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KIBBUTZ NURSING: AN EXEMPLAR OF PRIMARY HEALTH CARE

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ABSTRACT

Kibbutz nursing has long been established as a role that addresses the needs of a community's health that arises from the underlying philosophy of the kibbutz communal structure. Despite the number of years of this nursing practice, there is a paucity of literature concerning its development and scope. While parallels may exist with other rural and remote nursing services throughout the world, the kibbutz philosophy of "each according to his ability and to each according to his needs" has governed the important areas of education, labor, and the provision of health to its members. This model of nursing care illustrates a number of examples of primary health principles that can be adapted and applied in other rural nursing practices. The article also discusses problems nurses face in such an intimate setting as the kibbutz.

Key words: kibbutz, primary health care, communal, rural practice

Kibbutz nursing is a specialty area of practice that has existed for nearly 100 years in Israel, yet it has received relatively little attention; little has been published regarding its practice scope and development. This is particularly puzzling as a significant underpinning of kibbutz nursing is its focus on community health and preventive care delivered within a community setting. Such care provides an example that may be useful to other rural communities who seek ways of adhering to the important principles of empowering individuals, families, and communities. Furthermore, kibbutz nursing is structured in a manner that enables members of a community to achieve health through self-reliance where people live and work, allows consumers to take responsibility for health and well being, and adheres to principles of primary health care (WHO UNICEF, 1978, p. 6 cited in Wass, 2000). The purpose of this article is to provide a description of kibbuz nursing practice and its relationship to primary health care principles

These primary health care principles, which have been articulated through a number of documents and forums, were formulated with the belief that nations would be able to use them to guide strategies for health promotion. Ultimately, people from all walks of life

would join forces in order to achieve "health for all" by the year 2000 (Wass, 2000). While commendable, these goals have not been achieved internationally. Many examples of such efforts have been cited in primary health care textbooks. However, there is little to no reference to the kibbutz model, which has been in place for many years prior to these charters for reorientation of health and community. Despite a number of changes in kibbutz structure that encompass economics and social, labor, and health policies within the kibbutz, the kibbutz movement retains its fundamental ideals in relation to health care needs of its members, a strategy that differs not only from the rest of Israel's population, but from the rest of the world as well.

Kibbutz: Definition, Locations, and Philosophy

By definition, the kibbutz is the world's most successful commune movement that began close to 100 years ago. Its underpinning philosophy was the desire to build a new kind of human being, a just society and thereby, a model for a better world. That utopian ideal has been forced to reinvent itself a number of times over the past century of existence, yet, for the most part, the kibbutz continues to retain its essential characteristics based on voluntary membership, democracy, collective responsibility, and a notion of equality. While some kibbutzim were positioned in strategic locations for defensive purposes, other locations were chosen as sites that had been believed impossible to settle (ranging from the swamps of the northern part of the country to the Negev Desert in the south).

There are 267 kibbutzim (plural term of kibbutz) located throughout Israel that vary in size considerably from a handful of members to populations of over 2000. A common philosophy binds all of them to the kibbutz ideal, but religious orientation varies from highly observant membership to secular or atheistic outlooks. The kibbutzim are populated both by native Israelis and recent arrivals from all parts of the world. While only three percent of the Israeli population lives in a kibbutz, their population has contributed considerably in leadership throughout the country. Notably, two Prime Ministers, Golda Meir and Levi Eshkol, both were members of kibbutzim. Other examples of leadership from kibbutz residents abound throughout Israeli society.

Many kibbutzim continue to earn their collective income from agriculture, but others have shifted their income base to industry, tourism, and recreation. Despite these changes, it is the approach to health care that continues to retain elements of the democratic ideal initially conceived by the movements' founders based on their social philosophy of "from each according to his ability and to each according to his needs," (Gavron, 2000, p.33).

In much of the world, health care is increasingly unaffordable. This is particularly so in the United States and Great Britain, but not exclusive to these countries. Both nations struggle to deliver increasingly expensive care to their populations. In contrast, the kibbutz maintains a policy of primary health care and supportive philosophical framework that is flexible enough to meet the needs of members and, wherever possible, avoid costly hospitalization or nursing home care. While avoiding hospitalization may not always be possible or even preferable, in the author's experience, members of a kibbutz often may be discharged from the hospital earlier. It is a well-established fact that within a kibbutz there exists a support structure of professional health care workers that can provide appropriate

rehabilitation or recuperative care for members.

