need to protect US citizens from economic and security threats. Appendix D shows the impact of these policies on actual numbers of immigrants from 1850 until 2007. This history has created the immigration policy that exists today.

5.1.1.2 Current Immigration Policy

According to the US Census Bureau's 2007 American Community Survey, in 2007 12.6 percent of the total US population was foreign born. The largest group of foreign-born immigrants in the US was those born in Mexico, at 30.8 percent. This

was followed by 4.5 percent from the Phillippines, 3.9 percent from India and 3.6 percent from China (excluding Hong Kong and Taiwan). These countries, along with El Salvador (2.9 percent), Vietnam (2.9 percent), Korea (2.7 percent), Cuba (2.6 percent), Canada (2.2 percent) and the Dominican Republic (2.0 percent) make up 58.1 percent of all foreign born citizens residing in the US in 2007 (US Census Bureau, 2007).

Those seeking permanent residence in the US must file a petition with the US Citizenship and Immigration Services (USCIS) branch of the Department of Homeland Security in order to demonstrate their eligibility for residence under a particular visa category. Two main eligibility categories exist: family sponsored immigration and employer sponsored immigration.

Those who are eligible under family sponsored immigration fall into a number of different categories. The immediate families of US citizens (parents, spouses and unmarried children under the age of 21) automatically receive an immigrant visa once their visa petition is approved by the USCIS. Relatives who are eligible for immigration visas in the remaining categories have to wait until a visa number becomes available and are subject to ceilings on admission by (Meissner & Kerwin, 2009). Appendix E outlines the ranking of preferences for family sponsored immigrants. Both citizen sponsors and Legal Permanent Resident (LPR) sponsors of family members must sign an Affidavit of Support proving that they are able to support the applicant at 125 percent the mandated poverty line (USCIS).

In order to be eligible to be an employer sponsored immigrant, a labor certification request must be completed by the U.S. employer on behalf of the applicant, and submitted to the Department of Labor's Employment and Training Administration. Only once the request is granted by the Department of Labor is it passed on to USCIS for approval (USCIS).

In addition to those granted immigrant visas based on family or employer sponsors, each year a number LPRs enter the US based on other categories: the Diversity Lottery (DV) program[9], the "Registry" provision of the Immigration and Nationality Act (INA)[10], and through investment[11] (USCIS). However, these represent

[9] The DV program annually makes 55,000 immigrant visas available to people who come from countries with low rates of immigration to the United States through a lottery.

[10] Based on INA persons who have resided in the United States since before January 1, 1972, have continuously resided in the United States since entry, are of good moral character, have never engaged in terrorist activities and do not have criminal or security records, are eligible for US citizenship.

the minority of LPR visas and thus labor supplies and family ties still have the greatest affect on the ability to immigrate permanently to the US (Gelatt, 2007).

In all cases, USCIS checks applicants' names, watch lists and confirms that they are actually eligible for an immigrant visa. Once their petition is approved by USCIS, applicants apply to their local US Embassy or Consulate in order to undergo an interview and a series of rigorous background checks. Ultimately it is the Department of State, locally represented by US Embassies or Consulates, that approves applicants and grants visas when an immigrant visa number is available. For those who have been approved, the granting of immigrant visas can take an extended amount of time, depending on the applicant's level of preference and the number of applicants of the same national origin. The average waiting time to receive an immigrant visa in 2008 was nine months, down from 18 months in the years preceding it (Meissner & Kerwin, 2009).

After receiving an immigrant visa, grantees can travel to the United States, but are subject to inspection at the port of entry. US Customs and Border Protection (CBP) officers briefly interview visa holders in order to determine the validity of their documentation. Most visa holders are subsequently inspected for a second time. Once they successfully clear border control with an immigrant visa they become LPRs in the United States. It must be noted that a significant portion (up to 60 percent) of those obtaining LPR status annually are not new entrants to the US but have been temporary residents who subsequently change to permanent status (Gelatt, 2007). Nevertheless the process of altering status is much the same, requiring a petition of eligibility approved by the USCIS, rigorous background checks and the receipt of an immigrant visa number (USCIS).

There is an additional, separate category of residence for refugees and asylum seekers. Refugees are people residing outside their country of origin who cannot return there for fear of serious harm. Refugees may apply for refugee status only from outside the United States. Asylum seekers are individuals meeting the definition of refugee, who already reside in the US. In order to apply refugees and asylees must submit an application requiring extensive supporting documents to substantiate their claim to fall under the refugee category. Afterwards they must undergo an interview for approval. Refugees and asylees may then stay in the US with this status for a year.

[11] 10,000 immigrant visas per year are available to qualified individuals seeking permanent resident status on the basis of their engagement in a new commercial enterprise.

A year after the granting of refugee status, refugees are required by law to apply for LPR status. Asylees are also eligible to apply for LPR status a year after being granted asylum status, but are not mandated by law to apply. In order to apply a refugee or asylee must submit the same form as any individual seeking to apply for LPR status (USCIS).

Following conferral of LPR status for any category of immigrant, naturalization is the final step in the path to becoming a US citizen with full rights, privileges and responsibilities. After five years residence in the United States, LPRs can apply for naturalization. Spouses and children of LPRs and US citizens can apply for naturalization after only three years of US residents. Applicants for naturalization must demonstrate their ability to read and write basic English and pass a United States civics and history test. In addition, employment history and criminal activity is checked in order to ensure that the applicant has upstanding moral character. After filing for naturalization, applicants must remain in the US. Overall, once accepted as an LPR, the requirements for naturalization to US citizenship are relatively limited (Lynch & Simon, 1999). While naturalization is the legal conclusion of the immigration process, it is not mandatory and LPRs can remain in the US indefinitely. However many immigrants are motivated to naturalize because of the improvement of wages and living standard it offers, as well as the benefits it confers on those with citizenship status (Meissner & Kerwin, 2009). One of the benefits of citizenship in the US, specifically health care, will be examined in the next two sections, both for US citizens in general, as well as for immigrants specifically.

5.1.2 Health Policy

In contrast to the other liberal welfare states investigated in this study, the United States government does not provide universal health insurance to its citizens (White, 1995). In fact, all Western industrialized countries except the United States provide comprehensive health insurance for essential health services to their citizens (Quadagno, 2005). This differentiation between the United States health care system and others is not a new phenomenon. In fact, since 1920 at least 16 European nations had implemented some form of nationalized, compulsory health insurance. A number of attempts were made in the United States between the 1910s and the 1930s to implement compulsory health insurance plans, but none succeeded (Thomasson, 2002).

5.1.2.1 Historical Development of the Health Care System

Before the late 1920s, there was almost no demand for health insurance in the United States. Costs for medical care were relatively low because of the lack of development of medical technology and the widespread treatment of illness at home as opposed to at hospitals. Thus the expenditure on health insurance was deemed unnecessary (Anderson, 1968). However, many times the greatest cost due to sickness was the loss of income resulting from an inability to work. As a result, those who had the financial means purchased private sickness insurance instead of health insurance (Thomasson, 2002). At the same time, there was a low supply of health insurance as insurance companies saw health losses and medical expenses as uninsurable – indefinite and immeasurable, unexpected and uncontrolled, subject to catastrophic loss and not widely distributed (Thomasson, 2002). These factors made it unprofitable for insurance companies to provide health insurance.

During the late 1920s a demand for health insurance slowly developed as a result of a number of factors. The use of hospitals increased due to the development of medical technology located in hospitals. The development of medical technology also increased the number of illnesses treatable through expensive technology and thus the number of patients requiring technological treatment in hospitals increased. In addition, the small size of urban homes, as compared to rural homes, prevented space to care for the sick. Finally, anti-infection techniques made in-hospital surgery more common (Thomasson, 2002). At the same time, the reputation of the field of medicine increased as standards of care and physician licensure were improved. These improvements came as a result of Abraham Flexner's report to the American Medical Association that criticized the medical system and recommended more stringent entrance examinations for physicians and better medical facilities, higher medical fees and tougher medical standards (Flexner, 1910). This in turn increased the number of sick people who took advantage of health care services (Rosenberg, 1987) while reducing the supply of doctors. Finally, faith in health care was further boosted by the visible effectiveness of drugs including antibiotic sulfonamide (1935), penicillin (1946) and the polio vaccine (1955).

Before insurance companies began to offer health insurance, hospitals developed prepayment plans as a way to ensure that patients paid their hospital bills. This trend increased during the depression in the 1930s when hospitals lost significant revenue. In order to make up for this lost revenue, hospitals offered prepayment plans

to groups of employees (Thomasson, 2002). In 1929 the first Blue Cross prepayment plan was developed by the Baylor University Hospital. At that time Baylor hospital was suffering from scarce finances as a result of reduced hospital occupancy and an inability of many patients to pay their hospital bills. As a pilot program, Baylor offered Dallas teachers 21 days of hospitalization annually for six dollars per year. Initially 1,300 teachers signed up for this program, and within five years more then 408 employee groups had similar plans covering more then 23,000 people (Consumers Union).

With the growing financial crisis in the United States, which affected both the budget of hospitals and the ability of citizens to pay for health care, prepaid Blue Cross programs, like the one at Baylor Hospital, spread throughout the country (Consumers Union). In 1933 the American Hospital Association (AHA) approved its own hospital insurance plan. This plan rejected the one-hospital model (like Baylor) and promoted a multi-hospital plan which increased consumer choice. Promotion of public welfare was central to the AHA vision of hospital insurance. As a social welfare service, the AHA promoted and successfully passed enabling legislation giving Blue Cross plans special status as nonprofit organizations with tax-exempt status and without the normal regulations on insurance companies (Consumers Union). These factors encouraged the rapid growth of similar plans which made these plans readily available (Thomasson, 2002). By 1946 twenty million people across the United States were members of Blue Cross Plans in 43 states. These plans were mostly statewide plans instead of single- or multi-hospital plans (Anderson, 1968).

From the outset, physicians were generally opposed to prepaid medical plans as they feared intervention would reduce their income and limit price discrimination (Thomasson, 2002). Physicians were used to making judgments outside the narrow definition of illness including determining if the disabled were fit to work, pronouncing death and verifying the mental competence of people to write their own wills. They realized that if an outside body became responsible for financing health care, that body would also seek to control their financial liability and prevent physicians' control of these non-illness related judgments (Quadango, 2005). As a result, the American Medical Association (AMA), which had originally developed as a professional organization based on federated membership, transformed into a political force on all levels that worked to prevent the establishment of health insurance.

However as American citizens found it increasingly difficult to pay for medical services and out-patient care, which was not included under Blue Cross prepaid hospital plans, small groups of doctors and medical groups began to develop agreements with employers that provided prepaid non-hospital medical services. While the AMA succeeded in preventing the inclusion of health insurance in the Social Security Act of 1935, this Act served as a warning to medical associations throughout the country that insurance covering non-hospital based services was on the horizon (Quadagno, 2005). In the late 1930s when a new plan for national health insurance was promoted, the AMA realized that they needed to preempt both this plan and other prepaid medical service plans provided by hospitals and create their own plan (Thomasson, 2002). The California Medical Association (CMA) established the first prepayment plan supported by a medical association and others soon followed. These plans, known as Blue Shield, aimed to provide affordable access to medical services (Consumer Union). All states had Blue Shield type plans by the end of the 1950s which covered almost half of all physicians' services nationwide (Anderson, 1968). Just as Blue Cross plans served as the financial arm for hospitals (AHA), Blue Shield plans served the same role for doctors (AMA).

In its infancy in the United States, health insurance was a social welfare service provided by nonprofits mostly to groups of employees. However, the success of Blue Cross and Blue Shield programs to protect themselves against problems such as adverse selection and moral hazard, typically associated with health insurance, removed the barriers for commercial insurance agencies to develop health insurance policies (Thomasson, 2002). As for-profit companies, these insurance agencies brought a competitive dimension to the development of health insurance. In many cases, commercial insurance agencies were able to offer lower policy rates. As non-profits Blue Cross and Blue Shield were required to use a community rating system which gave the same rates to sick people as to healthly people. Conversely, commercial insurance agencies were able to provide lower rates to healthier groups of employees, a reality that gave their policies a competitive edge.

During the 1940s and the 1950s the connection between health insurance and employment was strengthened by government policy. During World War II, in light of scarce available labor, the 1942 Stabilization Act limited the wage increases that could be used to compete for labor. However, it did not prevent the provision of health insurance plans as an incentive to potential workers. In addition, tax laws, like

the Internal Revenue Code of 1954, promoted employment-based health insurance by giving tax exemption to employer and employee contributions to health insurance. These policies set the stage for a system heavily based on employer-provided health insurance that has yet to be changed.

President Truman entered his presidency in 1945 with the goal to establish compulsory national health insurance. With the conclusion of Truman's Commission on the Health Needs of the Nation (1951) a report was published concluding that while there was still no consensus among relevant parties on the source of financing of the American health insurance system, there was a consensus that the basis would be a voluntary health insurance system (Anderson, 1968). The Truman administration did not succeed in achieving its wider goal of national health insurance because of the opposition of the AMA and aligned forces.

In 1953, when President Eisenhower took office, sixty percent of the population was covered by some type of health insurance (Anderson, 1968). The Eisenhower Administration and the Republican Party further entrenched the idea of voluntary insurance plans and held that the appropriate role of the government in the health system was to fund medical research and provide health care to the impoverished, while the private sector could most efficiently provide health insurance to the general population (Quadagno, 2005). The Eisenhower administration also played a significant part in expanding health insurance programs for special groups (see below) (Anderson, 1968).

Since the emergence of health insurance, doctors and the AMA were the most active opponents of government intervention. Employer groups, trade unions and insurance companies allied with the AMA and enabled them to successfully prevent the expansion of health insurance legislation (Quadagno, 2005). However, by the 1950s the powerful trade unions began to break their alliance with the AMA in favor of advocating for disability and health insurance for their union members. In 1956 the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), the largest federation of unions in the United States, advocated successfully for disability benefits and then turned to a decade long battle for health insurance for senior citizens (Quadagno, 2005). In 1960 the Kerr-Mills Bill was passed which provided health care for senior citizens (over 65 years of age) and those under the poverty line. Both the Disability Bill and the Kerr-Mills Bill were signed by Eisenhower (Anderson, 1968). The AFL-CIO aimed to provide health care to all

senior citizens not dependent on their income, and the Kerr-Mills bill was the first step towards this goal (Quadagno, 2005).

Following the election of Democratic President Kennedy, the subsequent Presidency of Lyndon B. Johnson, and the Democratic sweep of the Congress in 1964 the movement for health insurance for senior citizens and the poor gained speed. The AFL-CIO and the Democratic executive and legislative branches were soon joined by the AHA, the Blue Cross Association and the insurance industry who supported public health insurance for the most costly groups of citizens. This alliance was more then enough to successfully combat the opposition of the AMA (Quadagno, 2005). These programs were framed by the Democratic Party and their labor supporters as mechanisms for providing increased access to medical services (Starr, 1982). In 1965 Medicare was signed into law by President Johnson and covered hospital insurance for the elderly (Medicare Part A), government-subsidized out-patient care for the elderly (Medicare Part B) and significantly expanded Kerr-Mills by providing Federal assistance to State governments in order to cover health care for the poor (Medicaid) (Starr, 1982).

Since the end of the 1960s there has been an almost continuous rise in the cost of health care. American Presidents since that time have tried a variety of different means to control and reduce health care costs in America. Although a proponent of the free market economy, the Nixon administration attempted cost containment through wage freezing, fee increase capping, the establishment of health maintenance organizations (HMOs) and professional standards review organizations (PSROs). None of these policies proved successful in significantly reducing the costs of health care. The Carter administration attempted to cap hospital charges, a proposal that was defeated by the opposition of the AHA and the business community, and attempted to reintroduce some form of universal health insurance coverage, which also failed after Carter turned his attention to the Iranian hostage crisis.

The Reagan administration's national recovery plan was based on supply-side economics which held that tax cuts would generate economic growth. In order to sustain these tax cuts, government expenses had to be reduced and as a result twenty-two separate health programs were combined into four federal block grants provided to states. In addition, under Reagan, the mechanism of federal payments to hospitals for Medicare treatment was altered. Instead of paying hospitals after services were rendered, hospitals began to receive predetermined fixed rates. In turn, the hospitals

shifted these increasing costs to commercial insurers, whose rates were not regulated, which increased hospital costs of commercial insurers by thirty percent within five years. Finally, under Reagan the AMA agreed to replace the traditional fee-for-service payment plan with a predetermined fee schedule based on the complexity and time demands of specific medical services.

Even President Clinton who managed to bring the United States out of a budget deficit and who was elected on a campaign promising universal health insurance coverage, failed to achieve this goal and was unable to significantly reduce the cost of health insurance (Giamo & Manow, 1999). One significant step that was made under Clinton was the implementation of the State Children's Health Insurance Program (SCHIP), which increased federal funding to states in order to insure low-income children. The percentage of children with health insurance coverage increased significantly since the implementation of SCHIP. Finally, the most significant change in health care under George W. Bush's administration was the enactment of the Medicare Modernization Act of 2003 which provides Medicare recipients with coverage of 75 percent (up to $2,250 a year) of pharmaceutical costs. Previously prescription drugs were not covered under Medicare (Quadagno, 2005).

Despite the historical stagnation of attempted health care reform, recently significant progress has been made in this field of reform under the Presidency of Barak Obama. A significant focus of Obama's campaign platform was health care reform and only fourteen months after being sworn into office, comprehensive health care reform legislation had been passed. Despite the fact that no Republican member of the House or the Senate voted for the reform, on March 23, 2010 the Patient Protection and Affordable Care Act became law. Through incremental changes over at least the next five years, the Act will extend health insurance coverage by requiring most US citizens and residents to have health insurance, and imposing a tax penalty on those without coverage. State-based health benefit exchanges and small business exchanges will be created and through cost-sharing and subsidies, these programs will make insurance affordable to uninsured Americans not eligible for Medicaid (low and moderate-income families) and to small businesses previously unable to afford health insurance for their employees. In addition, the Act will expand income eligibility for Medicaid and in effect increase the number of Americans eligible (Kaiser Family Foundation, 2010b). While this Act does not create universal public health insurance,

after the decades of attempted health care reform, it is a significant accomplishment and its meaning has just begun to unfold.

5.1.2.2 Current Health Policy

The majority of American citizens and residents receive private-employer sponsored health insurance. According to the Kaiser Family Foundation's Employer Health Benefits 2010 Annual Survey, 157 million non-elderly people received health insurance through their employers (Kaiser Family Foundation et al, 2010). In fact, sixty percent of the non-elderly population in the US was covered through employer sponsored insurance (Kaiser Commission on Medicaid and the Unemployed, 2009). These employer-sponsored health insurance programs are provided by for-profit as well as non-for-profit companies (i.e. Blue Cross/Blue Shield). Financing of the premium is primarily by the employer, with the remainder is paid for by the employee. Some larger companies are "self-insured" which means that they pay directly for the health care costs of their employees and contract with a third party to administer an insurance plan. Benefits, such as the level of cost-sharing and pharmaceutical coverage, vary significantly for different private plans. These plans are financed both by the employer and the employee (Chua, 2006).

Those whose employers do not provide health insurance, who are self-employed or who are unemployed can buy insurance on the private market but these options are frequently prohibitively expensive (Giamo & Manow, 1999) and in 2008 only five percent of the non-elderly population purchased private health insurance individually (Kaiser Commission on Medicaid and the Unemployed, 2009). Premiums vary depending on health or risk of the individuals seeking coverage. In addition, private health insurance providers are able to deny coverage to individuals based on pre-existing conditions which further prohibits those seeking this type of insurance (Chua, 2006). These insurance programs vary widely in terms of benefits and are completely financed by the individuals buying the insurance. One goal of the recent Patient Protection and Affordable Care Act was to create options for these uninsured Americans not eligible for public health insurance. The impact of the reform has yet to been seen (Kaiser Family Foundation, 2010b).

Publicly funded health insurance in the United States is composed of a number of selective programs. These programs include Medicare and Medicaid. Medicare coverage is limited to specific populations: the elderly and disabled. Access to

Medicaid is determined by a means-test and thus only those with a certain level of need are covered by Medicaid (Giamo & Manow, 1999; Longest, 1994). Expansion of Medicaid eligibility is one outcome of the recent health care reforms. Those individuals that are not covered by employer provided health insurance, private health insurance or either of the two public health insurance programs remain uninsured. However, following the recent reforms more affordable options will be available to these individuals. In 2008 17% of the non-elderly population in the US was uninsured. For detailed demographics of insurance coverage of the United States population see Appendix F.

Public Health Insurance - Medicare and Medicaid

Medicare is a federally funded program that has a number of sections – Part A covers hospital services, Part B covers physician services and Part D provides a prescription drug benefit program (Part C refers to Medicare Advantage – HMO's that administer Medicare benefits).

Eligibility and Coverage: Eligibility for Medicare Part A is established by paying health insurance (HI) payroll tax on one's income for at least 40 quarters (usually 10 years). After establishing eligibility, Americans over 65 years of age are automatically entitled to Medicare Part A. In addition, those under 65 who receive Social Security cash benefits on the basis of disability are covered by Part A after a 24-month waiting period. Finally, regardless of age those in need of kidney transplant or renal dialysis are also covered by Part A. Furthermore, people over 65 and all those covered by Part A may voluntarily enroll in Part B by paying a monthly premium of $58.70 (in 2003). As of September 2010, 47 million individuals were covered by Medicare (Kaiser Family Foundation, 2010a).

Benefits: Medicare Part A covers inpatient hospital services, up to 100 days of post-inpatient skilled nursing facility (SNF) care, some home health services and hospice care. Each time a patient's hospital admission begins, so too does a benefit period, and the patient must pay a deductible, while Medicare pays the remaining costs for the first 60 days of hospitalization. Benefits included in Part B comprise physicians' services, laboratory services, durable medical equipment (DME), hospital outpatient department (OPD) services and other medical services. The beneficiary must pay a $100 deductible on Part B and Medicare pays 80 percent of the remaining costs (U.S. House of Representatives, 2004).

Administration and Financing: Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) which is part of the Department of Health and Human Services (DHHS). Fiscal intermediaries, like commercial health insurers or Blue Cross/Blue Shield, do much of the work reviewing claims and making payments. Part A is financed through the health insurance (HI) payroll tax levied on current workers and their employers while Part B is financed through monthly premiums paid by beneficiaries and through Federal general revenues (U.S. House of Representatives, 2004). Fifteen percent of the Federal budget is allocated to financing Medicare benefits (Kaiser, 2010).

Medicaid is a means-tested entitlement program which is financed by both Federal and State funds. Medicaid programs are designed and administered individually by each State under Federal guidelines. Federal funding levels are based on each State's willingness to finance covered medical services and a matching formula. Medicaid is the most expensive means-tested program in the United States; in 2007 total Federal and State spending was $330.8 billion on Medicaid (Holahan et al, 2009). Even the U.S. House of Representatives (2004) official report on programs under the jurisdiction of the Ways and Means Committee acknowledges that "Medicaid is an enigma" (Section 15: 1). The confusion surrounding Medicaid stems in part from the differences between the individual Medicaid programs of each state. These state to state differences include income eligibility levels, services covered and the method for and amount of reimbursements for services. However, certain Federal rules do govern all Medicaid programs and thus serve as a way to generalize between programs (see below) (U.S. House of Representatives, 2004).

Eligibility and Coverage: Fifty different population groups are defined as potentially eligible for Medicaid by the Federal Medicaid statute. These groups are divided into: the categorically (financially) needy[12], medically needy who have too much money to be categorically needy[13] and special groups[14]. In addition, the State Children's Health

[12] Including but not exclusive to: families who meet Aid to Families with Dependent Children eligibility requirements (AFDC), pregnant women and children under 6 whose family income is at or below 133% of the Federal poverty level, children ages 6-19 with family income up to 100% of the Federal poverty line, caretakers (relatives or legal guardians) of children under 18, Supplemental Security Income (SSI) recipients, individuals or couples living in medical institutions and who have a monthly income up to 300% of the SSI income standard.

[13] Including but not exclusive to: children under 21, 20, 19 or 18 who are full-time students, caretaker relatives, aged persons (65+), blind persons (as determined by SSI program or state standards), disabled

Insurance Program (SCHIP) covers uninsured children (up to age 19) not otherwise covered by Medicaid (CMS, 2005).

Benefits: Benefits under Medicaid differ between eligibility group and between States. However, there are certain mandatory services prescribed by the Federal Medicaid Statute. Mandatory services for categorically needy eligibility groups include: inpatient hospital care, outpatient hospital care, laboratory and x-ray services, certified pediatric and family nurse practitioners, nursing facility services (for ages 21+), Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (for children under 21), family planning services and supplies, medical and surgical dental services, home health services (for those entitled to nursing facility services), nurse mid-wife services, pregnancy related services, 60-days of postpartum services, prenatal and delivery services and postpartum services specifically for those under 18 (CMS, 2005). The Statute also enumerates optional services that will be matched by Federal grants if a state chooses to include these services in their Medicaid benefits.

Administration and Financing: The Federal and State governments jointly fund Medicaid through taxes, while the states administer the program. Depending on the financial status of each individual state the Federal government matches state funding by at least 100 percent (the percentage is higher for poorer states). In 2004 the Federal government financed 57 percent of total Medicaid costs. At the Federal level the same body that oversees Medicare, CMS, oversees Medicaid. The Federal Medicaid statute requires that on the state level a single state body administer Medicaid. Though it differs by state, usually Medicaid is administered by the state welfare agency, the state health agency or an umbrella human resources agency. In addition, the state may process claims themselves or subcontract this work to a fiscal or health insurance agency (U.S. House of Representatives, 2004).

Despite the fact that the United States does not provide universal health insurance a significantly larger percentage of its GDP goes to health care then that of countries that do provide health insurance (Blank & Burau, 2004). This is particularly disheartening as 45.7 million non-elderly Americans remain uninsured (Kaiser Commission on Medicaid and the Uninsured, 2009).

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persons (as determined by SSI program or state standards) and persons who would be eligible if not enrolled in health maintenance organization (HMO).

[14] Including by not exclusive to: Medicare beneficiaries whose income is at or below 100% of the Federal poverty level and whose resources are at or below twice the standard allowed under SSI, qualified working disabled individuals, women with breast or cervical cancer and people with tuberculosis.

5.1.3 Immigrant Access to Public Health Insurance

While the majority of United States citizens receive employer-sponsored health insurance, due to the fact that an overwhelming number of immigrants are employed in full-time but low-wage jobs with minimum benefits like health insurance, they are less likely then native citizens to have employer-sponsored health insurance (Kaiser, 2008; Carrasquillo et. al., 2000; Fremstad & Cox, 2004). To compound this fact, availability of employer-sponsored health insurance for all employees in America has decreased significantly since 2001 (see Appendix G) which has disproportionately affected non-citizens (Clemens-Cook & Garrett, 2006). Overall, non-citizens are significantly more likely to be uninsured, both privately and publicly, then US citizens.

Prior to Welfare Reform in 1996 non-citizens who entered the United States legally were eligible for Medicaid coverage based on the same income and categorical standards as US born citizens. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 made legal immigrants arriving in the US after August 22, 1996 ineligible for cash assistance, food stamps and changed the eligibility requirements for Medicaid (Friedland & Pankaj, 1997). Following the enactment of PRWORA legal non-citizens must live in the US for five years before they are eligible for Medicaid. The requirement is referred to as the "five-year bar." Since the implementation of SCHIP in 1997 the five-year bar also applies to non-citizen children who otherwise meet the eligibility requirements for SCHIP. Specific categories of post-1996 immigrants are exempt from the five-year bar. These include refugees and asylum seekers who retain full Medicaid coverage for their first seven years in the US. Appendix H summarizes eligibility for certain categories of immigrants following PRWORA. The recent Patient Protection and Affordable Care Act does not remove the federal five-year ban on immigrants. However, it does make recent immigrants eligible for subsidies for state-based health benefit exchanges thus intending to reduce the number of uninsured legal immigrants (Kaiser Family Foundation, 2009).

States have the authority to modify federal requirements for Medicaid and SCHIP eligibility. States can both extend the ban on eligibility for more then five years or until citizenship is attained or conversely, can use state funds, unmatched by the federal government, to provide Medical insurance to non-citizens in the US for less then five years. (Elwood & Ku, 1998; Fremstad & Cox, 2004; US Congress A,

2004; Kaiser, 2008) As of 2004, 23 states had created programs using state funds to provide some type of coverage to immigrants falling under the five-year ban. Despite this trend, since 1996 the number of uninsured non-citizens has grown (Fremstad & Cox, 2004).

Neither welfare Reform of 1996 nor the recent reform affects elderly immigrant eligibility for Medicare. The requirements for legal immigrants and native born citizens alike remains equal – Medicare recipients must have worked 40 quarters (usually ten years) and paid Federal Insurance Contributions Act (FICA) taxes on their income (US Congress B, 2004). Based on these requirements Medicare provides almost universal coverage to native-born citizens as well as legal immigrants. However, while 96 percent of elderly native born citizens are covered by Medicare, only two-thirds of elderly immigrants are covered because they have not been in the US long enough to work the required quarters (Capps et. al., 2002). Like native elderly citizens, elderly immigrants can buy Medicare coverage by paying monthly premiums which is set by the number of quarters they have worked in the United States. Those who have worked 30-39 quarters can buy Medicare Part A by paying a $174 per monthly premium and Part B by paying $78.20 per month. Those who worked less then 30 quarters can buy Part A for a $316 monthly premium and Part B for $78.20 (US Congress B, 2004). While elderly legal immigrants are the group of immigrants most likely to have government sponsored health insurance (Carrasquillo et. al., 2000), as a group they are still substantially more likely then elderly native born citizens to be uninsured (Friedland & Pankaj, 1997).

In addition, PRWORA did not affect access to emergency care. Under the Emergency Medical Treatment and Labor Act regardless of an individuals' ability to pay for services, hospitals are required to screen and stabilize all individuals seeking emergency medical care. In addition, non-citizens can receive Emergency Medicaid which covers emergency treatment if they meet certain stringent age requirements and if their condition falls under a specific range of medical services for life-threatening conditions. Both legal and undocumented immigrants are eligible for emergency medical treatment and Emergency Medicaid (Ellwood & Ku, 1998; Kaiser, 2008).

Low-wage occupations without employer-sponsored health benefits and eligibility requirements for public health insurance coverage are not the only barriers to immigrants in attaining health insurance. First of all, some non-citizens who are in fact eligible for Medicare or Medicaid/SCHIP fear that receiving these benefits will

adversely affect their immigration status and their chances of becoming US citizens. While there is no connection between immigration status and public benefits, this fear, especially post PRWORA, is widespread (Ellwood & Ku, 1998; Ku & Matani, 2001). In addition, language proves to be a significant barrier in health insurance coverage. Immigrants with Limited English Proficiency (LEP) are more likely to be uninsured then English speaking immigrants. Language proficiency affects both an immigrants' ability to find a job with health benefits and creates difficulties in accessing appropriate information on application procedures, eligibility guidelines, participating providers and requirements for recertification (Ku & Waidmann, 2003; Weiss et. al., 2006). Ponce et. al. (2006) found that immigrants with LEP eligible for both Medicare and Medicaid seemed to fare better under Medicaid. This can be attributed to the fact that Medicaid falls under federal civil rights laws requiring Medicaid health professionals to offer free language assistance. This requirement is not true for physicians who provide Medicare and thus may be more difficult to access.

Taking all of these factors into consideration, it is not surprising that a significantly greater number of immigrants in America are uninsured as compared to native born citizens. As of 2008 46 percent of non-citizens were uninsured whereas only 15 percent of US citizens were uninsured (Kaiser, 2009). In 2008 18 percent of native non-elderly American citizens were recipients of Medicaid (or public insurance), only 11 percent of non-elderly naturalized American citizens and 13 percent of non-citizens were recipients of Medicaid (or public insurance) (Kaiser Family Foundation, 2009). See Appendix I for details. In fact, public health care expenditures for immigrants are substantially lower then those for native citizens – in 2004 immigrants accounted for health expenditure 55 percent lower then natives citizens (Mohanty et. al., 2005). This data is contrary to the popular belief that immigrants drain public welfare systems (Wang & Holahan, 2003; Ku et. al., 2003). The examination of the development of immigration policy and health insurance policy in the United States, in comparison with Canada and Israel, will provide a greater understanding of current policy regulating immigrant access to health insurance in the United States.

5.2 Canada

5.2.1 Immigration Policy

Canada is a plurinational country incorporating English and French speakers as well as First Nation native citizens. In addition, Canada is a settler nation, founded on principles of integrating immigrate populations. As of 2005, 18 percent of Canadian citizens were born outside of Canada (Banting, 2005). New immigrants to Canada receive settlement services and language training and historically have achieved economic independence comparable to native born Canadians (Banting, 2005).

5.2.1.1 Historical Development of Immigration Policy

The historical development of immigration policy in Canada can be divided into a number of distinct periods:

Expanding the Population (1867-1914) – Since the establishment of the Confederation of Canada in 1867, immigration was viewed as a means to expand the population of the country, advance the economy and develop society and infrastructure (Reitz, 2004). The Act of 1910 established the method by which the Canadian government would approach immigration until 1962; a method that focused on admitting immigrants based on their country of origin (Green & Green, 2004). Due to the fact that Canadian policy makers saw it in the interest of the country to admit the maximum number of immigrants, there were hardly any barriers to immigration at the beginning of this period. The first barrier to immigration based on origin, the Chinese Immigration Act, was established in 1885 and limited the number of Chinese immigrants allowed on cargo ships bringing immigrants to Canada (Kelley & Trebilcock, 1998). Despite this relative openness, the majority of immigrants originated from Britain, the United States and Northwestern Europe where migration agents were stationed to attract potential immigrants (Kelley & Trebilcock, 1998). For the most part, these immigrants were farmers, industrialists and female domestic workers who were encouraged to settle in the western regions of Canada (Kelley & Trebilcock, 1998; Green & Green, 2004).

During the beginning of the 20th century, a number of policies were implemented as a response to growing domestic pressure to limit those immigrants who had difficulty assimilating. Thus, landing taxes and immigrant quotas were set on immigrants from East India, China and Japan. In addition, naturalization requirements

were increased from three years of residency to five years of residency. Finally, to supplement these selection and naturalization policies, deportation provisions were enhanced (Kelley & Trebilcock, 1998).

A number of immigration policy themes emerged during this time that continued throughout the history of Canadian immigration. First of all, a pattern was established whereby immigrant recruitment was expanded to non-traditional countries of origin when the demand for labor increased beyond the available supply. In addition, decisions on immigrant recruitment were made by the Canadian Cabinet through Orders in Council which created a high level of flexibility in immigration policy, while excluding public debate on the decisions. Finally, business and land owners benefited the most from immigration policy with the influx of affordable labor, while native Canadian laborers potentially suffered from increased competition and less power to sway the decision of policy makers (Green & Green, 2004).

The War Years (1914-1929) – During World War I the Canadian economy fluctuated and in response so too did immigration policy. During the years leading up to World War I and the years immediately following the war, economic hardships in Canada lead to more selective immigration policies. These policies were created in order to fulfill the specific labor needs of the Canadian economy. In 1919 an Order in Council was established that enabled the government to limit immigration due to conditions "temporarily existing in Canada" as well as impose a literacy test on applicant immigrants (Green & Green, 2004). This policy enabled the government to base immigration on the short-term absorptive capacity of the Canadian economy.

In contrast to these two sub-periods of recession, during the actual war, a significant need for labor existed in order to replace soldiers deployed overseas as well as to provide production labor in the emerging war related industries[15] (Kelley & Trebilcock, 1998). Admission to Canada based on country of origin continued to prevail with preferred immigration from Great Britain, the United States, Ireland, Newfoundland (then a colony of the United Kingdom), Australia, New Zealand and South Africa due to the fact that these immigrants were seen as most easily assimilated. Applicants from Northern and Western Europe were subject to similar immigration policies as those from preferred countries, but farmers were targeted.

[15] Tanks, aircraft, sea vessels and explosives.

Those outside these countries were subject to a variety of regulations and quotas and only admitted if they were sponsored by a previously admitted relative (Green & Green, 2004).

Depression and World War II (1930-1946) – With the onset of the Great Depression and the election of a Conservative government in Canada, a series of immigration policies were enforced that together served as the tightest immigration policies in Canadian history (Kelley & Trebilcock, 1998). The Order of Council of March 1931 effectively closed Canada to all immigrants until the end of World War II, except to farmers with financial means, immediate relatives of Canadian residents and those from Great Britain or the United States with sufficient finances to support themselves until they found employment (Green & Green, 2004). Similar to previous times of restriction, stricter naturalization policies and deportation activities were imposed. For example, immigrants receiving welfare, members of Communist parties and those engaged in labor movement agitation could be deported (Kelley & Trebilcock, 1998). Whereas since Confederation immigration was seen as essential to nation building, after 1930 the government focused on economic recovery as essential to the nation and thus, immigration was limited only to those who would contribute to the economy without additional financial burden. Thus, immigration remained limited to those of British or American origin (Kelley & Trebilcock, 1998).

As in the case of World War I, the outbreak of World War II stimulated the Canadian economy. However, while strict deportation policies eased up, overall immigration policy remained exclusive. During the Great Depression immigration policy reflected domestic pressures, while during World War II policy responded to international events. Internal government documents from the period of World War II, as well as records of public debate, reveal that the main reason immigration policy in Canada did not liberalize during World War II was due to a fear of an influx of refugees, mainly Jewish, from the war (Kelley & Trebilcock, 1998).

Reopening: Selective Immigration (1946-1961) – For almost a century since the Confederation of Canada, immigration was viewed as a reflection of economic and social trends and thus policy reflected these trends. Only following World War II and the existence of large numbers of displaced persons, did Canada comprehensively assess and then implement cohesive immigration policy.

Following World War II, Canada experienced significant economic growth. This, coupled with low birth rates during the Great Depression and war, lead to an opening up of channels of immigration. During this period, immigration focused on skilled workers as well as professionals settling in urban areas, as opposed to farmers. In addition, while immigrants from the preferred countries were still favored, immigrants from diverse countries, mostly in Europe, were admitted in increasing numbers (Kelley & Trebilcock, 1998). Policies were set in accordance with Prime Minister Mackenzie King's widely quoted speech of 1947:

> The government will seek…to ensure the careful selection and permanent settlement of such numbers of immigrants as can advantageously be absorbed by our national economy…Canada is perfectly within her rights in selecting the persons whom we regard as desirable future citizens. It is not a 'fundamental human right' of any alien to enter Canada. It is a privilege…The people of Canada do not wish, as a result of mass immigration, to make a fundamental alteration of the character of our population.