This support structure has become more important than ever in light of the enormous burden that random terrorist attacks have made on the hospital and emergency services all over the country. No data is available that provides a residential breakdown of terror victims; however, it is likely that any kibbutz member who has sustained injury from attack will receive follow up treatment through the kibbutz health services. While not necessarily primary health care in these instances, nevertheless, it is a clear example of community care for its members in addition to preventive primary care initiatives taken within kibbutz settings. Both preventive and curative services are undertaken wherever feasible by kibbutz health professionals, providing an important continuity of care to members.

As the cost of health care continues to escalate, the concept of providing more care within communities, especially preventive care, becomes desirable. Not only is it cost effective, but it also relieves burdens on hospital systems and helps build long term relationships between members of a community who require care and the professionals involved in care delivery. While the kibbutz model may not be adaptable to all societies, its fundamental goal is commendable and at least some of the approaches to health care may be suitable in other circumstances (e.g., rural locations). Small country towns may find analogous situations to the kibbutz framework that may be adapted to their own setting. To understand the basis of health care approaches and policy within the kibbutz, it is necessary to have some understanding of kibbutz development, society, and principles.

Kibbutz History and Structure: The Changing Dynamic of Kibbutz and Health Care

The social phenomenon of the kibbutz has been the focus of numerous social studies from a variety of backgrounds. These studies have ranged from the issues of gender to the rearing and education of children. Both Bruno Bettelheim (1969) and Melford Spiro (1975) studied children in two neighboring kibbutzim. Bettelheim concluded that children raised in communal children's houses, where children live and are cared for in a group home by a designated childcare worker, would fail to become achievers in any field. Bettelheim postulated that their social health would be damaged by the overriding need to adhere to the social philosophy of the kibbutz ideology. However, his theories have been disputed and, in some cases, refuted by the achievements of adults who were raised in communal care in the kibbutz system.

Communal sleeping arrangements for children were initiated early in the kibbutz movement and while many kibbutzim have subsequently shifted sleeping arrangements back to the traditional model of sleeping at home within a nuclear family structure, other kibbutzim have held to the model as a fundamental expression of their philosophy. Even in those settlements where children now sleep at home in a more traditional nuclear family arrangement, they continue to be reared during the working hours in group homes and cared for professional childcare workers.

Communal sleeping for children was conceived as both a strategic necessity and a practical arrangement, but was also a logical extension of kibbutz philosophy. Strategically,

children's houses were placed in the center of the settlement, making them the last place that could be physically attacked. This was particularly important in settlements that were at risk of assault. In practical terms, the care of the children by a competent childcare worker ensured that mothers continued to have job equality (adhering to the underlying democratic principles). Indeed, some women in kibbutz have held important positions that would have been curtailed by a lengthy maternity leave to care for children. Other women have chosen to remain in traditional women's roles, choosing to work in childcare, kitchen, and laundry duties. However, the choice fundamentally remains with each woman.

A number of women have chosen to undergo specific training as "baby nurses" who provide such care after completion of a course, often provided by the Kibbutz Movement. Such courses include growth and development content as well as issues such as discipline, child safety, and accident prevention. It is often the baby nurse working in conjunction with the kibbutz nurse who will ensure that children receive immunizations or that illness in children is identified quickly so that they may be isolated until assessment by the kibbutz nurse.

All children receive "well child" care that includes regular weight and height assessment and developmental testing. This is undertaken by the kibbutz nurse in conjunction with the baby nurse and other childcare workers as a team. Findings are then discussed with parents, who are welcome to attend any assessment. Paradoxically, despite the collective responsibility for children, family ties remain high within the kibbutz structure.

Consequently, the care of children has been deemed a matter of the significance that concerns the entire membership, irrespective of an individual's family status (that is, whether or not an individual member has children). As such, the physical, mental, and social health and well-being of the children is viewed as the collective responsibility of the entire settlement. Their care, education, and health are matters of vital interest to the entire community. This is a clear indication of the community's acknowledgement that children are valued by all.

An Ethic of Community Responsibility

The kibbutz must be understood as an intentional and voluntary community framework. All members have consciously chosen to live the kibbutz lifestyle. This deliberate decision on the part of the members sets it apart from other communal societies. Members are free to leave the kibbutz should that be their decision.

Communities that revolve around the ethic of responsibility for each other have developed in other parts of the world, but the kibbutz continues to be a source of intense and ongoing interest. This is primarily true in the study of education and labor division. There has been no comprehensive study of health care to members. This is puzzling, as health and health care needs have always been a fundamental aspect of communal living.