Six new Orders in Council set policy trends reflecting this statement. These Orders served to widen sponsorship rights, allow the admission of Polish war veterans and Dutch farmers, create procedures for admitting displaced persons, expand immigration recruitment across Europe and broaden the class of workers that could enter as contract labor (Green & Green, 2004). Finally, the 1952 Immigration Act, the first new Immigration Act since 1910, simplified the admission process and the management of immigration by granting the Cabinet comprehensive authority over the admission of immigrants (Knowles, 2000).

Establishing Procedures (1962-1978) – Continued economic growth coupled with increasing social and political dedication to values of equality and non-discrimination led to significant changes in Canadian immigration policy during this period. In 1962 new regulations were established in the House of Commons which led to policy significantly different then that outlined by Prime Minister Mackenzie King in 1947. The 1962 regulations eliminated the category of preferred status countries and revoked previous limits on immigrants from Asia. As it was stated in the regulations, immigration would be granted to "a person who by reason of his education, training, skills and other special qualifications is likely to support himself until he is established, or has come with arrangements for employment or has come under approved arrangements for establishment in a business, trade or profession or in

agriculture." For the first time in Canadian history, origin was no longer a factor for admission of non-sponsored immigrants. Potential economic contribution was the most significant factor determining admission of individual immigrants (Kelley & Trebilcock, 1998).

However, family-sponsored immigrants remained the largest group of immigrants. Simultaneously the Canadian economy faced high rates of unemployment which put the acceptance of large numbers of uneducated and unskilled sponsored immigrants under scrutiny. As a response, the government issued a White Paper[16] in 1966 which proposed decreasing immigration based on sponsorship and increasing individual immigration (Knowles, 2000). This would effectively increase the number of educated and skilled immigrants to correspond with both short-term labor demands as well as long-term economic considerations.

The 1966 White Paper let to the adoption of the Norms of Assessment points system of 1967. While the 1962 regulations set out the factors to be considered when determining the eligibility of a non-sponsored applicant, these criteria were placed in the hands of immigration officials to interpret and apply. The point system filled this gap by creating an objective scale and assigning points to non-sponsored applicants based on factors of long-term economic success[17], short-term labor demands which could be constantly reviewed and updated[18] and absorption rate[19]. The system also limited immigration based on sponsorship to only immediate family, in order to decrease the number of unskilled sponsored immigrants, and created a "nominated" category of applicants for those with distant relatives in Canada. Those applying for immigration under the nominated category were evaluated based on only five of the point system categories – education, personal assessment, occupational demand, occupational skill and age – in order to assess their economic success, while still honoring the commitment to family reunification (Green & Green, 2004).

Beginning in the mid-1970s economic growth began to decline and unemployment increased as a result. In order to reduce the number of unemployed new immigrants admitted to Canada, in 1974, a ten point penalty was placed on individual applicants without previously arranged employment (Green & Green,

[16] A White Paper is issued as a government statement of position on a specific issue.
[17] Age, education and training.
[18] Occupational skill in demand, knowledge of English or French, arranged employment, and employment opportunities in area of destination.
[19] Personal assessment made by immigration official in an interview, relatives in Canada.

2004). In addition, a Green Paper[20] was issued in the same year in response to growing economic problems in urban areas. The paper argued that the growing diversity of immigrants, mostly settling in urban areas, was the single factor causing economic decline and racial tensions. The paper provoked vigorous academic, public and political debate with countless claims that the attitude of the paper was outright racist towards immigrants.

In response, in 1975, a Joint Senate-House of Commons Committee rejected the Green Paper's conclusions that immigrants were the single cause of growing urban unrest. Instead, the committee supported implementing a federal annual immigration quota in conjunction with province labor demands, in order to prevent channeling immigrants into cities where they were unlikely to find employment, however skilled they may be. Thus, any non-sponsored immigrant, satisfying the point system requirements, would be admitted on a first-come, first-serve basis until the annual quota was fulfilled. The committee recommendations became the 1976 Immigration Act which was passed almost unanimously and implemented in 1978. The Act also created four distinct categories of immigrants – family class (formally sponsored), assisted relatives (formally nominated), independent immigrants and refugees – each of which would be selected separately. In addition, the 1976 Immigration Act also served to limit, to some extent, the range of ministerial discretion conferred by the 1952 Act. However slight, this trend, to limit the ministerial role in decision making, continued in the following period (Kelley & Trebilcock, 1998).

Thus, it is evident that a significant shift in immigration occurred during this period in Canadian history. As Prime Minister Mackenzie King's 1947 statement reveals, for almost a century, Canadian immigration policy focused primarily on preserving the demographic character of the nation and responding to short-term labor demands. However, in the 1960s and 1970s the process shifted, with the support of political and public consensus, to a system based on due process which honored principles of family reunification, while taking into consideration both short and long-term economic demands.

[20] A Green Paper is designed to give factual background on policy issues and present policy options in an attempt to reach consensus on new legislation.

The Clash over Refugee Policy (1979-1993) – During the 1980s and early 1990s the economic recession continued. With this backdrop, in 1985 the new Conservative government carried out an assessment of immigration policy as is evident from the Immigration Minister's Special Report to Parliament of 1985 as well as the Annual Report to Parliament on Future Immigration Levels of the same year. These reports found that the fertility rate among Canadian citizens had fallen below replacement rates and that the Canadian population would begin to decline during the 21st century unless immigration was increased. As a result, the government's policy recommendations, in the form of the 1990 five-year immigration plan, was unveiled and for the first time in Canadian history, the government, and a Conservative government at that, committed itself to increasing immigration despite the economic situation (Green & Green, 2004).

Another trend that characterizes this period was a substantial increase in refugee admissions. While in 1977 only 7,300 refugees were admitted, 27,900 were admitted in 1979 and 40,300 in 1980 (Kelley & Trebilcock, 1998). This significant influx of refugees was partly a result of increasing numbers of refugees worldwide; victims of civil war and religious, ethnic and political persecution. However, this international trend was not the only factor contributing to the enormous increase in refugee admissions in Canada in the late 1970s. Included in the 1976 Immigration Act were significant modifications to existing refugee policy. What was once an *ad hoc* approach to refugee selection became formal as the 1976 Act set out three ways by which refugees could be settled in Canada. First of all, a distinct class of "displaced and persecuted" persons was created so that refugees did not have to adhere to standard selection criteria. This class of immigrants could be sponsored by the Canadian government, a private institution or an individual and the regulations regarding sponsorship for this category of immigration were loosened. In addition, the 1976 Act enabled the Immigration Department to accept applicants into a special-measures landing program in order to ease absorption, on a case specific basis for people from certain countries. Finally, an inland-refugee determination system was implemented in order to grant refugee status to people already present in Canada.

During the early 1980s, as a result of the multi-step process to determine refugee claims set out by the 1976 Act, and an inability on the part of the Immigration Department to handle the claims, a significant backlog in refugee claims materialized. In 1986, in an effort to clear the backlog, amnesty was given to refugee claimants

already present in Canada who were deemed likely to successfully establish themselves. Based on this principle, 85 percent of the inland refugee claimants gained immigrant status (Kelley & Trebilcock, 1998). The Conservative government was disconcerted by the influx of refugees, the fear that potential immigrants were manipulating the system by falsely claiming to be refugees and the backlog of refugee claimants. They therefore backed two bills, C-55 and C-84, in an attempt to make conferral of refugee status more stringent as well as decrease the existing backlog. The resistance to these bills, by both the Opposition and non-governmental organizations in the field, was harsh and included allegations of immorality on behalf of the government as the subject of refugee asylum is steeped in sensitive moral implications. However in the end, both bills were passed based on tenuous consensus, and led to a streamlined refugee determination process, separate from the main immigrant system. This new system balanced the desire to maintain Canada's legal and moral obligation to ensure the protection of legitimate refugees, while effectively deterring manipulation of this status. In general, the new refugee determination system successfully sped up the process to confer refugee status and prevented major backlogging (Kelley & Trebilcock, 1998).

Immigration policy during this period elicited more debate than in the previous period and the final consensus attained was significantly more fragile. However, this period established a norm by which immigration policy was determined through open public and political debate as opposed to executive or administrative policy making as it was in the past. The development of this standard combined with the due-process system of immigrant acceptance created an ever more democratic process.

Balancing Between Inclusion and Security (1993-current) – In 1993 the Liberal Party became the ruling party in Canada. Not insignificant in their election victory were immigrant supporters. Almost immediately the new government began to outline policy initiatives in the field of immigration in order to distinguish themselves from their Conservative predecessors and appease their electoral base (Nord, 1997). As a continuation of the previous trend to elicit public debate on the subject of immigration, the Ministry of Immigration held town hall meetings throughout the country on the subject of immigration, organized bilateral discussions with provincial governments and created working groups of academics and policy makers in the field.

As a result of these actions, the Liberal Party, and the Ministry specifically, was able to support their inclusionist view against those in the Opposition, by relating to their policies as the will of the citizens of Canada (Nord, 1997). The five-year plan, a result of the conclusions gleaned from these widespread meetings, included maintaining immigration levels at one percent of the population level, curtailing misuse of the immigration and refugee system and investigating crime and welfare abuses tied to new immigrants, broadening opportunities for independent, economic immigrants and restructuring the point system in order to emphasize specific industries (Green & Green, 2004; Knowles, 1997; Nord, 2007).

Under the Liberal Party, the Immigration and Refugee Protection Act (IRPA), the first major change to the 1976 Immigration Act, was legislated in the spring of 2002. The significant alterations made by this act included changes to the structure and procedures of the Immigration and Refugee Board, the definition of family for purposes of reunification, the point system as well as a redefinition of skilled worker migration and more stringent measures against those found to be smuggling, trafficking in people and engaging in criminal activity (Freilich, Opesso & Newman, 2006; Dauvergne, 2002). IRPA also included specific provisions in order to prevent terrorism including expanded security checks for refugees and asylum seekers and checking names, fingerprints and photographs of applicant immigrants against security databases (Adelman, 2002). While IRPA was enacted following the terrorist attacks in the United States on September 11, 2001, this event only served as an impetus to pass legislation representing national economic interests already existing in draft form (Adelman, 2002; Dauvergne, 2002). Throughout its term, the Liberal Party, which held office until 2006, wavered between publicly supporting inclusive immigration policy while actually enacting policy that tightened immigration procedures.

5.2.1.2 Current Immigration Policy[21]

According to the Office of Citizenship and Immigration Canada (CIC) in the year 2008 247,243 people migrated to Canada and the top five source countries for permanent residents were the People's Republic of China, India, Philippines, the

[21] Unless otherwise noted, information about the current immigration process in Canada was taken from the official website of the Citizenship and Immigration Canada Office: http://www.cic.gc.ca/english/index.asp

United States and the United Kingdom (Citizenship and Immigration Canada, 2009). As defined in the Immigration and Refugee Protection Act (IRPA) three categories of permanent residents exist; these include the family class, the refugee class and the economic class. Of the immigrants in 2008, 26.5% immigrated in the family class, 60.3% were economic immigrants, 8.8% were refugees and the remaining 4.3% were temporary resident permit holders, refugee claimants residing in Canada or individuals admitted based on humanitarian or compassionate bases (Citizenship and Immigration Canada, 2009).

In order to apply for Canadian citizenship, one must be first granted permanent residence status. All applicants for permanent residence status must undergo medical, criminal and background screening. Separate rules apply for the three different categories of permanent residents.

Permanent residents or citizens of Canada over the age of 18 may sponsor the following family members in their application for permanent residence status: spouses, common-law partners, conjugal partners, dependent children, parents, grandparents, siblings, nieces and nephews, orphan grandchildren under 18 and the accompanying relatives of these applicants. In order to apply for permanent residence in the family category, the sponsoring relative must first apply to be an approved sponsor and commit to financially support their applicant relatives. Only once the sponsor is approved may the applicant for permanent resident status start the application process. Payment of an application fee is required, based on type of family relationship, for both the sponsor and applicant. Following the submission of an application for permanent residence status, the Case Processing Centre (CPC) of the Citizenship and Immigration Canada office reviews the case and either accepts or denies permanent residence status based on the application and background checks. An accepted applicant receives a permanent residence visa and a Confirmation of Permanent Residence (COPR) which they must present to Citizenship and Immigration Canada officers at their point of entry into Canada.

Those applying for permanent residence in Canada in the economic category must fall into one of three cases: have already arranged employment in Canada, have been living in Canada legally as a temporary worker or student for one year, or have work experience in a specific category defined by the Canadian government as

eligible for permanent residence status[22]. In addition, eligible applicants must have at least one year of full-time experience in their field (or the equivalent part-time experience) within the past ten years and must fit into the Canadian National Occupation Classification List as skill type 0, A or B[23]. Any person meeting these eligibility requirements can then submit an application including a processing fee. The application will be processed based on the point system according to six factors: education, abilities in English and/or French, work experience, age, adaptability and pre-arranged employment in Canada. If accepted for permanent residence status, an economic immigrant will, like a family class applicant, receive, a permanent residence visa and a Confirmation of Permanent Residence (COPR) which they will be required to present to Citizenship and Immigration Canada officers at their point of entry into Canada.

Those persons seeking permanent residence status as refugees must claim refugee status either at the port of entry into Canada or, if they are already residing in Canada, at a local Citizenship and Immigration Canada (CIC) office. The Officer receiving the refugee claim, based on available documentation, determines whether or not a case is eligible for referral to the Immigration and Refugee Board of Canada (IRB). In some cases, refugee claimants arriving at land borders are unable to make claims due to the Safe Third Country Agreement between the United States and Canada. In addition, refugee claimants may be denied by CIC officers based on a background of security or criminal activity. Once referred to the IRB a refugee claimant must complete and submit a Personal Information Form. Following submission, the refugee claimant will be called to the IRB for a hearing. Only then will the IRB determine whether or not the claimant is in fact a Convention refugee. Convention refugees are people who are outside their home country or country where they normally live, and who are unwilling to return because of well-founded fear of persecution based on race, religion, political opinion, nationality or membership in a particular social group. Those who are accepted as "protected persons" by the IRB can then apply for permanent residence status. Those who are not accepted as "protected persons" may submit their case for judicial review within 15 days of their notice of rejection.

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[22] The list of approved categories of workers changes constantly and can be found at: http://www.cic.gc.ca/english/immigrate/skilled/apply-who-instructions.asp#list

[23] For the Canadian National Occupation Classification List see: http://www5.hrsdc.gc.ca/NOC/

Those granted permanent residence status through any of the three categories are able to live, work and study anywhere in Canada. In addition they are protected under Canadian law and given most social benefits that Canadian citizens receive, including health care coverage (see section below). However, they may not vote or run for political office, hold jobs requiring high-level security clearance or remain in Canada if convicted of a serious criminal offence. In exchange for these rights, permanent residents must pay taxes and adhere to all Canadian laws. Permanent residents who have resided in Canada for at least three years of the previous four years may apply for citizenship. Those who pass a Citizenship Test and have not been precluded from citizenship by criminal activity will become naturalized Canadian citizens. Immigration policy in Canada allows almost instant access to major institutions of society and a clear and direct pathway to full citizenship (Bauer, Lofstrom & Zimmermann, 2000).

5.2.2 Health Policy

5.2.2.1 Historical Development of Health Care System

Directly following the Confederation of Canada in 1867, the *Constitution Act* gave responsibility to each province for establishing, maintaining and managing hospitals and asylums. Health care was viewed as an extension of the responsibility for hospitals and thus under provincial authority (Vayda & Deber, 1992). On the federal level, from 1867 until 1919 the Department of Agriculture was responsible for issues of public health. In 1919 the Department of Health was created and took over these responsibilities. (Minister of Health, 2005). Other health responsibilities fell on families, religious institutions and charities (Maioni, 2002).

At the same time developments in the field of health insurance in Great Britain and Germany sparked interest and discussion among experts in Canada (Naylor, 1986). Initially the Canadian Medical Association (CMA) was critical of the British state medical system and its effects on the field of medicine. However, during World War I, amidst a feeling of wartime collectivism, the CMA began to respond more positively to the idea of medical professionals becoming civil servants. This optimistic attitude towards a state medical system faded quickly after the war and the CMA discontinued its efforts to support such a system (Maioni, 1998). Only in 1934, as a result of the increasing number of unpaid medical services during the Depression,

did the CMA endorse, on principle, the concept of government financed health insurance (Maioni, 1995).

In 1929 the Canadian government instructed a Standing Committee of the House of Commons on Industrial and International Relations to investigate unemployment and sickness insurance. The committee's recommendations were two-fold. It recommended a more in-depth survey of public health with special attention to the potential for a national health insurance plan. In addition, it recommended that provinces individually pass legislation for sickness insurance plans with the option of the federal government engaging in a cost-sharing agreement (Maioni, 1998).

The prevailing view of the federal government focused on provincial responsibility, as evident from the committee's recommendations, and also apparent in the historic role of provincial governments in leading the way towards national health insurance policy. During the 1930s and 1940s the provinces of British Columbia, Alberta and Ontario proposed an array of universal provincial health insurance plans with limited success due to lack of CMA support and scarce funding (Maioni, 2002). In 1947 the first universal provincial hospital insurance plan, the Saskatchewan Hospital Services Plan, was implemented in Saskatchewan (White, 1995). By 1950 British Columbia, Alberta and Newfoundland had created similar hospital insurance plans (Minister of Health, 2005). Other provinces expressed interest in creating comparable plans but sought financial support from the federal government.

On the federal level, only in 1940 did the Canadian government begin to address federal involvement in provincial health insurance plans. The Royal Commission on Dominion-Provincial Relations of 1940 recommended that the federal government play a role in the fiscal support of health insurance despite the fact that these insurance plans were under provincial authority (Maioni, 1997). Thus, a proposal for universal national health insurance was developed by the Interdepartmental Advisory Committee on Health Insurance. In 1942, the committee presented its draft for health insurance legislation, which would provide grants to provinces (Maioni, 1995). Furthermore, increasing success on both federal and provincial levels of the new Co-operative Commonwealth Federation (CCF), a social democratic alternative to the Liberal and Conservative parties, whose platform included universal health care, induced the ruling Liberal party to strengthen, albeit cautiously, its support for health care reform. In 1943, Prime Minister Mackenzie

King instructed a House of Commons Special Committee on Social Security to study the subject of health insurance. The 1942 proposal was submitted to this committee along with other relevant proposals. The final report of the Special Committee included significant constitutional reservations about implementing federally funded national health insurance and raised considerable financial concerns. These concerns were shared by both the ruling Liberal Party and the Conservative opposition, despite the need to present a political alternative to the CCF (Maioni, 1997).

After the 1945 elections, when the Liberal Party won by only a narrow majority, it was evident that the fears regarding raising political support for the CCF were correct. Thus, in 1948 a program of federal grants to provinces for public health and hospital construction was implemented. While Prime Minister Mackenzie King stated publicly that this program was merely the first step towards health insurance, in reality his government considered this program a means of deferring extensive health reform. However, CCF continued to increase its electoral support with universal health insurance as one if its central aims (Maioni, 1997). In addition, the Canadian public seemed ready for a government sponsored health plan; a 1942 Gallup poll showed that three-quarters of Canadian citizens supported a national health plan (Maioni, 1995). Thus the Canadian government was under significant pressure.

Plans for universal health insurance met resistance from the CMA, which had received criticism over their complacency towards socialized medical care, especially compared to their American counterparts (Bothwell & English, 1981). Thus, in 1949 the CMA amended their previous position and rejected universal health insurance, instead supporting prepaid voluntary health insurance and limiting the government's role in providing for indigent populations. In addition, both the Canadian Hospital Council and the Catholic Hospital Council supported only voluntary health insurance (Maioni, 1995).

At the same time, provoked by the 1942 draft legislation, labor organizations began to voice their support for a universal health insurance plan under federal control. While these organizations had always supported sickness insurance they had previously been cautious to vocalize their support of government initiatives as they were not aligned with a political party on this issue. However, existing proposals did not meet their concerns; labor organizations feared that by merely providing grants to provinces, standards and conditions of health insurance would not be equal on the national level. In addition, they believed that provincial based plans would leave too

much room for medical associations to control the plans and thus rejected the proposal due to the lack of a fully federally controlled health insurance plan (Maioni, 1995).

In 1955, the Conservative government in Ontario, which was under pressure from the CCF opposition and its Labor movement allies, refused to legislate a universal provincial hospital insurance plan without federal support, as other provinces had done. This served as an impetus to respond to the public and political pressure for a national universal plan (Maioni, 1997). The Hospital and Diagnostic Services Act was passed by the federal government in 1957 and implemented in the following year. Through this Act the federal government committed to pay half of hospital costs nationwide, through a formula that favored poorer provinces, on the condition that the provinces guaranteed that all insured hospital services were available on a uniform basis, with no means-tests. The Act also required provinces to approve all hospital budgets and equipment purchases (White, 1995). By 1961 all provinces and territories had legislated for universal hospital insurance supported by cost sharing on the part of the federal government (Maioni, 2002).

In the development of non-hospital based medical services insurance, the province of Saskatchewan, where CCF was in government, was again the forerunner. In 1962 Saskatchewan developed a plan for province-wide universal medical services insurance. This plan triggered a twenty-three day doctor strike. The compromise reached between the doctor's union and the provincial government was that physician-controlled insurance plans could be maintained which would handle doctors' accounts and payments, and in effect prevent the government from further restructuring health care delivery in Saskatchewan (White, 1995). The strike, which was unsuccessful in preventing universal health insurance in Saskatchewan, caused the CMA to lose its reputation as a force blocking universal health insurance and put this issue on the national agenda (Maioni, 1997).

The 1965 election of a minority Liberal government in the Canadian House of Commons, and the success on the part of the New Democratic Party (an alliance formed by the CCF and the labor movement) to draw votes from dissatisfied Liberal party supporters, as well as their relative power in the House of Commons, provided the political impetus for the legislation of a universal national health insurance plan. Since the political agenda promoting a universal national health insurance plan was nonnegotiable in the eyes of the minority Liberal government, the CMA was resigned

to negotiate the terms of this plan instead of attempting to block it completely (Maioni, 1997).

Following the Saskatchewan example, in 1966 the federal government almost unanimously passed the Medical Care Act and Medicare, the national health insurance, went into effect in 1968. The Act committed the Federal Government to contribute half of the costs of medical services provided by doctors outside of hospitals. Again, this Act created a formula that increased the subsidy provided to poorer provinces. However, the provinces and territories had to develop health insurance plans that met four criteria: comprehensiveness, universality, public administration and portability. First of all, the plan had to provide comprehensive coverage of all medically necessary services provided by physicians. In addition, all plans were mandated to provide universal coverage to all legal residents of their respective province. Plans had to also be publicly administered either directly by the provincial government or by an authority directly responsible to the provincial government in order to prevent a case where the federal government was subsidizing private plans. Finally, plans had to be portable so that beneficiaries could maintain health care coverage when they traveled outside the province or when they moved permanently by transferring to the plan of their new province (Minister of Health, 2005). In addition, in order to appease the CMA, a fee-for-service policy was maintained. In some provinces, the ability of doctors to extra-bill patients or opt-out of public programs was allowed (Maioni, 1997). Private insurance companies were given permission to offer supplementary services not provided by Medicare so that they did not compete with the non-profit, public plans. By 1971 all the provinces and territories were part of this national system (Minister of Health, 2005; White, 1995).

In effect, the Medical Care Act created a decentralized universal national health insurance plan, or Medicare. While the federal government specified general requirements that each province and territory was required to adhere to in order to receive federal financing, each province and territory was given the authority to create and manage their own Medicare plan (Minister of Health, 2005). In 1977, under the Established Programs Financing Act (EPF), the existing cost-sharing federal financing system was replaced by per capita federal transfers to provinces which were determined by GNP growth. In addition, the 1984 Canada Health Act added a fifth principle, that of accessibility, to the previous four criteria by which provincial programs were required to adhere in order to receive federal funding. The 1984 Act

also included monetary sanctions for non-compliance of provinces to these principles (Maioni, 2002).

5.2.2.2 Current Health Policy

Since its inception, the Canadian national health insurance system has been a decentralized system. In fact, the thirteen provinces and territories differ significantly in terms of financing, administration, delivery and the range of public health services they provide (Marchildon, 2005). The federal government is responsible for setting, administering and enforcing the national principles for Medicare, partially financing the system, delivering direct health services to specific groups[24], and for public health issues (Canada Health Act Division, 2005). The provinces and territories are responsible for managing and delivering health care services on a non-profit basis, planning, financing and evaluating the provision of hospital, physician and allied health care services and for managing some aspects of pharmaceutical care and local public health issues (Canada Health Act Division, 2005). In addition, each local provincial non-profit organization providing health care must be held directly accountable to their respective provincial or territorial government for decision-making regarding benefits and services and must provide records and accounts for public auditing (Minister of Health, 2008).

The main source of financing for Medicare is through provincial, territorial and federal taxation. Taxation makes up 70 percent of the total national health expenditure and the majority of these taxes are individual income taxes, consumption taxes and corporate taxes. In addition, some provinces also charge taxes, or premiums, earmarked for health care. Private financing makes up 27 percent of the total health expenditure which is divided at 15 percent from out-of-pocket payments and 12 percent from private health insurance policies. Finally, the remaining 3 percent of the national health expenditure is from social insurance funds, most of which are health benefits from worker compensation or donations for research, health facility construction and hospital equipment. In most provinces financial allocation has changed from provincial health ministries to regional authorities that are required to submit budgets to their respective provincial Ministry of Health. This further

[24] The Canadian federal government is responsible for delivering direct health services to veterans, native Canadians living on reserves, military personnel, inmates of federal penitentiaries and the Royal Canadian Mounted Police (Canada Health Act Division, 2005).

decentralized mechanism allows provinces to employ a population-based funding method in order to identify populations with specific health needs in each region. However, some provinces still use global budgets. Furthermore, 83 percent of physician payment nationwide is on a fee-for-service basis, while recently some provinces have opted for a combined system of salary, capitation and fee-for-service (Marchildon, 2005).

The Canada Health Act, under the criteria of comprehensiveness, stipulates that health insurance plans provided by provinces and territories must cover all insured health services provided by hospitals, physicians or dentists[25] (Minister of Health, 2008). In practice this means that virtually all hospital, physician and diagnostic services are covered by provincial health insurance plans. Most dental, vision, long-term care and home care services, as well as pharmaceuticals prescribed outside a hospital setting are excluded from these plans. In fact nationally, 33.8 percent of prescription drugs, 21.7 percent of vision care and 53.6 percent of dental care is financed privately, either directly by the patient or through private supplemental health insurance plans (Marchildon, 2005). Sixty-five percent of Canadian citizens have private supplemental health insurance plans, which are only permitted to provide services not covered under Medicare. The majority of those citizens with private supplementary insurance receive this coverage through their employers (OECD, 2004). In addition, provinces and territories provide additional coverage, above that which is stipulated by the Canada Health Act, to certain vulnerable populations[26]. Depending on the province or territory, this coverage often includes prescription drugs, dental care, vision care, medical equipment, independent living support and services of other professionals like podiatrists or chiropractors (Minister of Health, 2005).

Primary health care professionals (PHC)[27] serve as gate-keepers in the Canadian health system. When Canadians need health services they generally contact a PHC professional. The PHC directly provides initial health care services, refers patients for specialized care and, in general, coordinates the patient's health care in order to guarantee continuity of care and facilitate the movement of patients within the system when specialized care is needed (Minister of Health, 2005). While in

[25] Usually limited to surgical dental services that require a hospital setting.
[26] Seniors, children, social assistance recipients (Minister of Health, 2005)
[27] Primary health care professionals include family doctors, nurses, nurse practitioners, physiotherapists and pharmacists (Minister of Health, 2005).

practice treatment varies, this system attempts to integrate each patient's primary and secondary care in a system that covers all Canadian citizens and residents.

5.2.3 Immigrant Access to Public Health Insurance

Medicare ensures that all residents of Canada have access to medically necessary hospital and physician care on a prepaid basis. The only requirement for coverage is legal residence in a Canadian province or territory (Canada Health Act Division, 2005). According to the Canada Health Act, a resident is defined as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province." Each province and territory has the authority to determine minimum residency requirements for Medicare coverage. In fact, the Act gives no guidance on such minimum residence requirements beyond the possibility for an initial three-month waiting period. However, some provinces require an annual minimum residence, as well as evidence of an intention to return to the specific province for the minimum residence period each subsequent year. Four provinces, British Columbia, Ontario, Quebec and New Brunswick as well as the Yukon Territory have implemented the three-month waiting period for new residents of the province, including new immigrants to Canada and those with permanent residence status. In all other provinces, upon registration with the local ministry of health and proof of residency, Medicare coverage begins. In addition, some provinces offer Medicare coverage to a wider population, including temporary workers and students. After a three-month waiting period, refugees, protected persons, refugee claimants and their dependents, who are not yet covered by provincial or territorial plans, can receive emergency or essential health-care coverage through the Interim Federal Health (IFH) Program under the office of Citizenship and Immigration Canada (Minister of Health, 2008).

While immigrants and those with permanent residence status receive identical Medicare coverage as native born Canadians in their respective province or territory of residence, a number of barriers to accessing of health care services exist. First of all, newcomers often face financial barriers. Due to the fact that they are less established in the local workforce, they often have lower levels of social support and are less likely to receive supplementary coverage by their employers. In fact, dental utilization among new immigrants is the lowest of any population group as it is not

covered by Medicare (Bowen, 2000). In addition, as is common to the immigrant experience world-wide, language gaps and cultural differences create non-financial barriers to the accessing of health care among immigrants. Immigrants face difficulties understanding how the Medicare system works, their rights within the system, the role of physicians and other practitioners and the management of their appointments. Assistance aimed at helping immigrants integrate into the health system in Canada and access their rights and necessary services does exist but is provided by a variety of sources: settlement agencies, community organizations and family members. Accuracy regarding Medicare therefore varies according to the source of information (Bowen, 2000). Thus, depending on the province or territory of residence, employment and financial resources, as well as language comprehension and cultural obstacles the access of immigrants to Medicare differs in practical terms.

Overall, the universal public health insurance system in Canada is quite generous when it comes to coverage of immigrants. Explanations for this level of coverage may be attributed both to Canada's health insurance system as well as to its attitude towards immigration. Investigation of immigrant access to public health insurance in Canada, in the comparative context of both the United States and Israel, should shed light on factors influencing policy outcomes.

5.3 Israel

5.3.1 Immigration Policy

The Zionist movement, beginning in the late 19th century, sought to reestablish a sovereign Jewish homeland in the biblical Land of Israel (*Eretz Yisrael*) primarily through encouraging Jewish settlement of Palestine. Immigration, specifically Jewish, is therefore a defining characteristic of Israel predating the state and the policies subsequently enacted in order to officially sanction immigration, reflect the unique goals enabling the ingathering of exiles of an ancient war. This section outlines the historical development of immigration policy in Israel.

5.3.1.1 Historical Development of Immigration Policy

Pre-state Immigration Policy (1880s -1948) – Zionism, the national movement for the return of the Jewish people to their homeland and the resumption of Jewish sovereignty in the Land of Israel, emerged in Europe in the late 19th century in the context of the broader phenomenon of nationalism and as a response to anti-Semitism

and Jewish assimilation. From its inception the movement sought to encourage Jews to return to the biblical Land of Israel, at that time known as Palestine, in order to build the foundation for a sovereign Jewish State.

Thus, while the modern State of Israel was founded only in 1948, Jewish immigration to Palestine began in the 1880s under the Ottoman rule of the region. Under Ottoman and subsequently British Mandatory rule, five waves of immigration between 1882 and 1930 brought Jews from Russia, Poland, Hungry, Germany and even Yemen, to rural agricultural communities, newly established villages, and modern cities like Tel Aviv and Herzaliya as well as, ancient cities such as Jerusalem, Tzfat and Hebron. Whereas anti-Semitism was always an impetus for Jewish settlement, with the rise of Nazi Germany in the 1930s and the subsequent programmatic resettlement and extermination of Jews throughout Europe, immigration from both Eastern and Western Europe accelerated as Jews tried to escape persecution and death (Sachar, 1996).

Concurrently violence between the growing Jewish population and the native Arab population pressured the British Mandatory Government to issue the White Paper of 1939 limiting Jewish immigration to Palestine. The White Paper stated that further Jewish settlement in Palestine would lead to British rule by force. In order to prevent this situation a quota for Jewish immigration was set at 10,000 immigrants annually for the next five years, plus another 25,000 Jewish refugees (a total of 75,000 immigrants). After this further Jewish immigration would be permitted and the sale of land to Jews would be prohibited. The Jewish leadership in Palestine saw this decree as effectively freezing growth of the Jewish community and blocking Palestine as a safe haven for Jews during their most acute time of need and thus began to clandestinely organize illegal immigration operations or *Aliyah bet* (Sachar, 1996).

As a result of these legal and illegal waves of Jewish immigration to Mandatory Palestine, the Jewish community increased from 24,000 before the First Aliyah in 1882 to between 560,000 and 580,000 on the eve of independence in 1948 (Neuman, 1999).[28] See Appendix J for statistics on the waves of immigration prior to 1948. Jewish settlement created the infrastructure necessary for nation building and created a demographic reality wherein when the British Mandate of Palestine ended in 1948, the Jewish presence could not be ignored.

[28] The Arab in Palestine population also grew during this time. In 1882 there were 260,000 Arabs in Palestine and by 1935 they numbered 960,000 (Sacher, 1996)

The Concept of the "Oleh[29]" in Israeli Immigration Policy (1948-1970) – The ideological nature of immigration to Israel was reflected in the first official document of the modern State of Israel, the Declaration of Independence. In the first two paragraphs, the Declaration of Independence establishes the State of Israel as a natural continuation of the ancient Jewish community in the Land of Israel: "*Eretz Yisrael* – the Land of Israel – was the birth place of the Jewish people…Here they first attained statehood…After being forcibly exiled from their land, the people kept faith with it throughout their Dispersion and never ceased to pray and hope for their return to it and the restoration in it of their political freedom," (Israel Declaration of Ind.). The Declaration then goes on to state the first official decree on the immigration policy of the new state: "The State of Israel will be open for Jewish immigration and for the Ingathering of Exiles," (Israel Declaration of Ind.). Furthermore, before signing the Declaration, the Provisional Council, set up to govern the country until official elections were held, signed its first piece of legislation which abolished the 1939 British White Paper (Halamish, 2008). With these proclamations, the establishment of the State of Israel was both ideologically and officially founded upon the principle of encouraging specifically Jewish immigration, while simultaneously pledging to guarantee equal rights for non-Jewish citizens.

In 1950 the Israeli Parliament, the Knesset, formally authorized open Jewish immigration by passing the Law of Return (Halamish, 2008). The Law of Return begins by simply stating "every Jew has the right to come to this country as an oleh," (Law of Return 5710-1950) and thus established a special status for Jewish immigrants, that of "oleh." It is apparent in the choice of the name, the "Law of Return," that the founders of the State of Israel wished to confer a *right* upon the Jewish people to *return* to their ancient homeland and thus is a statutory articulation of the link between Israel and the Jewish Diaspora. This reflects the uniqueness of the Israeli nation-state. While it holds to the first criteria of a nation-state: "all citizens of the state belong to the same nation," Israel does not hold to the second criteria: "all the members of that nation reside in that nation-state," (Klein, 1997:55). In viewing Jewish immigration to Israel as a return of members of a common nation to their state, a type of ethnic immigration emerged in Israel.

[29] See Appendix C for definition of the term "oleh."

Ethnic immigration policies as they exist in Israel should be distinguished from ethnic immigration policies in most other Western nations[30]. Prior to World War II many settler nations, including the United States and Canada, specified the particular countries from which immigrants would be accepted for citizenship. There the concept of ethnicity can be replaced by citizenship. However, Israel sees Jewish immigrants not as a distinct ethnic group receiving immigrant privileges, but as co-ethnics returning to their homeland. No matter what citizenship these co-ethnics hold they are all included under the Jewish nationhood and thus can immigrate to Israel (Joppke & Rosenhek, 2002). Israel thus gives priority to citizenship by *jus sanguinis* (right of blood), nationality given by ancestry, rather then by *jus soli* (right of ground), where citizenship can be attained by any individual born in the territory of that state. Usually settler nations, seeking to absorb immigrants, give priority to *jus soli* in an attempt to rapidly absorb immigrants and create an attachment between members. While creating open immigration for Jews regardless of citizenship, prioritizing immigration according to *jus sanguinis*, effectively restricts the immigration of members of other ethnic groups (Gal, 2008). This reflects Israel's interest to quickly absorb specifically Jewish immigrants, as opposed to all those seeking Israeli citizenship.

The Law of Return legislated in 1950 specified a few cases in which a Jew would not be granted oleh status and thus denied citizenship. These included, persons "engaged in an activity directed against the Jewish people," and persons, "likely to endanger public health or security of the State," (Law of Return, 5710-1950: 2.b.1-2). The 1955 amendment to the Law of Return specified that a Jew applying for citizenship "with a criminal past, likely to endanger public welfare" could also be prevented from receiving oleh status (Law of Return, 5714-1955: 1.2). While those Jews who could be denied oleh status were explicated in the law, until 1970 the definition of who was included in the ethnic category of Jew was not defined.

As a response to the ambiguity of the Law of Return and the debate surrounding "who is a Jew" a number of legal cases were brought to the Supreme Court. In one case in particular, the Lieutenant Shalit case, the court ruled in favor of the petitioner, registering children without a Jewish mother as Jewish (and therefore

[30] Germany is an exception to this – ethnic immigration policy in Germany is similar to that in Israel (Joppke & Rosenhek, 2002).

not considered Jewish by Jewish law[31]), but simultaneously called on the Knesset to provide statutory clarity on the issue of "who is a Jew?" (Weiss, 2002). The second amendment to the Law of Return responded to this need for clarity and specified that for the purpose of granting oleh status, a Jew "means a person who was born of a Jewish mother or has converted[32] to Judaism and who is not a member of another religion," (Law of Return, 5730-1970: 4B). Furthermore it extends the rights of oleh status to "a child and grandchild of a Jew, the spouse of a Jew, the spouse of a child of a Jew and the spouse of a grandchild of a Jew, except for a person who has been a Jew and has voluntarily changed his religion," irrespective of if the Jewish relative is alive or if he himself immigrated to Israel (Law of Return, 5730-1970: 4Aa-b). Thus, oleh status can be granted to a person that is not considered a Jew by Jewish law.