As early as the establishment of the first kibbutz, Degania Aleph, in 1910, it became apparent that the kibbutz ideology and philosophy would need to address health care and all needs of members, including other aspects of life such as economics and education. While differences have always existed within the kibbutz network, they all continue to be inhabited by members consisting of families and singles, non-partnered members, transient

volunteers, and elderly parents of members who are residents. All members choose to be a part of the kibbutz, accepting and adhering to its basic philosophy and principles. This is unlike other communal societies which have, in some instances, been a consequence of dictatorial governments. In such societies, the residents may not have chosen to live in a communal society.

Within this dynamic society there exists a broad range of residents that incorporates all ages and stages of the lifespan, ranging from newborn babies to great grandparents, with a strong family focus. As in all populations throughout the world, each age group tends to have different health care needs. These needs include infant immunisation and developmental screening; antenatal and postnatal care; contraception; work related injury care and prevention (both agricultural and industrial); care of members with chronic illnesses; and dementia care. In recent years, the care of elderly veteran members has been particularly problematic and kibbutz solutions based on the fundamental philosophy have developed to meet these needs.

The issue of care for elderly members in part resulted from the natural aging process of founding members in the older settlements. In addition, there has been a demographic change within the movement characterized by departure of members that began in the 1980s. This has been further compounded by kibbutz youth delaying their return to kibbutz life after compulsory army service and also by a decreased birth rate (Avrahami, 2000). These factors have led to a higher percentage of older members who require more expensive care and a population imbalance, with a higher percentage of the most productive members leaving the kibbutz and decreasing actual income required for expensive care. The Bet Oren affair exemplifies this fundamental problem.

In the 1980s, Bet Oren, like many other kibbutzim, suffered a severe economic crisis, leading to an equally severe social crisis, which resulted in the veteran members being given a choice of moving to another kibbutz or leaving kibbutz society altogether. There was relatively small financial compensation for their years of contribution towards the kibbutz. The Bet Oren affair caused genuine fear and devastation throughout the movement, especially among the older members concerned about their futures (Avrahami, 2000).

Despite the dilemma faced in Bet Oren, other kibbutzim have been caught in an equally difficult predicament in the care of their veteran members. In a number of kibbutzim, the decision has been taken to keep frail and infirm members "at home," including veteran members who suffer from dementia. This has resulted in a considerable cost. In some instances, this has necessitated the construction or renovation of buildings for the explicit purpose of caring for elderly members as well as the cost of additional staff to care for them. Some direction and assistance is provided by a kibbutz nurse. For other members, it may have meant moving to a building closer to the facility, at the very least, on ground floor level, to avoid unnecessary accidents or injury in climbing stairs within residential buildings.

Discussions of building regional centres to care for elderly members has resulted in an emotional debate in which economics is pitted against the principles of kibbutz. This debate challenges its most fundamental code of "to each according to his needs." In this case, the needs of the elderly are borne by the younger members, who are challenged to contribute

more of the general income toward the care of the veterans at the expense of other needs of the community. With increasing populations of elderly members, this issue is likely to continue to provoke debate and challenge the system to provide alternatives that are cost effective but attempt to maintain quality of life, a commendable aspect of the kibbutz attitude towards its elderly members. Furthermore, the underlying principle of collective responsibility for older members, irrespective of blood ties, conveys that the care of the elderly is paramount to the entire kibbutz. That is, all members must take responsibility for the elderly members of kibbutz society. An elderly parent requiring care is not an issue for an individual family to manage. This is clearly linked to the underlying philosophy of collective responsibility, unlike more traditional societies in which family members must deal with the issues of aging parents. In more traditional societies, family members may be faced with the dilemma to leave employment to care for an aging parent or to place the parent in a nursing home. The concept of women leaving their jobs in kibbutz to care for a parent, or to remove the elderly members, is for the most part, an anathema to the majority of kibbutz members and a contradiction to the overall notion of the collective responsibility.

Economic Changes and Health Implications for Kibbutz

Within the last 15 years, Avrahami (2000) observed that kibbutz members have come to terms with some failing within the system. They have lost their sense of economic security and have been forced to take responsibility for their own financial well being. In the case of the founding generations of many of the kibbutzim, they have been forced to come to terms with the painful acceptance that the identity established between kibbutz and its members has been severed. Many have undergone sweeping changes that would have been unthinkable twenty years ago, such as individuals paying for previously accepted services such as dining hall meals, laundry facilities, electricity, and water. Despite these changes, at least one area has been considered as "untouchable," that is, the provision of health care for members. Avrahami (2000) notes in *The Changing Kibbutz*, "care is taken not to privatize health services, education, and social security, which remain the full responsibility of the community," (p. 27).

Kibbutz Hasolelim provides one example of the retention of health care. Despite sweeping changes designed to reorient the kibbutz and its enterprises, its position made clear the importance of providing health care to all members. The position in this case guaranteed "care and rights to invalid or disabled members," (Gavron, 2000, p. 96). Furthermore, services that would continue to be provided by the community included health care. Likewise, Kibbutz Hatzerim, which is an enviable financial situation compared to many other kibbutzim today, has committed to a long standing policy of collective responsibility for health care of members. Their policy decision is to leave health care virtually untouched and members are exempt from any payment for health care. It is clear that, despite some variation in economic circumstances, the kibbutzim are committed to the ideal of providing health care for all members and that this aspect of kibbutz life will not undergo the privatization that has taken place in so many areas of social restructure.

Despite differences that have arisen within the kibbutz system, one can assume that the provision of health and health care will continue to be a collective responsibility, irrespective of privatization that is being implemented throughout the system, and that cost

will be borne as it has been, by the collective community, not the individual member. This constant in a kibbutz world undergoing so many significant changes stems from the initial philosophy that was formed at Kibbutz Degania Aleph in which members accepted collective responsibility for each other in the well known phrase, "From each according to his ability and to each according to his needs" (Gavron, 2000, p. 33). Consequently, the health care and needs of members have become, through this philosophical underpinning, the responsibility of all members of each kibbutz.

While most hospitalizations in Israel are covered by National Health, it is feasible that aspects of hospitalization that might require additional funding are covered by the kibbutz. Two examples include blood units for surgical procedures and ambulance services. Many kibbutzim have purchased an ambulance and have trained drivers who work with the kibbutz nurses in the event of emergencies that require rapid transport to a hospital. Likewise, an arrangement has been with the blood bank services in many kibbutzim where the kibbutz undertakes the provision of units of blood equivalent to ten percent of its population per year. This mutually beneficial arrangement provides any member of a kibbutz services from the blood bank and unlimited units of blood during hospitalization. The kibbutz nurses organise a blood donor drive once or twice a year in conjunction with the local blood bank to ensure that the arrangement can continue to ensure that blood banks have a regular supply of donations. Such an arrangement is indicative of the underlying philosophy, the acceptance that the intentional community takes responsibility for the members' health care needs. In the case of blood donation, it is often the younger members who consistently serve as blood donors to the benefit of any member requiring a blood product. This communal notion defines the kibbutz method of health care philosophy and can be viewed as an example of primary health care, linking ideology and commitment in practice.

Solutions to Health Care Problems: Kibbutz Nursing

Kibbutz nursing encompasses a wide variety of nursing practice skills, including physical assessment, infection control knowledge, mental health assessment, and interview skills that are central to practice within this setting. The kibbutz model addresses both preventive and curative services for all members in every age group. Screening tests (e.g., for cancer or cholesterol level) and routine laboratory specimens relating to acute illness continue to be collected in the kibbutz clinic to be sent to regional Kupat Cholim laboratories for analysis. While some kibbutzim have resident doctors who hold regular surgery hours for members, other have scheduled hours for general practitioners and may arrange for specialists to conduct clinics at private cost to the kibbutz paid for by the collective. Nevertheless, the bulk of the specimen collection and distribution, prescription of medication, initiation of health promotion strategies, and diagnostic clinical judgement continue to be the primary responsibility of the kibbutz nurse along with any emergency intervention.

Additional responsibilities of the kibbutz nurse include preparation of first aid bags for school and youth outings, and preparation of shelters in times of perceived terrorist threats (most prominently, a first aid shelter). Kibbutz nurses are expected to cope with suicides, murders (there are few of these, although they have occurred in recent years), acute injuries, drowning, and acute psychotic episodes, as examples of the breadth of the role expected by

members. Finally, the nurse often prepares a short article for the weekly kibbutz newspaper distributed to all members on a significant issue related to health. This newspaper article may provide details of an upcoming screening procedure or include important information about infection control if an outbreak occurs within the settlement.

Consequently, the role of the kibbutz nurse is varied with considerable emphasis on the ability to make judgements. In addition, the nurse may make referrals to regional services for specialised care such as gynecology, mental health services, and depending on the kibbutz, dental services, if they are not provided within the kibbutz. While in the author's experience, kibbutz nurses have been female, there is no reason why a male would not be acceptable in such a role. Any member, male or female, would approach the kibbutz educational committee for permission and funding to study. The issue of gender would not necessarily become a factor in that decision. Many male kibbutz members are medics who learned these skills during required military service and may be of assistance in emergency situations.