According to the Ministry of Foreign Affairs, the extension of oleh status beyond the traditional definition of Jewish by Jewish law was included in order to prevent family separation in cases of intermarriage (Lustick, 1999). Records of discussions in Knesset surrounding the passage of the second amendment to the Law of Return in 1970 illustrate that the assumption that non-Jewish immigrants would quickly assimilate into Israeli society and even convert to Judaism was widely held among Israeli policy-makers at the time (Weiss, 2002).

In fact, much effort has been devoted to absorbing all immigrants with oleh status. While these efforts have resulted in varying levels of successful absorption, primary needs such as housing have always been provided to olim in the form of direct provision or subsidies. Intensive language learning institutions (*ulpanim*) were specifically established for immigrants and direct financial assistance, employment training and placement and student scholarships are provided at varying levels depending on country of origin, age and family status. The Ministry of Immigrant Absorption and the Jewish Agency, a quango, are responsible for the absorption of olim and the determination of the level of benefits they receive upon arrival.

Establishing Other Means of Obtaining Israeli Citizenship (1952) – For Jews and their family members, immigration policy is quite inclusive. Nevertheless, the Law of Return, in relating only to Jews and their relatives, effectively excludes all non-Jews.

[31] According to Jewish Law, in order to be considered Jewish, a person must have a Jewish mother.
[32] The 2nd amendment to the Law of Return does not specify the type of conversion that a person must undergo in order to be considered a Jew. However, in practice all conversions performed outside Israel are accepted, while only Orthodox conversions performed inside Israel are accepted (Klein, 1997).

However, while immigration through the Law of Return is the primary means of obtaining Israeli citizenship, it is not the only means. The Nationality Law of 5712-1952 explicated the four means by which one can gain Israeli citizenship: by return, by residence in Israel, by birth and by naturalization. Immigration under these categories will be examined below.

Labor Migrants (1991-present) – While not eligible for Israeli citizenship through any formal policy, since 1991 labor migrants have made up an important category of foreigners residing in the State of Israel. Furthermore, in order to compare Israel to the United States and Canada, where labor migration is central to general immigration policy, policy regarding labor migrants in Israel must be considered.

After 1967 and the occupation of the West Bank and the Gaza Strip[33] by the Israeli Army, Israel had access to a new population of workers. In 1969, after much discussion among Israeli policy makers and interest groups, Israel began issuing permits to Palestinians from the Palestinian territories to work in sectors where not enough Israeli workers were available. Quickly the Palestinian labor force, working primarily in construction, agriculture and services, came to complement, instead of compete with the Israeli labor force (Bartram, 1998). By the mid-1980s Palestinians from the territories comprised 6-7 percent of the total Israeli labor force (Bartram, 1998).

When the first Palestinian Intifada, or uprising against the Israeli occupation, began in 1987 the Israeli army frequently began to close check-points between Israel and the Palestinian territories. As a result, Palestinian laborers commuting to work in Israel found it increasingly difficult to get to their place of employment. The situation was further exacerbated by the first Gulf War and terrorist attacks during the early 1990s. Consequently employers in the fields depending on Palestinian labor began to put pressure on the Israel government to find an alternative source of affordable labor (Bartram, 2005).

The Israeli government was reluctant to allow temporary migrant workers, a clear affordable alternative source of labor, to enter Israel. This reluctance on the part of the Israeli government to allow the entrance of temporary migrant workers to Israel was based on the experience of countries in Western Europe where temporary migrant

[33] The West Bank and the Gaza Strip will be referred to as "the Palestinian territories."

workers often remain in their host countries after the expiration of their work permit in order to seek permanent residence (Bartram, 2005; Ezra, 2000). This trend was particularly troublesome for Israeli policymakers as they sought to prevent the settlement of a non-Jewish minority population within the State of Israel, a Jewish ethnic state (Raijman & Semyonov, 2004). The Palestinian labor from the territories had been a perfect source of affordable labor as each evening the workers returned to their homes outside the sovereign State of Israel, thus not disrupting the demographic balance in Israel.

Simultaneously, an influx of immigrants from the Former Soviet Union had arrived in Israel requiring housing. Thus, the construction industry, one of the industries significantly affected by unreliability of Palestinian labor, was facing considerably increased demands. Thus the pressure put on the government to find an alternative source of affordable labor mounted. In 1991 the government decided to grant 3,000 work permits to foreign construction workers to mitigate the labor requirements in this industry (Bartram, 1998).

In 1993, following a sequence of terrorist attacks by Palestinians, a general closure of the territories was enacted. Subsequently, the crisis of affordable labor was magnified; instead of being unreliable, now Palestinian workers were simply unavailable for extended periods of time. After failed attempts to pressure Israeli workers to enter the industries Palestinians had once occupied, the government consented to employer pressure and allowed the entrance of ten thousand temporary migrant workers in the fields of construction, agriculture, industry, and nursing (Bartram, 2005). Israeli policy regarding permits to migrant workers was not officially established, but during the 1990s a clear pattern emerged: following a terrorist attack the Israeli army would close the border between Israel and the Palestinian territories, employers would demand increasing numbers of permits for migrant workers and the Israeli government would usually respond by granting 20,000 new permits (Bartram, 1998). Permits were granted to employers who would then work with manpower agencies to recruit migrant workers. In an attempt to limit migrant workers from remaining in Israel, these workers were tied to the employer who held the permit for their employment, prohibiting them from working for any other employer, and their permits were limited in terms of time they were allowed to remain in Israel.

In the seventeen years since foreign workers were first allowed to enter the Israeli labor market their numbers have grown (see Appendix K). In addition to the legal migrant workers with permits to work in Israel, illegal workers began entering Israel as early as the first half of the 1990s (Bartram, 1998). In many cases these individuals overstayed a legal work permit or entered Israel as tourists. Due to the fact that employers and manpower companies sought increased numbers of workers, and were not bound to provide illegal workers with the legally mandated benefits[34] they were required to provide to legal workers, they unofficially supported this phenomenon. Policy regarding migrant workers is ever changing, thus, the next section will detail current employment policies regarding legal migrant workers as well as attempts to limit illegal workers.

5.3.1.2 Current Immigration Policy

The Law of Return, the Nationality Law and the Entry into Israel Law establish the basis upon which both Jews and non-Jews can establish citizenship in the State of Israel.

Citizenship under the Law of Return

Those eligible for citizenship under the Law of Return must apply for an aliyah (oleh status) visa with their local aliyah representative (if they are residing outside of Israel) or with the Ministry of Interior (if they are already residing in Israel). They will be asked to provide a report on their health and a declaration of entries and exits to and from Israel. In order to prove they are Jewish or have relevant Jewish kinship, applicants for oleh status must provide a letter on synagogue letterhead from a rabbi of a recognized Jewish community attesting to the applicant's Jewish background. In addition, parents' or grandparents' Jewish marriage certificate, or *ketubah*, may be required for proof of Judaism. Finally, after submission of the relevant documents, the candidate will be interviewed by an aliyah representative or the Ministry of Interior to inquire about the candidate's Jewish background, family status, past experience in Israel, health condition, education, employment history, motivation for moving to Israel and his or her plan upon arrival (Overview of the Aliyah Process, 2009).

[34] i.e. minimum wage, health benefits, vacation days

Once approved for an aliyah visa, the oleh is provided with a fully subsidized one-way plane ticket to Israel. Upon arrival in Israel, the candidate immediately becomes a full Israeli citizen with oleh status. This status bestows a number of significant benefits on the new immigrant. Depending on age, family status, country of origin and prior education, these benefits can include tax breaks, language courses, employment training assistance, academic scholarships, housing subsidies or placement and direct financial assistance. In the short-term, these benefits are meant to assist the new immigrant in the process of settlement in Israel and provide financial support in the first months while looking for employment. In the long-term they are meant to aid the immigrant's assimilation into Israeli society.

Citizenship by return is reserved only for those who are included under the Law of Return. However, those ineligible for Israeli citizenship under the Law of Return can gain citizenship by residence in Israel, by birth and by naturalization. While those immigrating under the Law of Return receive extensive benefits in order to assist their absorption in Israel, those gaining citizenship in the other categories receive limited[35] or no[36] absorption benefits. This dichotomy, benefitting Jewish immigrants and their relatives, is consistent with the ideologically foundations of immigration policy in Israel.

Citizenship by Residence

Section 3 of the Nationality Law specifies that in order to gain Israeli citizenship by residence one must fulfill three conditions: 1) residency in the State of Israel; 2) presence in Israel after the establishment of the state in 1948 and; 3) registration in the 1951 Population Registry. This section effectively grants Israeli citizenship to Palestinians remaining in the State of Israel after the 1948 war and excludes from citizenship those Palestinians who fled from Israel prior to or following the establishment of the State of Israel (Nationality Law of 5712-1952; Shachar, 2000). Following submission of relevant documentation, an individual who meets the criteria required for citizenship by residence receives automatic citizenship.

[35] Those approved for citizenship by birth.
[36] Those approved for citizenship by residence or by naturalization.

Citizenship by Birth

Citizenship by birth is reserved for those born to an Israeli parent, regardless of religion or ethnicity (Nationality Law of 5712-1952; Shachar, 2000). The 1980 amendment to the Nationality Law states that Israeli citizenship by birth can be transmitted in perpetuity regardless of the place of birth of parents or their place of residence (Shachar, 2000). Following submission of relevant documentation, an individual who meets the criteria required for citizenship by birth receives automatic citizenship.

Citizenship by Naturalization

As opposed to the above three categories by which a person can obtain Israeli citizenship, citizenship by naturalization is the only path that is not automatic. First of all, six prerequisites, as outlined in Section 5 of the Nationality Law, are necessary in order to qualify for citizenship by naturalization. According to these prerequisites, the applicant must: 1) be in Israel; 2) have been in Israel for three out of five years preceding the day of submission of a naturalization application; 3) have been granted permanent residence status[37]; 4) have already settled or intend to settle in Israel; 5) have a basic knowledge of the Hebrew language and; 6) have renounced his prior citizenship or have proven that he will cease to be a foreign national upon becoming an Israel national (Nationality Law, 5712-1952). Once an applicant for Israeli citizenship through naturalization has fulfilled these prerequisites an application is submitted to the Minister of the Interior. Ultimately acceptance for citizenship based on naturalization is at the full discretion of the Minister. Therefore the Minister can wave prerequisites for specific applicants as well as deny citizenship to an applicant who has fulfilled all the prerequisites (Nationality Law, 5712-1952).

Section 6 of the Nationality Law specifies a number of categories of people that are granted certain exemptions when applying for citizenship through naturalization. First of all, a person who has served in the Israeli Defense Forces (IDF) or who has a son or daughter who fell during IDF service, but is not eligible for citizenship according to the Law of Return, is exempt from the prerequisites to citizenship by naturalization, but is still at the discretion of the Minister of Interior. In addition, since November 2002, "lone soldiers" (soldiers without immediate family in

[37] According to the Entry into Israel Law 5712-1952 granting of permanent residence status is at the full discretion of the Minister of Interior.

Israel) are entitled to request temporary citizenship status for one parent who is not entitled to citizenship according to the Law of Return. The parent is permitted to reside in Israel during the soldier's regular service as well as for up to four years following his or her service. After this time the parent may submit a request for permanent resident status. After five years the parent, who previously received permanent residence, may submit a request for citizenship. Finally, the partner of an Israeli, who is not eligible for citizenship through the Law of Return, may obtain citizenship through a gradual process. First the partner may receive a work permit, then a temporary residency status permit, then permanent residency status and only then Israeli citizenship[38]. This process is the same for any children of the foreign partner, whereas children born jointly to the Israeli citizen and the foreign partner are granted citizenship immediately. In the case of divorce during the process, the process is subsequently ended and the foreign partner must leave Israel even if he or she has children in Israel (בריטברד, 2003).

While Israel does provide a means for citizenship through naturalization, this process is ultimately dependent on the discretion of the Minister of Interior. Thus the subjective judgment of one person, liable to be influenced by party politics and personal alliances, is responsible for the fate of any potential immigrant through naturalization. In reality, possibilities for naturalization are minimal (Shachar, 2000).

Current Policy Regarding Migrant Workers[39]

According to the Central Bureau of Statistics, at the end of 2008 there were 222,000 legal foreign workers in Israel, making up almost three percent of the residents in Israel (CBS, 2009: 27, 86). Currently migrant workers are permitted to work in Israel in one of the following fields: construction, agriculture, nursing care, welding and industrial professions, hotel work and ethnic cookery. The government sets quotas for permits to employ migrant workers in each sector. Employers in these sectors that are interested in employing migrant workers apply through the Department for Foreign Workers in the Ministry of Industry, Trade and Labor to receive a permit. After receiving a permit for a migrant worker, employers recruit labor, primarily through

[38] While a work permit is applied for through the Ministry of Interior, according to the Entry into Israel Law 5712-1952 granting of both temporary residence status (up to three years) and permanent residence status is at the full discretion of the Minster of Interior.

[39] Unless noted otherwise, the source of information for this section is take from the Ministry of Industry, Labor and Trade "Foreign Workers' Rights Handbook" (Jan. 2009).

manpower companies, but sometimes privately. Once officially hired, migrant workers receive a work visa stamped with the name of their employer which is valid for no more then a year. While some employers receive permits to hire migrant workers for more then a year, the worker him or herself must renew their work visa after a year through the Ministry of Interior. The maximum period a migrant worker may extend their visa to stay in Israel is five years and three months.

A specific migrant worker may only work in the field for which he or she received a visa. In order to change their specific employer, a migrant worker must quit their job with their current employer, apply for a tourist visa with the Ministry of Interior and then are given between four and eight weeks to find a new employer in the field of work for which they originally received a visa (Wagner, 2006). These policies hold for all legal migrant workers, except those working in construction. Migrant workers working in construction may only be employed by officially licensed manpower agencies. These agencies serve as the worker's official employer, assigning each employee to work with specific building contractors. Furthermore, migrant workers in the field of construction can only change employers quarterly.[40]

According to Israeli labor regulations and the Foreign Workers Law, 5751-1991, a number of benefits are guaranteed to all legal migrant workers in Israel (Ellman & Laacher, 2003). First of all, while migrant workers are not eligible for public health insurance, their employers are obligated to provide them with private medical insurance. In addition, migrant workers are required to pay into the Israeli Social Security system and in return receive insurance in case of work injuries, maternity leave, severance pay and compensation for unpaid wages. Furthermore, like Israeli citizens, migrant workers are entitled to standard minimum wage, overtime and travel allowances according to Israeli law. Similarly, under the Hours of Work and Rest Law, 5711-1951, migrant workers are entitled to at least 36 hours of rest weekly to include Friday, Saturday or Sunday depending on their religion. According to the length of their employment, migrant workers are entitled to paid vacation as well as sick pay. Finally, employers must provide migrant workers with housing which meets standard conditions[41] during the time they are employed as well as for seven days after their employment is terminated.

[40] January 1st, April 1st, July 1st, and October 1st.

[41] Minimum standard housing conditions are stipulated as: at least 4 square meters sleeping space per worker, no more than 6 workers in one room, personal cupboards and bedding for each worker, heating

While these policies and entitlements are outlined by the Ministry of Industry, Trade and Labor, according to non-governmental advocacy organizations, in practice they are rarely enforced and violations, and even exploitation, are all too common (Wagner, 2006; Dahan, 2008; Hotline for Migrant Workers, 2009; New Israel Fund). In addition to the fact that migrant workers are often subject to violations of their rights, certain rights are officially denied to them. In an attempt to prevent migrant workers from establishing a personal life in Israel, they are prohibited from getting married and having children. Couples who get married and women who become pregnant[42] are subject to loss of their work visa if discovered by the Ministry of Interior (Dahan, 2008). Furthermore it is prohibited for two or more members of same first-order family (parents, children, spouses) to receive work permits in Israel (Dahan, 2008). Thus, while specific branches of the Israeli economy depend on the labor of migrant workers it is evident that the conditions of their employment, their personal rights as well as the absence of policy regulating a path to citizenship specifically for them, are designed so that they will not remain in Israel in the long term.

Refugees and Asylum Seekers

With the aftermath of Nazi atrocities during World War II and the displacement of European Jews an international refugee crisis emerged. Thus, in 1951 the United Nations Convention Relating to the Status of Refugees was adopted in order to provide the legal foundation for assisting refugees (UN, 1951). The young State of Israel took a central role in the formation of this convention and officially signed it in 1954. Refugees recognized as such in accordance with the 1951 convention are protected against deportation until the situation in their home country changes to such an extent that they will be safe upon return. Since 1951 Israel has recognized a total of

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and ventilation, reasonable lighting and electric outlets in each room, hot and cold water in the bathroom, kitchen and showers; sinks, kitchen counters and cupboards, burners, refrigerator, table and chairs, a washing machine for 6 workers, a fire extinguisher. There must be reasonable access to the living quarters as well as to bathrooms.

[42] Recently this issue has been particularly relevant. While officially migrant workers are not permitted to have children in Israel, as of August 2010 an estimated 1,200 children of migrant workers were living in Israel. On August, 1st the Israeli Cabinet approved the recommendation of an interministerial committee to give some of these children permanent residence – those who were born in Israel or arrived before the age of 13, have lived in Israel for five consecutive years, be enrolled in first grade or higher, speak Hebrew and who's parents entered Israel legally – while deporting all others. According to these stipulations as many as 700 children are at risk of deportation (Wagner, 2010; Friedman, 2010).

170 non-Jewish refugees. These refugees are given temporary residence status which must be renewed each year. However, they are not eligible for any social assistance (as outlined in the UN convention) nor is there a procedure for naturalization (Refugees' Rights Forum, 2009).

As of September 2009 there were approximately 18,900 refugee claimants in Israel. This is the result of a significant increase in the past four years of African refugees into Israel. For example, 453 refugee claimants entered Israel in 2005, whereas one year later in 2006 1,204 entered (Refugees' Rights Forum, 2009). In 2002 Israel developed a procedure for determining refugee claims. However, the procedure prohibits the granting of even temporary asylum to subjects of enemy states. The majority of the refugee claimants entering Israel in the past three years have been African, 85 percent from Sudan and Eritrea. However, Sudan is considered an enemy state and thus refugee claimants from Sudan cannot be conferred refugee status.

With conflicting concerns on the part of Israeli policy makers, in the past few years Israel has implemented a number of patchwork solutions. Some refugee claimants have been deported back to Egypt (the border from which they crossed into Israel) and some have been imprisoned in Israeli jails. Others have been given work visas that must be renewed every six months and 452 Sudanese refugees from the region of Darfur were given temporary residence status. The rest of the African refugee claimants reside in Israel on conditional release visas (S2A5) which do not permit them to work (Refugees' Rights Forum, 2009). Israel is now at a crossroads in terms of refugee policy between its historical connection to the UN Refugee Convention and its current conflict between demographic and humanitarian concerns.

5.3.2 Health Policy

5.3.2.1 Historical Development of Health Care System

The current Israeli health care system, like immigration policy, has its roots in the pre-state period. In 1911 the sick fund, Clalit Health Services, was established by agricultural workers in collective agricultural communities, or *kibbutzim*, to provide health care for workers and their families. The establishment of Clalit created the basis for the Israeli health care system which, to this day, is based around sick funds, or health plans. The General Federation of Labor, or the *Histadrut*, took over the Clalit health fund in 1920 and it became one if its bases of political power (Carrin &

James, 2005). By the early 1940s three other health plans were established: Maccabi, Meuchedet and Leumit (Rosen & Merkur, 2009).