It should be also noted that, while it is preferred that nursing staff have registered nurse qualifications, there may be a lack of such members within a kibbutz and licensed practical nurses may deliver health care. In the author's experience, there has been at least one nurse practitioner in practice in kibbutz. Such preparation would clearly enhance the critical skills necessary for practice and should be encouraged within the kibbutz movement. However, a clear delineation between the levels of nurse is not always readily understood by members and can lead to some confusion as to which services may be provided by which nurse. Overall, there has been a tendency towards flexibility and, in practice, licensed practical nurses may often take on registered nurse functions, if necessary. This is a point of contention that has yet to be fully addressed. It should be noted that continuing education programs are conducted by various organizations for all kibbutz nurses, based on standards of practice as set by the Ministry of Health and linked to evidenced based practice.

Principles of Primary Health Care and Kibbutz Nursing

The Ottawa Charter previously cited provides broad strategies that support the empowerment of communities in their vision of health having its place within that setting. Each of these principles is found in the kibbutz structure and the manner in which health is made a priority in the kibbutz movement. Health policy continues to be formulated through the kibbutz "Health Committee" in which certain principles are clearly articulated in terms of health care provision. Examples of these principles are discussed in this section.

Allocation of Resources

The Health Committee considers allocation of resources. An example of this might be the provision of reading glasses or contact lenses to members. In the past, such needs might have been all encompassing under the philosophy of "to each according to his needs." In today's changing kibbutz structure, there may be limits placed under such a need to avoid unlimited spending. For instance, a member may have to choose between glasses and contact lenses or a limited number per year (as would be stipulated in many health insurance policies), a change related to the privatization strategies being undertaken. While it is clear that all members will never agree to the guidelines established by the committee, the

structure of the kibbutz would still permit any member to challenge a decision made by the committee and ensure a hearing at the most basic level of policy building. Such a challenge would be an unusual occurrence in most health care policy bodies, and in many ways demonstrates a commendable example of true democracy in action.

It is difficult to determine the costs of care due to the demographic nature of individual kibbutzim. Clearly, a relatively new settlement that is composed primarily of young members and families will have different needs than the more established kibbutzim with a higher percentage of aging members. A number of costs are covered by the National Health Insurance. This can include the cost of medication, wound care items, and allied health services such as x-rays, medical care, and hospitalization. The majority of expenses related to health are covered by the insurance scheme. Other items, such as individual blood glucose monitoring equipment, may not be covered. If the kibbutz clinic has a glucose monitor provided by the insurance scheme, from the point of view of the insurer, an additional unit is an unnecessary expense. Such a perspective does not consider the independence of the diabetic member and the kibbutz nurse may argue that the individual should have the use of equipment which would be purchased by the kibbutz. However, the nurse may be placed in a position of having to justify purchase of this equipment, or other costs related to health, to the members of the health committee. These committee members often have no background in health professions. They may not understand the necessity of expenditure, leading to frustration on the part of the nurse.

Privacy

The kibbutz, with its collective structure and philosophy, creates an environment that provides support for members who have particular health care needs. These needs range from nursing services to aged care workers in a number of kibbutzim. A fundamental problem for some ill members of the kibbutz is that their health problems become the "common property," that is, public knowledge of everyone within the settlement. This can be advantageous in terming of recruiting support, however, this knowledge can become a disadvantage as it may lead to undue embarrassment for some members undergoing procedures that would have been kept private and impersonal in another setting. Examples of such may include treatment of sexually transmitted diseases, such as HIV, or infertility. The kibbutz nurse is under considerable pressure to maintain confidentiality when approached by members regarding the health status of the member in question. Consequently, some members may be reluctant to seek early treatment for a problem.

The general consensus is that the kibbutz nurse tends to "know everything" about members long before others. This can be supported by the notion that many members do not approach the clinic for physical care, but view it as a social visit where they can discuss any number of issues. These issues may not be related to physical health, but clearly have a purpose for the member. Members may visit the clinic as often as desired, since there is no charge for nursing services. So well accepted is the notion that the "kibbutz nurse knows everything about everyone," that it has entered into popular fiction in Batya Gur's "Lina Mishutefet," translated as "Murder in a Kibbutz" as an accepted norm in kibbutz society, (Gur, 1994). Clearly, the nurse is in a position to "know" a great deal of information concerning members that she is able to relate back to the framework of health and health care needs. Conversely, this knowledge may lead the nurse to make rapid and erroneous conclusions

regarding a current problem that has propelled the member to seek health care.