Although there was no government health insurance plan in 1948 when the State of Israel was established, 53 percent of Israeli citizens at that time were covered by one of these health plans. This high level of coverage can be attributed to the Histadrut's commitment to cover all its members[43] as well as government policy providing health plan coverage to new immigrants and recipients of government assistance (Carrin & James, 2005). Coverage continued to grow and by the mid-1980s about 95 percent of Israelis were insured by one of the four health plans (Rosen & Merkur, 2009). In a system where membership in a health plan was not mandatory, this high level of coverage was due to the fact that membership dues were graduated based on income and family status and because access to services was based on need and not the ability to pay (Israel Ministry of Foreign Affairs, 2002).

In addition, since before the establishment of the State of Israel through the 1980s public health and preventative health services, intended to prevent disease and promote individual health, were provided by the national government and some of the municipalities. Furthermore, as early as 1913 Hadassah, the American Zionist women's organization, sent a group of doctors and nurses to Palestine in order to examine the health conditions of the Jewish population. Hadassah was significant in providing preventative health services and setting up hospitals in urban centers throughout the country to provide services for under-privileged Jews. As a women's organization, Hadassah had a special interest in the health of pregnant women, infants, toddlers and school-age children. Thus *tipat halav* clinics (well-baby clinics) were set up to meet the needs of this population, effectively providing a nationwide system of mother and infant welfare services on a voluntary basis (Tulchinsky, 1985; Shvarts, 2000; Rosen & Merkur, 2009). Following the establishment of the State of Israel in 1948, Hadassah hospitals and *tipat halav* clinics were transferred to the Ministry of Health for operation by district health offices (Shvarts, 2000). Services provided by these clinics included vaccinations, routine developmental and growth check-ups, hearing, vision and communication testing, parent education about child development and growth as well as consultation and referral for diagnosis and treatment as necessary.

[43] 80% of those covered by a health plan in 1948 were members of Clalit, the Histadrut health plan (Carrin & James, 2005).

Despite the public health and preventative health services provided by national and local government, and the high level of coverage by the four health plans, the Israeli health insurance system suffered from a number of problems in the 1980s. These problems included: the financial instability of Clalit[44], the largest sick-fund; constraints on free choice of a sick fund – Meuchedet and Maccabi provided higher quality care than Clalit but accepted only low-risk members willing to pay higher premiums which led to a two-tiered system; distribution of resources to sick funds proportionate to members' income and not their needs; inequality of services for low income populations and those in the periphery where health funds had little motivation to develop quality services; ambiguity surrounding service provision and eligibility since each plan offered different services and did not make these services public and a disproportionate amount of uninsured Arab citizens – whereas only 4 percent of the overall public was uninsured, 12 percent of Arab citizens were uninsured (Rosen & Merkur, 2009).

Thus, in 1988 the Netanyahu Commission, a State Commission of Inquiry, was established in order to investigate the functioning and efficiency of the Israeli health care system (Rosen & Merkur, 2009). Among the recommendations of the Netanyahu Commission was the legislation of a National Health Insurance (NHI) law which was successfully passed and came into effect in January 1995 and created the health insurance system in place today (Rosen & Merkur, 2009). Political success in the implementation of NHI is attributed to growing public dissatisfaction with the existing health care system compounded by media attention given to this dissatisfaction manifested by the coverage of heart-wrenching stories of sick citizens not receiving adequate care. In addition, concerns regarding the financial stability of the existing plans led to a political consensus regarding the need for comprehensive change and thus both the Likud government and the subsequent Labor government to adopt the Netanyahu Commission recommendations. In the past fifteen years since NHI was adopted, implementation has been incomplete, complicated by political and bureaucratic complications. However, NHI did succeed in instituting universal health coverage for all citizens regardless of income through a managed competition system based on the four existing health plans. Since the implementation of NHI in 1995, all permanent residents of Israel are required to enroll in one of the four health plans.

[44] At this time Clalit was insuring two-thirds of the population (Gross et al, 2001).

5.3.2.2 Current Health Policy

The current health insurance system in Israel is based on the guidelines set out by the National Health Insurance (NHI) Law 5754-1994.

Organizational Management/Structure – Following implementation of the National Health Insurance Law in 1995, the four existing health plans in Israel continue to function as independent, non-governmental organizations but within a legal and regulatory framework set out by the law (Rosen & Merkur, 2009). In addition, the Ministry of Health regulates the enrollment process as well as evaluates and supervises the quality of care provided by the health plans (Gross et al, 2001).

Financing – Universal coverage provided through membership in the four health plans is financed through a combination of general tax revenue and a payroll tax. In 2005, sixty-eight percent of the financing for health care in Israel came from public sources, while thirty-two percent came from private sources. Public financing is comprised of two main sources: general tax revenue and the health tax. The health tax is deducted directly from an individual's salary by the NII and is paid based one's salary in comparison to the national average. Furthermore, the health tax does not differ between health plans in order to encourage plans to compete in terms of the quality of their services and not the price of these services (Rosen & Merkur, 2009). Appendix L details the sources of public financing from 1990 (before the NHI reform) until 2005.

The overall budget for health coverage is determined by the government, based on the budget of the previous year with necessary modifications as a result of inflation, demographic changes and technical developments. In 2007, eight percent of Israel's total GDP went to finance health care which was lower then both Canada at 8.8 percent and the United States of America at 13.4 percent (WHO, 2010: 130-136). The allocation of resources to each health plan is done according to a risk-adjusted formula in order to match allotted resources to the needs of the members served by each plan (Gross et al, 2001).

Coverage – The NHI law stipulated the benefits, including hospital care, community-based care and pharmaceuticals, legally required to be provided by each of the four health plans. A formal process, based on research, was implemented by the

government in 1997 providing a method to revise the required package of benefits (Rosen & Merkur, 2009). The NHI law also obligates the four health plans to accept any new applicant for membership regardless of pre-existing conditions or income in order to guarantee citizens' freedom to chose their health care plan (Gross et al, 2001). In many cases primary care physicians (PCP) act as gatekeepers to specialists and hospital visits. Competition between the four health plans since 1995 has significantly decreased the waiting time necessary to visit a PCP and in three of the four plans visits to PCPs are fully covered (Rosen & Merkur, 2009).

A number of services are still provided directly by the Ministry of Health. These include *tipat halav* clinics, institutional long-term care, mental health care and preventative and public health services. The NHI law mandated the transfer of well-baby care, long-term care and mental health care to the health funds in order to promote controlled competition and thus improved services as well as having removed the conflict of interest inherent in the Ministry's role in supervision as well as provision of these services. In practice these transfers have not taken place. In the case of mental health care, in the past fifteen years attempts have been made to transfer care to the health plans, and while this issue is still on the agenda of policy makers, thus far transfer of responsibility has not been successful (Mark et al, 1996; Rosen & Merkur, 2009). Thus, unless covered by voluntary, supplementary health insurance, patients are responsible for covering services and pharmaceuticals not included in the NHI mandated plan (Rosen & Merkur, 2009).

Voluntary Health Insurance –Voluntary health insurance (VHI) policies are permitted in Israel but are prohibited from offering services that are included in the NHI mandated package. For example, dental coverage is not provided by the mandatory NHI plan and thus coverage for dental care is primarily private[45] and thus may be included in VHI plans (Rosen & Merkur, 2009).

Two types of VHI coverage exist in Israel. For an additional fee, the four health plans offer VHI in order to generate revenue and provide coverage for services not included in the mandatory NHI plan. The content and cost of these supplementary plans are regulated by the Ministry of Health. The health plans must provide this

[45] Some publically funded dental services available for people with low income (Rosen & Merkur, 2009).

supplementary care to any member that requests it regardless of health status, pre-existing condition or age. In addition to VHI offered by the health plans, commercial insurers can also offer VHI. These plans tend to offer more extensive coverage but charge higher premiums than the supplementary coverage offered by the four health plans. In addition, commercial insurers may reject applicants based on health status and pre-existing conditions. Since 1995 the proportion of Israelis with VHI coverage has increased: in 1995 35 percent of Israelis had VHI coverage, whereas in 2001, 64 percent were covered. As of 2005 80 percent of Israelis were enrolled in at least one VHI health plan and 30 percent were covered by both health plan and commercial VHI (Rosen & Merkur, 2009).

5.3.3 Immigrant Access to Public Health Insurance

Immigrants who gain citizenship in any category,[46] as well as temporary and permanent residents, are entitled to standard health coverage under the NHI law in the same way as all other Israeli citizens: by signing up for one of the four health plans and deducting the health tax from their salary. However, immigrants who gain citizenship under the Law of Return (olim) are eligible for certain health benefits that are not given to those gaining citizenship in any other way. Olim are entitled to up to one year of free health insurance after relocating to Israel if they are unemployed. Whereas immigrants in other categories, as well as veteran Israelis, would not be covered by NHI if they were unemployed and did not individually pay a minimum health tax, olim are covered for one year. This ensures that an oleh will not remain uncovered due to financial circumstances while acclimating to Israeli society and searching for a job (Ministry of Immigrant Absorption, 2007). In addition, while immigrants under the Law of Return often face language or cultural barriers, services are provided in order to assist them to access their benefits and make sure that these barriers do not prevent them from registering for health care or taking advantage of their health care benefits[47].

Tourists, migrant workers and refugee claimants are not eligible for health coverage under the NHI law and thus must purchase private health insurance in Israel or abroad. However, according to law, employers must provide migrant workers with

[46] By the Law of Return, by residence, by birth and by naturalization

[47] Despite these services offered to all immigrants under the Law of Return, specific groups of immigrants, for example Ethiopian immigrants, have a more difficult time accessing their benefits because of inherent cultural barriers.

private health insurance and thus the cost of this insurance is not meant to fall on the worker him or herself. As a result of this requirement, a market of private insurance specifically for migrant workers has developed. The policies offered by private insurance companies specifically for migrant workers are characterized by extensive gaps in coverage and have even been given the nickname "plane ticket policies" because in many cases instead of covering health services in Israel, the policies pay for a one-way ticket for the sick migrant worker to return to their country of origin (אדוט, 2002). In addition, health policies bought for migrant workers belong to their employees. In many cases once a migrant worker falls ill their employer cancels the health policy and fires the worker, which results in a loss of work permit and illegal status in the State of Israel (אדוט, 2002). While migrant workers may engage in legal procedures in these situations, the advocacy organization Physicians for Human Rights states that most do not take up these procedures and instead return to their home country or remain in Israel illegally and ill (אדוט, 2002). Hence, while law does mandate health coverage for migrant workers, in practice coverage is limited and riddled problems.

Thus, immigrant access to public health insurance in Israel is consistent with its immigration policy. While providing universal health insurance to all its citizens (as well as temporary and permanent residents), immigrants under the Law of Return receive more health benefits then other immigrants. In addition, those residents in Israel ineligible for citizenship (migrant workers and refugees) are also ineligible for coverage under the national health insurance plan. While policy regulating immigrant access to public health insurance in Israel is consistent with overall immigration policy in Israel, it diverges from with similar policy in the United States and Canada. Through the prism of historical institutionalism and the impact of ideas, explanations for these policy divergences will be examined.

6. Discussion

Despite the fact that the United States, Canada and Israel are all settler nations with liberal welfare states, at present their policies regarding immigrant access to public health insurance differ. Both Israel and Canada provide universal health insurance to all of their citizens and to some legal residents. In Israel, following bestowal of citizenship, immigrants are eligible for all benefits granted to veteran citizens, including health insurance. In fact, upon arrival, those eligible for citizenship under

the Law of Return (olim), who are not yet working, receive a waiver for up to a year on the monthly deductible paid to insurance funds. Legal immigrants to Canada in most provinces are also eligible for health insurance almost immediately. However, in some provinces a waiting period of three months is imposed before immigrants are covered by the national health insurance plan.

As opposed to the Canada and Israel, the United States does not provide universal health insurance to its citizens. The health insurance system in the United States is primary based on employer-provided health insurance. As a result of this system, as a whole, immigrants are less likely to have health insurance then native-born Americans. This is due to the fact that most immigrants are employed in low-wage jobs which do not offer benefits like health insurance, (Kaiser, 2008; Carrasquillo et. al., 2000; Fremstad & Cox, 2004). In addition to employer-provided health insurance, the United States offers two publically provided health insurance plans – Medicaid and Medicare – for which certain immigrants are eligible. Details of immigrant eligibility in these insurance plans will be discussed below.

The historical development of both public health insurance policy, as well as immigration policy, has impacted the current level of access to public health insurance in the United States, Canada and Israel. This historical legacy, as well as the impact of ideas in each country, will be examined in the attempt to understand the divergence in immigrant access to public health care in the three countries studied. First, however, findings in terms of current access to public health care must be examined in depth.

6.1 Applying the Analytical Framework – Indictors of Access

In order to compare current access to public health insurance in a systematic way, four specific indicators of access will be compared for each country. These indicators are: *citizenship* – does an immigrant need to first become a naturalized citizen to be eligible for public health insurance, or is there another pre-citizenship status (e.g. permanent residence) that qualifies them; *length of residence* – is there a minimum residence requirement in the country before becoming eligible for public health insurance; *means tested need* – does income level determine eligibility; *participation in the workforce* – does non-participation in the workforce preclude access to benefits?

6.1.1 Citizenship

In the United States, the path to citizenship begins with an immigrant visa based on eligibility in a particular immigrant category. Upon receipt of an immigrant visa, the grantee may enter the United States and become a Legal Permanent Resident (LPR). Finally, after five years of residence in the United States, LPRs may apply for naturalization to become a United States citizen. Citizenship is not required for access to the two publically provided health insurance plans in the United States, Medicaid and Medicare. LPRs who meet the other eligibility requirements of Medicaid and Medicare (as explored below), are eligible for these plans before they become naturalized American citizens.

Like in the United States, before becoming a citizen, immigrants to Canada must be granted Permanent Residence Status based on a particular immigrant category. After residing in Canada for at least thirty-six months of the previous four years, Canadian Permanent Residents may apply for citizenship. Again, similar to the United States, citizenship is not a requirement for eligibility in Medicare, Canada's national health insurance plan. Permanent Residents are also eligible for coverage.

The path to citizenship in Israel differs for each category of potential immigrants. Once an applicant for immigration under the Law of Return, by residence or by birth, is approved, they immediately become Israeli citizens and thus receive the social benefits bestowed on veteran Israelis. This includes national health insurance. The path to citizenship for applicants under naturalization is not automatic. Applicants under naturalization must be first granted permanent residence status. Permanent residents, as well as those granted temporary residence, are eligible for Israeli national health insurance, before becoming citizens, as long as they pay standard premiums required of all Israeli citizens.

6.1.2 Length of Residence

Following the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), or welfare reform, of 1996, according to federal law, immigrants to the United States must wait five years before becoming eligible for Medicaid. In addition to the exemptions made to this policy for refugees and asylum seekers, state governments are given authority to modify the five-year ban. States can either extend the five year residence requirement, making it more difficult for immigrants to qualify for Medicaid, or can decrease the residency requirement by

using state funds to provide coverage for those immigrants with less then five years of residency in the United States. Access to the other American public health insurance plan, Medicare, is not formally dependent on residency. However, because eligibility for Medicare hinges on minimum years of workforce participation (see below), in effect, this also means that immigrants must have lived, and worked, in the United States for a minimum time period as well.

According to the Canadian Health Act, the federal law establishing Medicare, the Canadian national health insurance plan, the only requirement for coverage is residence in a Canadian province or territory. The Act gives authority to each provincial or territorial government to determine minimum residence requirements for Medicare eligibility. Accordingly, except for four provinces (British Columbia, Ontario, Quebec and New Brunswick) and the Yukon Territory who have implemented a three-month waiting period for coverage, all other provinces and territories in Canada bestow Medicare coverage upon new residents (including legal immigrants) upon registration with the local ministry of health and proof of residency.

Length of residence is not a factor in determining eligibility for public health insurance coverage in Israel. Coverage is immediate for immigrants upon becoming citizens or permanent or temporary residents as long as they pay the standard premiums required of all Israelis.

6.1.3 Means Tested Need

Medicaid, the United States public health insurance plan aimed at protecting financially needy Americans, employs a means test in order to determine eligibility. While the federal government provides funding for Medicaid, the program is administered individually by each state government. As a result, the means test for eligibility is different in each state. Immigrants, just like native Americans, applying for Medicaid must pass the means test in order to be granted coverage. The other American public health insurance plan, Medicare, does not employ a means test.

With universal health insurance, neither Canada nor Israel employ a means test for coverage in their national health insurance plans. Discounts on premiums and deductibles are offered to some populations dependent on income, but income never impacts eligibility.

6.1.4 Participation in the Workforce

In the United States, eligibility for Medicare, the public health insurance plan aimed at covering the elderly and disabled, is established by paying the health insurance payroll tax on one's income for at least 40 quarters (usually 10 years). This eligibility requirement precludes up to one-third of immigrants to the United States. However, those immigrants who have not worked sufficient quarters to qualify for Medicare may pay higher monthly premiums in order to receive Medicare benefits. There is no required participation in the workforce in order to qualify for Medicaid. Finally, the majority of Americans receive employer provided private health insurance. Due to the fact that immigrants are typically employed in jobs with limited benefits they often to not receive this private health insurance.

Participation in the Canadian workforce is not an eligibility requirement for Medicare. However, in some cases employees offer private supplementary health insurance to their employees. Immigrants to Canada are less likely to secure jobs with employers providing this level of benefits and thus are less likely to receive employer provided supplementary health insurance then native born Canadians.

A health premium is deducted by the National Insurance Agency (NII) from the salary of Israeli citizens and residents. The amount of this premium is determined by individual income level. However, participation in the workforce is not an eligibility requirement for coverage under the Israeli national health insurance system and those not employed, still receive health insurance coverage.

6.1.5 Summary of Indicators of Access

The following chart summarizes the indicators that determine immigrant access to health care in the United States, Canada and Israel.

Country / Indicator	United States	Canada	Israel
Citizenship	LPRs are eligible before becoming naturalized citizens	Permanent Residents are eligible before becoming naturalized citizens	Permanent and Temporary residents are eligible before becoming naturalized citizens
Length of Residence	Medicaid: > 5 years (except in some states) Medicare: no minimum requirement	Only four provinces and one territory require 3-month residency, all other provinces and	No minimum requirement

		territories give immediate coverage	
Means Tested Need	Medicaid – Yes; actual means test different in each state. Medicare – no means test	No means test	No means test
Participation in Work Force	Medicaid – no participation requirement Medicare – yes; at least 40 quarters of payroll taxes or supplement in higher monthly premiums	No participation requirement	No participation requirement

As revealed by these indicators, in all three countries studied, once approved for legal residence status (permanent or temporary) or in the case of Israel, for automatic citizenship, immigrants are eligible for coverage by the respective public health insurance plan. Comparatively, the United States provides less extensive health insurance to both its citizens and permanent residents, as well as mandates more eligibility requirements for immigrants then Canada or Israel. While access to public health insurance in Canada and Israel is similar, with the minor exception of residence requirements in Canada, Israel stands out not because of the level of access it provides to immigrants, but because of its immigration policy as a whole. Through the prism of historical institutionalism and ideas in the realm of both immigration and public health insurance policy, this divergence as well as other differences specific to immigrant access to public health insurance between the three countries will be explored in the next section.

6.2 Explaining Divergences in Policy

While the United States, Canada and Israel are all classified as settler nations with liberal welfare states, policy in each of the countries determining immigrant access to public health insurance varies. The theoretical concepts of historical institutionalism and the impact of ideas help to understand these differences in policy outcomes.

6.2.1 The Institution of Universal Health Care

While the United States, Canada and Israel are all considered liberal welfare states, unlike the other two countries studied here, the United States does not provide universal health care to its citizens. The implication of this significant difference in

health care policy in the United States means that the United States provides significantly less public health insurance not only to its immigrants, but also to its native born citizens, than either Canada or Israel. Historical institutionalism sheds considerable light on the divergence of public health insurance policy in these three countries. Entrenched policy legacies, including formal organizations and rules as well as informal norms and procedures, govern policy outcomes on an ongoing basis (Thelen & Steinmo, 1992; Immergut, 1998). An analysis of the historical development of health care policy in the three countries helps to account for this divergence in policy outcomes.

In the United States prior to the 1920s, demand for health insurance was almost non-existent. However, as the dependency upon and the cost of hospital services increased and growing numbers of patients were unable to pay their hospital bills a need for hospital insurance developed. In 1929 the first hospital insurance plan was created by the Baylor University Hospital based on a prepayment system. This plan, initially offered to a group of teachers, unknowingly created the basis for an employment based health insurance system.

Following the Baylor plan, prepaid hospital plans, or Blue Cross Plans, expanded and within five years over four-hundred employee groups were covered by similar plans. With the support of the American Hospital Association (AHA), federal legislation gave Blue Cross Plans special non-profit status releasing them from the normal regulations applied to insurance companies and giving them tax exemption. Thus, from the outset, instead of creating its own health insurance legislation, the federal government acted in response to the Blue Cross system, an already existing institution.

Subsequently, with rising costs of non-hospital medical services, a need to create prepaid medical services plans developed. The American Medical Association (AMA), while initially opposed to these types of prepaid plans, realized that it was in their interest to support these types of plans as opposed to the proposals for government regulated health insurance promoted in the late 1930s. Thus the AMA created their own prepayment plan for non-hospital medical services, Blue Shield, which was based on the Blue Cross non-profit model and again provided to groups of employees. By the 1950s all states had Blue Cross and Blue Shield plans offered to groups of employees.

Following the success of Blue Cross/Blue Shield models, private insurance companies realized that they could successfully mitigate the risks typically associated with health insurance, and began to offer private health insurance, specifically to employee groups. Thus, with the increase in health insurance options, enrollment in health insurance plans rose steadily. However, all plans catered to groups of employees instead of individuals and no government plan existed.

The federal government served to strengthen this connection between health insurance and employment. The 1942 Stabilization Act, while prohibiting wage increases as an incentive to hire employees in a market with a labor shortage, enabled employers to offer health insurance as an incentive. Furthermore, the Internal Revenue Code of 1954 gave tax exemption to employer and employee contributions to health insurance. These moves on the part of the federal government further entrenched the connection between health insurance and employment.

Despite the fact that by the 1950s health insurance was strongly connected to employment, a political movement to create government health insurance did exist. As early as Truman's presidency, American presidential administrations[48] attempted to overhaul the employment based health care system and legislate for government provided universal health insurance. While none of these initiatives resulted in completely restructuring the existing system, the implementation of gradual changes to the employment based health insurance system was successful. The first significant change came with the legislation of Medicare and Medicaid in the 1960s, providing public health insurance to vulnerable Americans (the elderly and the poor). The success of this legislation was based on the collaboration of the AFL-CIO, which aimed at providing insurance to its retired members, with the Blue Cross association and insurance companies, which could not provide for these vulnerable populations and still remain economically profitable. Subsequently, in the past fifty-years, step-by-step changes have been made legislating for increased governmental involvement in the health insurance. President Clinton successfully legislated for SCHIP, providing increased coverage for low-income children, and under President Bush the Medicare Modernization Act was passed which increased federal coverage of pharmaceuticals for senior citizens. Most recently, the Patient Protection and Affordable Care Act was passed under President Obama. While Obama lobbied under the banner of universal

[48] Presidents Carter, Clinton and Obama.

health insurance, even this most recent reform, serves to modify the employment based health insurance system already in place by providing affordable health insurance options to those Americans that do not receive employer provided health insurance and are not eligible for health insurance under Medicare and Medicaid.

Thus, the historical precedence created by connecting health insurance to employment by the very first US hospital insurance plan in 1929, and the institutions put in place to regulate this system, have served as a foundation for the current American health insurance system. The path-dependence created by the existence of a system that links employment to health insurance, has allowed small, incremental changes to the system, but has also enabled the basic features of the system to persist.

The same is true of both the Canadian and Israeli systems, however in these cases the historical legacies of the preliminary health insurance systems provided a basis for universal health insurance. The Constitution Act of 1867, which also officially proclaimed Canadian independence, gave responsibility for the establishment, maintenance and management of hospitals and asylums to provincial governments. This allocation of responsibility for health to the provinces, which was extended by federal legislation in 1929 endorsing provincial health insurance plans, set the stage for the current Canadian health system. Thus a norm was institutionalized which made provincial health insurance systems the basis for the federal system.

In 1947 Saskatchewan was the first province to legislate for universal, province-wide hospital insurance. Following the Saskatchewan example, other provinces soon legislated for similar province based universal hospital insurance plans. By setting up provincial systems of universal hospital insurance, a policy legacy and infrastructure for universal health care was established. However, the impetus for federal health insurance came as a result of raising support for a third party, which supported universal health insurance, both on the provincial and federal level. Unlike in the United States federal constitutional republic where third parties have limited impact on the established two-party system, third parties in the parliamentary system in Canada, dependent on a majority coalition, have significantly more influence.

In the 1950s the Co-operative Commonwealth Federation (CCF), a social democratic alternative to the established Liberal and Conservative parties began to gain significant support on the provincial and federal level. Central to CCF's platform

was federal universal health insurance. In the province of Ontario, mounting pressure from CCF and the labor movement caused the Conservative government to refuse to legislate for provincial universal hospital insurance (as had been done in a number of other provinces) without federal support. As a result of this pressure from a third party that had influence on the federal level, the Hospital and Diagnostic Services Act of 1957 was passed. Through this Act the federal government committed to finance half of the hospital costs nationwide to provinces that provided all insured hospital services on a uniform basis. Within four years of this legislation all remaining provinces and territories had legislated for universal hospital insurance. Thus while the provincial system set the precedent for the type of health insurance, the institution of a parliamentary system in Canada impacted the federal legislation for universal hospital insurance.

The legislation of universal medical services insurance occurred in much the same way. Again the province of Saskatchewan was the forerunner, establishing universal medical services insurance on a provincial level with a few provinces following their lead. This set up the infrastructure for comprehensive federal universal health insurance. Again, the impact of a third party on the Parliamentary system, served as the impetus for legislation on the federal level. The 1965 election resulted in a minority Liberal government. The New Democratic Party (an alliance of CCF and the labor movement) succeeded in drawing votes away from Liberal party supporters giving them relative power in the Parliament, where the minority Liberal government needed to establish a coalition. Legislation of federal universal health insurance was non-negotiable for the New Democratic Party and as soon as 1966 the federal government passed the Medical Care Act establishing Medicare, the national health insurance.

While establishing uniform criteria for all provincial health insurance plans, Medicare exists as a decentralized system where the Canadian federal government finances half of the costs of health care nationwide, but the provinces have the authority to create and manage their own Medicare plans. It is therefore evident, that the authority given to provinces to manage health since Canadian independence in 1867 as well as the parliamentary system, established institutions that directly impacted current health insurance policy in Canada.

The current universal health insurance system in Israel, based on sick funds or health plans, has its roots in structures developed prior to the establishment of the

State of Israel in 1948. In the pre-state period, sick funds were created in order to provide health care coverage for workers. All three plans currently in existence were established before 1948 and were tied to groups of laborers as well as political parties[49]. This configuration politicized the health system from its conception.

Furthermore, from the establishment of the State of Israel in 1948 until 1977 the socialist Labor party was in power. Thus socialist values permeated the culture of Israel in many fields, including health. While universal health insurance did not exist, the perception that society as a whole was responsible for the welfare and health of fellow citizens prevailed. The Israeli government was responsible for public health and preventative health services as well as managed public hospitals. In addition, by 1988 ninety-six percent of Israeli citizens were covered by one of the four health plans. Health insurance coverage was seen as a right through Israeli citizenship.

However, despite this high level of health coverage, it was evident by the late 1980s that the Israeli health system was in crisis. The government commission that was formed to investigate this crisis recommended the legislation of universal health insurance. Due to the fact that there had been a federal role in the provision of health care since the establishment of the State of Israel, a system already in place that covered the vast majority of Israeli citizens, and a general conception that society is responsible for the health of its citizens, passing legislation for state sponsored universal health insurance was not difficult[50]. Today the four health plans founded before 1948, still provide health insurance to Israeli citizens, within the confines of a legal and regulatory framework set out by the National Health Insurance Law. Again, in the case of Israel the legislation of a public universal health insurance system did not create a completely new system; instead it based itself off of the already existing institutions.

An additional element exists in the development of the public health insurance system in Israel. In this case ideas, or more specifically values, also impacted the creation of a state-sponsored universal health insurance system. The socialist values that created the foundations of the State of Israel, impacted the conception of the role of government in provision of health insurance. The legislation of the National Health Insurance Law successfully passed, not only because it built on already existing

[49] Clalit, as part of the Histadrut or labor union, was tied to the Labor party, and Leumit was tied to the Revisionist party.

[50] It cannot be ignored that implementation of the NHI law has been wrought with difficulty, but following 1995 a state-sponsored universal health insurance system does exist in Israel.

institutions, but also because it was consistent with prevailing ideas about the role of government in ensuring the welfare of its citizens. The role of ideas will be explored in depth in the following section.

As is evident in the cases of health insurance systems in the United States, Canada and Israel, institutions have a significant impact on policy outcomes. In all three countries, the institutions put into place with regard to health insurance since their establishment (and in the case of Israel even before its independence), bear great weight on the types of systems currently in place in each country. Small, incremental changes have been effective in changing the systems, but attempts at large changes to overhaul existing institutions have not succeeded. Historical institutionalism is crucial to understanding the existence of universal public health insurance in Canada and Israel and its absence in the United States. As is evident from the investigation of indicators of access, the divergence in types of systems has a direct affect on immigrant access to public health insurance. In universal systems, like those of Canada and Israel, immigrants, sometimes after waiting a grace period, have immediate access to public health insurance provided to all citizens. Conversely, in the employer based health insurance system in the United States which provides public health insurance only for senior citizens and the poor, immigrants, like citizens have limited access to public health insurance coverage.

6.2.2 The Ideas and Settler Nations

While the prevailing health insurance system in each of the three countries studied here has a direct impact on the level of public coverage to which both immigrants and citizens have access, immigration policy in each country regulates who is eligible for these public benefits in the first place. The United States, Canada and Israel are all classified as settler nations, however the impact of ideas, sheds light on the divergences in immigration policy in the three countries.

As is evident from the sections examining the historical development of immigration policy in the United States and Canada, policy legacies in the field of immigration in these two countries are quite similar. Prior to independence, immigration in both regions was encouraged in order to populate and recruit labor for the fledgling colonies. Following independence, the founding leaders of both countries self identified their new nations as settler nations and continued to encourage diverse immigration primarily for economic purposes. In the United States

this view of immigration, as a means to economic success, is evident in the placement in 1903 of the Immigration and Naturalization Service (INS) as a branch of the Department of Labor and Commerce. In Canada, this is evident in the cycle of policy decisions made to increase or limit immigration based on the current status of the Canadian economy. At certain times, both countries have given priority to immigrants from specific countries of origin that are deemed to be most easily assimilated and thus most efficient in becoming contributing members of the host society and economy.

Discussion about immigration in both the United States and Canada has long centered on immigration as a threat to native labor. This idea, or cognitive paradigm, viewing immigrants primarily in terms of their economic potential has served to direct policy decisions in the field of immigration in the United States and Canada. In both countries avenues of immigration exist for those individuals trained in fields of labor that are in demand.

In addition to the primary paradigm of immigration as a means to economic development, a number of other ideas have impacted immigration policy in both the United States and Canada. From the outset both countries promoted permanent settlement and viewed immigration policy through this lens. Thus, in order to encourage immigrants to remain permanent contributors to the United States or Canadian economy, family reunification was given priority in immigration policy. The establishment of family categories of immigrants enabled both immediate and more distant family members to join their relatives in the United States and Canada. The policy paradigm of immigration as permanent contributed to specific classes of family immigrants.

Values, as a type of idea, have also had an impact on the development of immigration policy in both the United States and Canada. The founding leaders of both countries established freedom and democracy as a guiding value of their new countries. These values impacted the establishment of a refugee class of immigration in both countries. Both countries were relatively late in formally regulating refugee immigration policy[51], but the political discussions surrounding this legislation was colored by the understanding that inherent to American and Canadian values is the obligation to protect the freedom of persecuted peoples.

[51] The 1976 Immigration Act in Canada formalized what had been *ad hoc* refugee policy and the Refugee Act of 1980 did the same in the United States.

Immigration policy in both countries has also been framed in the context of national security. In the United States during and after World War II the fear of enemy nationals impacted policy. This is evident in the relocation and internment of both American citizens of Japanese origin and Japanese citizens residing in the US to internment camps following the Japanese bombing of Pearl Harbor. These immigrants, both naturalized citizens and residents, were viewed as threats to national security. Following World War II, the American INS was transferred to the Department of Justice, another indication that immigration was framed as a national security issue. The impact of the terrorist attacks in the United States on September 11, 2001 furthered the framing of immigration as a security issue not only in the United States but also in Canada. In the United States, policy changes in the field of immigration following September 11 were even more drastic. As a result of September 11 special provisions to arrest and detain immigrants have been given to the government under the Patriot Act. In addition, the INS was transferred in 2003 to the newly created Department of Homeland Security. Thus the authoritative control of immigration falls under the discretion of a department specifically designed to protect national security. In Canada, draft legislation of the Immigration and Refugee Protection Act existed before September 11, 2001, and included special provisions to prevent terrorists from entering Canada. The terrorist attacks of September 11 served to strengthen the already existing frame of immigration policy as a means of protecting national security. It is again clear that the use of an idea or the framing of immigration as a national security issue has led to specific policy outcomes in both the United States and Canada.

As settler nations, since their creation, both the United States and Canada have placed an emphasis on encouraging permanent settlement through immigration to their territories. Ideas in the form of cognitive paradigms, values and frameworks have influenced American and Canadian immigration policy – policy towards permanent settlement, favoring national economic interests while protecting national security, and providing shelter to the oppressed.

Immigration policy in Israel is quite different from that in the United States and Canada. Like the United States and Canada, Israel fits into the definition of a settler nation – the goal of its founding leaders was to settle the territory of the Land of Israel and remain there (Moran, 2002) and the Israeli government still actively encourages immigration for the purpose of settlement (Bauer et al, 2000). However,

unlike the founding leaders of the United States and Canada, the founding leaders of the State of Israel did not see themselves as foreigners to the Land of Israel, the territory they set out to settle. From the outset, the settlement of the Land of Israel was seen as the return of a people to its historic homeland. Instead of viewing immigrants as potential labor serving the economic interests of the country, immigration to Israel was viewed as an ingathering of ancient exiles. In short, Zionist ideology served and continues to serve as a basis for immigration policy in the State of Israel.

Zionism is the national movement for the return of the Jewish people to their homeland and the resumption of Jewish sovereignty in the Land of Israel. The impact of Zionist ideology is evident in immigration policy from the founding of the State of Israel in 1948. As stated in the Israeli Declaration of Independence on the eve of the establishment of the State, "The State of Israel will be open for Jewish immigration and for the ingathering of exiles," (Israel Declaration of Ind.). In 1950 the Knesset, the Israeli Parliament, passed the first formal immigration policy, the Law of Return. This law, specified a particular ethnicity, the Jewish people, instead of a specific country of origin, or citizenship (as immigration policy in the United States and Canada did at times), in order to privilege Jewish immigrants over all other potential immigrants to Israel. Through the Law of Return, immigration policy in Israel went further then privileging one type of immigrant over another, in effect it conferred the right to automatic citizenship on Jewish people worldwide. The conferral of oleh status on Jewish immigrants and their family members reflects the view of Jewish immigration not as the naturalization of foreign immigrants, but the return of co-ethnics.

Zionist ideology permeates all immigration policy in Israel, not only that related to Jewish immigration. This is reflected in the categorical difference between the first three categories of immigrants and the last category – immigration by naturalization. Immigration by return, by residence and by birth confers automatic Israeli citizenship upon eligible individuals. All of these categories are purely dependent on characteristics of the individual that are fixed. To immigrate under the Law of Return an individual must provide documentation attesting to the fact that they are Jewish or that a qualifying ancestor or relative is Jewish. To immigrate by residence, an individual must provide documentation that they are residents in the State of Israel, were present in Israel after the establishment of the state in 1948 and were registered in the 1951 Population Registry. Finally, in order to immigrate by

birth, an individual must provide documentation that they were born to a parent with Israeli citizenship. Thus, individuals seeking Israeli citizenship through these three categories are either eligible or ineligible based on unalterable characteristics.

As opposed to the first three categories of immigrants, the fourth category of immigrant, those by naturalization, are not automatically conferred with citizenship. In fact, no formal process of naturalization exists. Instead, immigrants by naturalization must meet six criteria in order to submit an application. Then the conferral of citizenship is at the discretion of the Minister of the Interior. There is no guarantee that a person who meets the six criteria will in fact be granted citizenship or even residence status. Unlike in the United States and Canada, where a clear path to naturalized citizenship exists, Israeli policy remains silent on this issue, ultimately leaving the decision in the hands of the Minister of the Interior.

Differing from other settler nations, Israeli immigration policy remains faithful to the Zionist ideology upon which it was founded. However, Zionism is not the only primary characteristic of the State of Israel. As established by the Basic Laws of Israel, Israel is both a Jewish and Democratic state. In order to maintain both of these identities simultaneously, Israel must maintain a Jewish majority. If Israel lost its Jewish majority it would then be forced to decide between its two identities – becoming either a Jewish minority state ruling a non-Jewish majority, or a democracy reflecting the identities of its population, effectively removing the Jewish character of the State of Israel. The absence of a naturalization process for non-Jews helps to protect against this occurrence.

The risk of implementing policy regulating formal naturalization (not at the discretion of the Minister of the Interior) to the character of the State of Israel is most blatant in the case of migrant workers and refugees in Israel. Whereas in the United States and Canada a clear path towards naturalization exists for labor migrants, which make up a significant portion of immigrants to these countries, in Israel not only is there an absence of a clear path to naturalization, migrant workers are also subject to stringent limits on the time they are allowed to remain in Israel[52]. In fact, migrant workers are forbidden from setting up the semblance of normalized life in Israel through laws prohibiting marriage between and birth to migrant workers. In addition, immigration policy in both the United States and Canada has established a separate

[52] The maximum time a migrant worker may remain in Israel legally in five years and three months.

category of immigration for refugees and asylum seekers in order to facilitate their immigration. In contrast, in Israel, there is no naturalization process for non-Jewish refugees and in the best case scenario they may be considered for permanent residence under the discretion of the Minister of the Interior. Whereas in the United States and Canada, policy reflects the intention to encourage settlement of immigrants, Israeli policy reinforces the attempt to prevent the permanent settlement of non-Jews. These policies are consistent with the ideology upon which the State of Israel was founded.