Health Care Services

The kibbutz provides a curative service while endeavoring to provide preventive services. Examples of preventive services include immunization of children and adults, prenatal care, and screening tests. The nurse has access to a database and will often urge women to have mammograms for early detection of cancer, while clearly understanding that she cannot force members to do so. Ultimately, the nurse seeks to provide information on the importance of the screening procedure thereby empowering the member to seek care. Ultimately, it is still the individual's responsibility to undergo any screening or preventive procedure and he/she may refuse to do so. A fundamental problem in the kibbutz nurse's role has been the understanding developed over a number of years that curative services have a tendency to take precedence over preventive services, particularly if there is any cost involved beyond accepted funding by Kupat Cholim national health insurance. It should be noted all kibbutz members have automatic membership in the National Health Insurance plan, with fees covered by the kibbutz.

An example of both curative and preventive services may be the identification of a member with an infectious illness. In such cases, the nurse may undertake ongoing assessment of the ill member and the disease process and institute appropriate treatment for a condition (such as hepatitis). Services may also involve screening tests for close contacts, such as family members, isolation of the member with hepatitis, and institution of infection control strategies to avoid the spread of the illness in the community. Consequently, while endeavoring to treat the ill member, the nurse seeks to provide education to prevent further illness. Another example may be a member who has experienced a myocardial infarction. In many instances, this will first be identified by the kibbutz nurse through a rapid assessment of symptoms and ECG. The member would then be transported to hospital for further assessment and care. Upon discharge, the nurse takes responsibility for ongoing care, including medication, laboratory tests, discussing dietary changes with both the member and kitchen staff, and ongoing monitoring of the member's condition.

Health Concerns and Kibbutz Member Contributions

In the role of nurse to the kibbutz, the nurse must possess personal skills in gleaning significant information. One advantage to the nurse is breadth of knowledge about all of the members. The nurse is aware of the personal history, past health history, and other factors that may affect health status (such as family support or, in the case, of some older members, the knowledge that they are Holocaust survivors). Such members may exhibit signs of post traumatic stress disorder and it may be beyond the scope of the kibbutz nurse to manage such conditions. In such instances, care of the member will be directed by a mental health professional outside the kibbutz, however, the kibbutz nurse will work closely with the mental health team and monitor the member's status. Every effort is made to avoid hospitalization of the member if at all possible.

A similar effort is made with regard to members suffering dementia. Wherever possible, members who have been diagnosed with dementia will be monitored and receive supportive care to enable the member to remain at home in a familiar environment rather than

placement in a nursing home. Such care may include an arrangement for a carer to "live" with the member so that there is continual monitoring of behaviour that may include risk to self and other members. Nursing assistants may be utilized to provide care, working under the direction of senior nursing staff. Since work is highly regarded in kibbutz, even members with dementia are likely to work at least a few hours each day, perhaps at tasks that require minimal intellectual ability (e.g., sorting laundry). These tasks valued by the community and can provide the member with an important familiar daily structure and a sense of pride in continuing to be employed at some capacity. In these instances, the nursing assistant will aid the member when necessary with personal hygiene and accompany the member to the communal dining hall for meals to ensure that proper nutrition is maintained. Communal dining provides an important social interaction with other members. This interaction is important not only for the member suffering dementia, but for other members of the community as well.

As a side note, in some kibbutzim, it is acceptable to assign the nurse to duties outside health care as the work roster may dictate. In these instances, it is not uncommon for the nurse to spend a number of hours working in the children's houses or working a shift in the factory in those kibbutzim that are industrialized (an increasing trend in contemporary kibbutzim). Likewise, many nurses will be required to perform guard duty services and assist in agricultural work when harvesting requires extra manpower. By virtue of membership, these variations in role are accepted by the kibbutz nurse. The additional duties are generally met with approval by the membership, as it provides an indication that the nurse is not in a privileged position compared to all other members. However, members may still choose to solicit health advice, despite an obvious delineation of the nursing role, when the nurse undertakes such work assignments.

Problems in the Kibbutz Nursing Role

Models of nursing practice in a number of rural and remote settings may find a number of parallels in practice similar to those experienced in the kibbutz setting. One example may be in any rural setting or small country town in which the nurse is readily identified by the population and approached for health advice outside of the clinic where one would ordinarily expect health advice to be solicited. There may be similar problems, issues, and sources of frustration to rural nursing practitioners, who are likely to live in the community; the delineation of "private life" as opposed to work hours may also be ignored by residents. In the case of the kibbutz, the nurse has the advantage of generally knowing the personal and social history, as well as the health history, of all members. This is likely to be the case in any small country setting.

However, this knowledge is intrinsically problematic. In some instances, it may lead to the nurse making assumptions that are erroneous regarding the presenting problem of the client. The deep personal knowledge may lead to a client withholding information, fearful that it may become fodder for gossip. Likewise, other members will be aware of the client seeking health care and may inquire as to the nature of the problem. This may inadvertently cause the client to avoid seeking health care in matters that are sensitive. In some kibbutzim, this concern has been acknowledged by hiring "outside" nurses as staff for their clinics. Resident member nurses are still required to cover any emergencies outside of regular clinic

hours and it would seem likely that any client matters would become a part of normal handover, thereby negating the client's belief that the matter is known only to the nurse who performed the initial examination.

Secondly, the educational preparation of the nurse may itself be problematic. In some kibbutzim, there may be only one registered nurse, working with a licensed practical nurse. This can lead to the licensed practical nurse feeling pressured to take on responsibility beyond what would be considered the scope of normal practice.

Furthermore, it may often be the case that a new graduate nurse is immediately enlisted to work in the kibbutz health services. New graduates may have little experience in physical assessment and clinical judgment. Yet the kibbutz policymakers often exert pressure on the new graduate to begin work immediately, as the kibbutz has covered the cost of education for the new nurse. Kibbutz leaders consider it reasonable for him or her to be employed within the kibbutz due to their economic investment in study. Patricia Benner (1984) noted that it takes a reasonable amount of time to successfully transit the novice level of practice to the expert level required in many areas of nursing practice. Clearly the role of nursing in the kibbutz is no exception to the concept that Benner described.. Lack of experience can lead to the new graduate's increased feeling of inadequacy in this new role. Likewise, education in primary health care and preparation for such a nursing role may not have been given adequate attention in the nursing curriculum, compounding the new graduate nurse's feelings of inadequacy.

Thirdly, the resident nurse often finds herself on call, in effect, to the members, twenty four hours a day. It is not uncommon for members to approach the nurse during meals, social functions, and during leisure activities for advice on health matters. This becomes a matter of frustration and in some instances, annoyance for all concerned and stems directly from the collective structure of the kibbutz. Such approaches result in the nurse being viewed as available twenty four hours a day, seven days a week. This can lead to the nurse withdrawing from social functions to avoid such encounters. Clear explanation is given to members seeking health advice and assessment that their matter could well wait for regular clinic hours, but in practice, the approaches may continue. This becomes an uncomfortable situation not only for the nurse, but also, for family members who may be nearby. This occurrence, not at all uncommon, interferes significantly with the nurse's family life, a paradox, as kibbutz fosters strong family ties, even in those kibbutzim where children still sleep away from parents.

Lastly, another issue is the care of members' guests. It is common for members to approach the nurse for acute care of guests visiting the kibbutz. In some instances, these may be acute emergencies. In other cases, it may involve providing medication, such as preventive asthma medication inadvertently left at home. Often the matter could wait until the guest returns home, but because the kibbutz health service is provided free of charge, and earlier reference to the importance of kibbutz health services remaining intact, members and guests may well believe it is acceptable practice to solicit the nurse's free and easily accessible services. Another paradoxical situation, therefore, arises. While it is commendable that the kibbutzim continue to provide health care for all members, unlike other areas that now incur charges (e.g., collective meals), the lack of charge for services may devalue the nurse and her services within the community just because they are available without cost. Clearly, the

types of situations described above can lead to burnout for the nurse and frustration in the role.

Addressing Problems in the Kibbutz Nursing

Several solutions have been devised and are accepted in many kibbutzim as acknowledgment of the inherent burnout of the nurse as outlined previously. In some instances, the nurse may apply to the kibbutz administration for permission to work in an outside health facility for a year, or longer if possible. This provides a much needed break, may enhance or update clinical nursing skills, and fosters networking with outside facilities, such as the local hospital.

Other strategies may include permitting the nurse to take a year (or longer) away from the role of kibbutz nurse and work in another area of the kibbutz. If this is not possible, the week may be broken up so that the nurse works only part of the hours in health services. However, the difficulties in delineating the two different areas of work and the propensity of members to approach the nurse in her "other job" may not solve the fundamental stress underlying the request to limit hours in health service.

Other nurses have applied to the kibbutz for permission to study at least part of the week, if not full time. This can be justified by the need to update knowledge and skills. It provides a well deserved break from nursing services and enables the nurse to return to her position, refreshed and armed with new knowledge to better provide health services.

From the position of the kibbutz, more members should be encouraged to study nursing and other allied health professions to provide a rotation in the care of members and relieve the stress of the nursing role. Finally, the kibbutz may choose to hire an "outside nurse," as previously discussed, to relieve the kibbutz nurse from her duties. In some instances, a combination of all of these solutions may be necessary. Ultimately, it is the kibbutz's responsibility to acknowledge the inherent stress in the role of the nurse living within the community and devise a solution that will provide some degree of satisfaction for the nurse without compromise of health care services.