Immigration policy in Israel is not merely public policy; it is the fulfillment of the Zionist goal to return the Jewish people to the Land of Israel. This unique ideology, or idea, sets Israel apart from other settler nations as is evident in the divergent immigration policies in Israel on the one hand as opposed to the United States and Canada on the other hand.

Historical institutionalism and the impact of ideas contribute to an understanding of the significant differences in both the health policies and immigration policies in the United States, Canada and Israel. Institutions and ideas in these two policy domains have shaped the specific policy outcomes governing immigrant access to public health insurance in the United States, Canada and Israel.

6.3 Conclusions – Explaining Divergent Policy Outcomes

Immigrant access to public health insurance is dually impacted by both immigration policy and health policy in the specific country to which they migrate. While the cases explored as part of this study, the United States, Canada and Israel, are similar in that they are all settler nations with liberal welfare states, immigrant access varies significantly between countries.

In order to even access health insurance in the first place, individuals must succeed in immigrating to a specific country. Thus immigration policy initially impacts immigrant access to public health insurance. In the case of the United States, Canada and Israel, ideas have had a significant influence on immigration policy. While fitting within the definition of a settler nation, the case of Israel is significantly different then the other settler nations investigated here because of the impact of one specific idea, or ideology, Zionism. The influence of Zionism is evident in every manifestation of Israeli immigration policy which offers and even encourages automatic citizenship to all Jews and their relatives and effectively excludes non-

Jewish immigration. As compared to the United States and Canada, Israeli immigration policy is exceptionally open and generous when it concerns Jewish immigrants, but exclusionary in relation to all other potential migrants.

Once potential immigrants successfully meet the requirements for legal immigration to a specific country, health policy plays a role in determining their eligibility for public health insurance. In the case of health policy, it is evident that institutions, and their historical development, play a significant role in determining public health insurance policy. In all three countries investigated here, initial health institutions and the precedents they established from the outset have directly influenced existing health policy. No complete reforms of health systems have been successful in any of the three countries. Instead, as a result of path-dependency, small incremental changes to existing institutions have created the current public health insurance system in each country. In the case of Canada and Israel, the result has been universal national health insurance, while in the case of the United States an employment based system prevails with the government only providing health insurance to specific vulnerable populations. Thus, immigrant access to health insurance is dependent on the type of health insurance system that exists.

Based on these conclusions, it is not surprising that the analytical framework applied in this research concluded that immigrants to both Canada and Israel have the more access to health insurance then those to the United States. This is a direct result of more comprehensive public health insurance policy in both Canada and Israel. However, to distinguish between Canada and Israel, immigration policy must be considered. While legal immigrants to Israel, residents as well as naturalized citizens, are granted immediate coverage by the national health system, and those to Canada may be required to wait a minimum residence period, this does not in fact indicate that Israel provides the most immigrant access to public health insurance. Due to the fact that immigration policy in Israel is quite exclusionary in terms of non-Jews, in effect a limited group of immigrants actually benefit from the generous access to public health insurance in Israel. Consequently, in terms of the three countries investigated in this study, taking into consideration both immigration policy as well as policy regulating public health insurance, the Canadian public health insurance system provides the greatest access to the widest range of immigrants.

Thus, the policy outcomes in terms of immigrant access to public health insurance in the three countries studied here are quite different. This is contrary to the

fact that all three countries are classified as settler nations with liberal welfare states. The theoretical background offered by historical institutionalism and the impact of ideas is critical to understanding the various policy outcomes in the case of immigrant access to public health insurance. This serves to strengthen the weight of these theories beyond this specific study to the field of comparative social policy in general.

7. Appendices

A) United States Immigration – Defining Terms

- *Immigrant:* a foreign-born individual residing in the US including naturalized citizens and lawful permanent residents (see below).
- *Naturalized citizen:* a foreign-born individual who has lawfully become a US citizen and has all legal rights of a US born citizen (except for eligibility to be Vice-President or President).
- *Lawful permanent resident - LPRs (Green Card holders):* a foreign-born individual who is admitted into the US to be reunited with family members, in response to an absence of American workers in a specific field, or on diversity visas. These individuals are on the path to become naturalized citizens but have not yet obtained citizenship. Also referred to as *legal non-citizen.*
- *Persons Residing Under the Color of Law (PRUCOL):* foreign-born lawfully-present or lawfully-residing immigrants that do not fit into other categories. Their status may be temporary (but legal) or pending. Examples include: certain applicants for asylum and immigrants with temporary protected status (TPS).
- *Humanitarian immigrants (Refugees/Asylum seekers):* legal immigrants who have well-founded fear of persecution in their home countries and were allowed either to emigrate to the US or to obtain lawful status if they were already in the US. Generally this category of immigrants can gain LPR status after a certain amount of time.
- *Non-immigrants:* foreign-born individuals who have entered the US for purposes of tourism, education or temporary work. They are granted non-immigrant visas and leave once their visa expires. Those who over-stay their visa become undocumented immigrants.
- *Undocumented immigrant:* foreign-born individual temporarily residing in the US who is not a legal resident (entered without authorization, overstayed temporary visa).

B) Canada Immigration – Defining Terms

- *Immigrant:* a foreign-born individual residing in Canada including naturalized citizens and permanent residents (see below).
- *Naturalized citizen:* a foreign-born individual who has lawfully become a Canadian citizen and with minimal exceptions, has the legal rights of a Canadian born citizen.
- *Permanent resident:* a foreign-born individual who is admitted to Canada in the family class, economic class or refugee class of immigrants. These individuals are on the path to become naturalized citizens but have not yet obtained citizenship.
- *Temporary resident:* a foreign-born individual who is admitted to Canada in order to reside for a temporary period of time; e.g. foreign student and temporary workers.
- *Tourist:* a foreign-born individual who is admitted to Canada for a limited period for the purpose of visiting as opposed to residing.
- *Undocumented immigrant:* a foreign-born individual residing in Canada who is not a legal resident or tourist.

C) Israel Immigration – Defining Terms

- *Oleh (plural: Olim):* an immigrant to Israel acquiring citizenship under the Law of Return; receives automatic citizenship and a benefit package upon arrival.
- *Making aliyah:* the act of becoming an oleh.
- *Permanent resident:* status conferred at discretion of the Minister of Interior with no time limit. Permanent residents are eligible to receive social security payments and national health care.
- *Temporary resident:* status conferred at the discretion of the Minister of Interior for up to three years with the possibility for extension. Temporary residents are eligible to receive social security payments and national health care.
- *Tourist:* status conferred on visiting tourists by the Ministry of the Interior or local Israeli Embassy representatives for up to three months with the possibility for extension.
- *Legal migrant worker:* foreign-born individual holding a work visas to work in a specific field in Israel for no more then five years and three months. By law they receive certain social benefits, but not public health insurance.
- *Asylum seekers/refugees:* status conferred by the Ministry of Interior with guidance from the National Status Granting Body and the United Nations High Commissioner on Refugees. Persons with this status may remain in Israel but do not have the automatic right to work unless specifically granted by the Ministry of Interior.
- *Undocumented immigrant:* foreign-born individual temporarily residing in Israel who is not a legally documented citizen/resident/tourist/worker/refugee.

D) Foreign-Born Population and Foreign Born as Percentage of the Total US Population, 1850 to 2007

	Number of foreign born	Foreign born as a percentage of the total US population
1850	2,244,602	9.7
1860	4,138,697	13.2
1870	5,567,229	14.4
1880	6,679,943	13.3
1890	9,249,547	14.8
1900	10,341,276	13.6
1910	13,515,886	14.7
1920	13,920,692	13.2
1930	14,204,149	11.6
1940	11,594,896	8.8
1950	10,347,395	6.9
1960	9,738,091	5.4
1970	9,619,302	4.7
1980	14,079,906	6.2
1990	19,767,316	7.9
2000	31,107,889	11.1
2007	38,059,694	12.6

Note: The term "foreign born" refers to people residing in the United States who were not US citizens at birth. The foreign-born population includes naturalized citizens, lawful permanent residents (LPRs), certain legal non-immigrants (e.g., persons on student or work visas), those admitted under refugee or asylee status, and persons illegally residing in the United States.

Source of Data: Collected by the Migration Policy Institute (http://www.migrationinformation.org/datahub/charts/final.fb.shtml)from the 2007 data are from the 2007 American Community Survey, the 2000 data are from Census 2000 (see www.census.gov). All other data are from Gibson, Campbell and Emily Lennon, US Census Bureau, Working Paper No. 29, Historical Census Statistics on the Foreign-Born Population of the United States: 1850 to 1990, US Government Printing Office, Washington, DC, 1999.

E) Ranking preferences for US family sponsored immigrants

Status of sponsor	Applicant relation to sponsor	Preference level
US Citizenship	spouse	no waiting
	unmarried child under 21	no waiting
	unmarried child over 21	1st
	married child of any age	3rd
	sibling (if sponsor is at least 21 years old)	3rd
	parent (if sponsor is at least 21 years old)	no waiting
LPR	Spouse	2nd
	Unmarried child of any age	2nd

Source of Data: United States Citizenship and Immigration Services (USCIS)

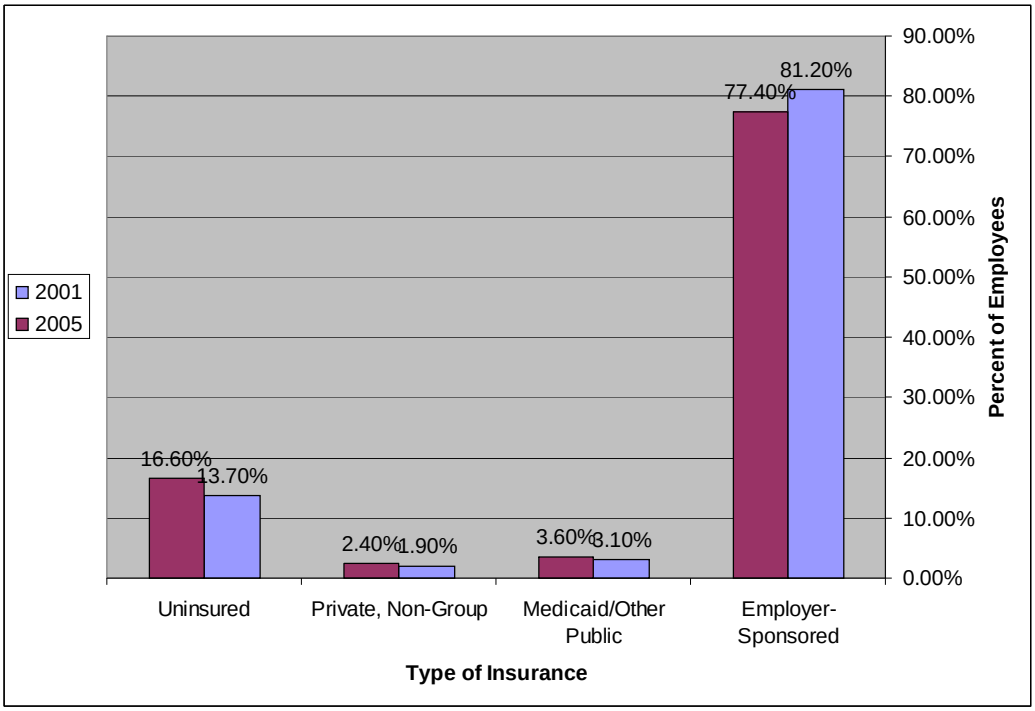
F) Characteristics of the Non-Elderly Uninsured in the USA, 2008

	Non-elderly (millions)	Percent of Non-elderly	Uninsured Non-elderly (millions)	Percent of Uninsured Non-elderly	Uninsured Rate for Non-elderly
Total - Non-elderly	262.8	100.00%	45.7	100.00%	17.40%
Age					
Children-Total	78.7	29.90%	8.1	17.70%	10.30%
Adults - Total	184.1	70.10%	37.6	82.30%	20.40%
Adults - 19-24	24.3	9.20%	7.5	16.40%	30.80%
Adults - 25-34	40.1	15.30%	10.8	23.50%	26.80%
Adults - 35-44	41.1	15.60%	8	17.60%	19.60%
Adults - 45-54	44.3	16.90%	71	15.40%	15.90%
Adults - 55-64	34.3	13.00%	4.3	9.40%	12.50%
Annual Family Income					
< $20,000	60.6	23.10%	21.9	47.80%	36.10%
$20,000-$39,000	52.2	19.90%	13.3	29.10%	25.20%
$40,000+	150	57.10%	10.6	23.10%	7.00%
Household Type					
Single Adults Living Alone	19.6	7.50%	3.9	8.50%	19.70%
Single Adults Living Together	31.3	11.90%	10.9	23.70%	34.70%
Married Adults	55.5	21.10%	8.1	17.60%	14.50%
1 Parent w/children	32.6	12.40%	5.9	13.00%	18.20%
2 Parents w/children	109.4	41.60%	12.8	28.10%	11.70%
Multigenerational/Other w/children	14.4	5.50%	4.2	9.10%	29.00%
Family Work Status					
2 Full-time	72	27.40%	5.4	11.70%	7.40%
1 Full-time	137.4	52.30%	25	54.70%	18.20%
Only Part-time	21.1	8.00%	6.4	14.10%	30.40%
Non-Workers	32.2	12.30%	8.9	19.50%	27.60%
Race/Ethnicity					
White only (non-Hispanic)	166.4	63.30%	21.1	46.10%	12.70%
Black only (non-Hispanic)	33.3	12.70%	6.9	15.00%	20.60%
Hispanic	44.7	17.00%	14.4	31.50%	32.20%
Asian/S. Pacific Islander	12.4	4.70%	2.3	5.10%	18.70%
Am. Indian/Alaska Native	1.7	0.70%	0.5	1.10%	27.90%
Two or More Races	4.3	1.60%	0.6	1.30%	14.10%
Citizenship					
US citizen - native	230.5	87.70%	33.70	73.80%	14.60%
US citizen - naturalized	12.3	4.70%	2.70	5.90%	22.00%
Non-US citizen, resident < 6 yrs	5.4	2.00%	2.5	5.50%	46.30%
Non-US citizen, resident 6+ yrs	14.6	5.60%	6.8	14.90%	46.40%
Health Status					
Excellent/Very Good	179.1	68.20%	26.2	57.40%	14.60%
Good	60.4	23.00%	14.3	31.30%	23.70%
Fair/Poor	23.2	8.80%	5.2	11.30%	22.20%

Confidence intervals and standard errors were calculated only for uninsured rates. () - Estimate has a large 95% confidence interval of +/- 5.0-7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Source of Data: Kaiser Commission on Medicaid and the Unisured, 2009:26

G) Health Insurance Coverage Changes Among Employees in the US (2001-2005)



Notes: All changes are significantly different. ($p<.05$)
Data may not total 100% due to rounding.

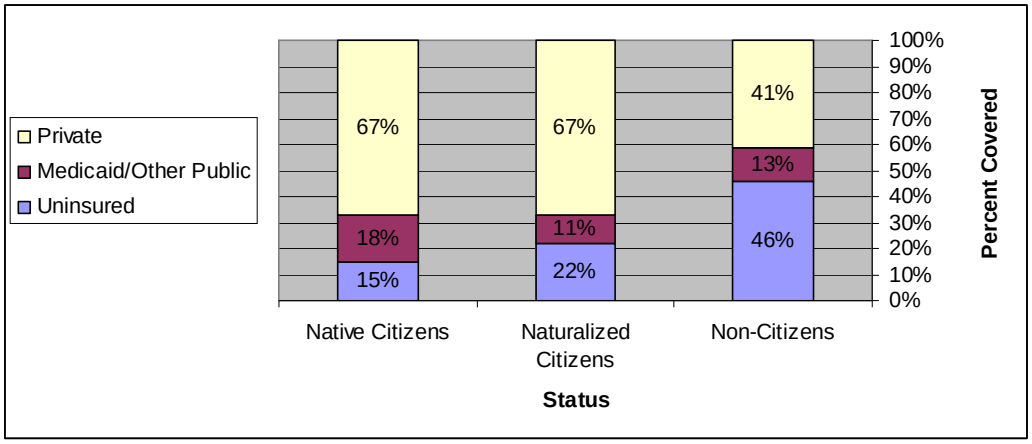
Source: Clemens-Cope and Garrett, 2006 (Urban Institute Analysis of the February 2001 and 2005 Contingent Work Supplement of the Current Population Survey (CPS) and March 2001 and 2005 Annual Social and Economic (ASEC) Supplement of the CPS)

H) Medicaid Eligibility for Immigrants Post-Welfare Reform (PRWORA) in the US

Immigrant Status	Eligible for Medicaid	Eligible for SCHIP	Eligible for Emergency Medicaid
LPRs residing in the US for > 5 yrs	✓	✓	N/A
LPRs residing in the US for ≤ 5 yrs	No	No	✓
Humanitarian immigrants	✓	✓	N/A
Pregnant immigrants who are: 1) LPRs residing in the US for ≤ 5 yrs; 2) "lawfully present;" or 3) undocumented	No	✓	✓
"Lawfully present" immigrants who are not pregnant	No	No	✓
Undocumented immigrants who are not pregnant	No	No	✓

Source: Fremsted and Cox, 2004

I) Health Insurance Coverage for Non-Elderly in the US by Citizenship Status, 2008



Note: Medicaid/Other Public also includes SCHIP, other state programs, Medicare, and military-related coverage.

Source: Kaiser Commission on Medicaid and the Uninsured, 2009 – Analysis of March 2009 Population Survey

J) Jewish Waves of Immigration Pre-Israeli Independence

Waves of Immigration	Immigrants
First Aliyah (1882-1903)	20,000-30,000
Second Aliyah (1904-1914)	35,000-45,000
Third Aliyah (1919-1923)	35,000
Fourth Aliyah (1932-1938)	82,000
Fifth Aliyah (1924-1931)	217,000
World War II/Aliyah Bet (1939-1945)	92,000
Post World War II (1947- May 1948)	61,000
TOTAL	**542,000-562,000**

Source: Sircon, 1957

K) Legal Migrant Workers in Israel (1970-2009)

Year	Total all Industries(thousands)	Industry	
		Construction	Agriculture
1970	19.8	10.8	5.0
1975	63.9	35.2	9.2
1980	70.4	33.8	9.6
1985	89.2	42.5	14.1
1990	107.7	64.1	12.0
1995	40.6	26.8	5.0
2000	78.0	32.2	3.7
2001	88.8	39.4	21.9
2001	89.2	39.5	22.0
2002	93.0	40.6	22.8
2003	72.3	24.3	23.7
2004	64.0	17.1	24.5
2004	60.1	10.8	21.9
2005	63.1	10.8	23.3
2006	65.9	11.7	22.6
2007	69.9	10.1	23.9
2008	79.9	11.0	25.9
2009	79.3	10.2	22.8

Notes: As of 2008, data includes foreign workers employed by Israelis in Judea, Samaria and the Gaza Area.

Source: Central Bureau of Statistics, Israel, 2010

L) Main Sources of Financing for Health Care in Israel (as percent of total) (1990-2005)

Source of Finance	1990	1995	2000	2005
Public	71	74	72	68
general taxation	20	26	42	39
employer tax	26	22	0	0
health tax	0	22	25	26
health plan premiums	18	0	0	0
other/unknown	7	4	5	3
Private	29	26	28	32
Total	100	100	100	100

Source: Bin Nun and Kaidar, 2007

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