Evaluation and Primary Health Care Goals

Evaluation

Despite intrinsic problems apparent within the kibbutz framework and the role of the nurse, the role and services provided for members indicates that the kibbutz model and philosophy aligns well with the principles of primary health care. It is not at all clear that the rigorous evaluation normally used to measure whether health promotion has been effective takes place at a formal level in a kibbutz setting. This is significant as the formal evaluation process enables nurses to assess how well any program has been implemented and is indicative of client satisfaction, (Hawke, Degeling, & Hall, 1994). While there may be informal evaluation, e.g., individual member feedback, it would also be helpful to maintain a database with statistical rates of participation that would be one measurable indication of success. Likewise, tracking behaviour change, such as dietary behaviour, while difficult,

could be further implemented with the assistance of the kitchen staff. Several important sources of evaluation would be historical comparisons with past efforts, comparisons with such activities in other kibbutzim, and consensus among nursing staff with regard to health promotion activity. An example of this might be the number of women undergoing regular mammograms. In such instances, early detection of breast cancer may enable life-saving treatment. The kibbutz nurse's social knowledge of all members can also foster development of appropriate support for individual families under such circumstances and help them cope with such a diagnosis and ongoing treatment. Furthermore, it is likely to become public knowledge within the kibbutz that a member has been diagnosed with breast cancer, as there will be a clear necessity of shifting work commitments to enable the member to be treated as quickly as possible. This knowledge may encourage other women to undergo a mammogram that would encourage early detection of breast cancer. Likewise, bowel cancer detection programs have been relatively easy to institute in the kibbutz with early detection and treatment having similar goals.

Health Policy Development

In terms of policy development, the kibbutz framework provides an interesting and powerful example of the individual as well as any group readily able to access the health committee as policy makers and enter into a dialogue where previous policy has not met specific needs. Furthermore, the nurse may act as advocate for the member during committee discussions when necessary. While all members' needs may not ultimately be met, a number can be dealt with at the community policy level, a dynamic which is flexible while taking into account the escalating costs of health care. On a more global level, the various kibbutz movements possess considerable political power in their united approach and ability to lobby for all members in terms of health care for their various member settlements. The united movements therefore, provide a potent means of lobbying thereby influencing government policy in terms of health care needs and services.

Creating Supportive Environments

In regards to the concept of creating supportive environments, the kibbutz framework is well disposed on some aspects. An example is the care of the elderly in which veteran members are supported in their home environment, or where not possible, are moved to a facility within the kibbutz to care for them. This enables them to remain in an environment that is familiar with family and friends able to visit often if the elderly member is unable to use the kibbutz facilities such as the communal dining hall. It provide an important contact point for all generations to mix, an aspect of life that is increasingly difficult in western, mobile, urban societies in which grandparents and grandchildren do not always get the opportunity to socialise and learn from each other. However, the very notion of immediate support engendered by the kibbutz can also create unnecessary dependence. An example of such a situation may arise with a member who has been newly diagnosed with diabetes. The kibbutz nurse will initially conduct all tests that measure glucose levels and provide appropriate health education and medication. Inadvertently, this may create a dependence that would not be as likely for other clients with diabetes in other locations as they would be more inclined to master the skills necessary for independent life. Likewise, the kibbutz health committee may see the purchase of additional glucose testing equipment for the individual as unnecessary expenditure as the equipment is available at the clinic.

Consequently, the framework of the kibbutz may create unnecessary dependence by virtue of its philosophy and social framework. Likewise, this impacts on the development of personal skills and taking responsibility for health at the individual level and it is a serious criticism of the framework in terms of individuality.

Community Action

It is clear that the kibbutz nurse and philosophy of the kibbutz fosters community action. Members can and do identify health needs and take action appropriate to the situation. Examples include infectious illness among the children in which the kibbutz nurse works with the childcare workers to prevent the spread of illness and provide supportive care when necessary. However, the nature of work in the kibbutz and its deep import on all members also creates serious issues in terms of exposure to infectious disease. If a child requires isolation, the only options are to keep the child at home (in the case where children do not sleep in a collective children's house, thereby creating a gap in the work roster of the attendant parent), or to isolate the child in an infirmary, if the kibbutz has such a facility. In the case of collective sleeping of children, an infirmary may be the only reasonable option or creation of a temporary isolation area within the children's houses, a difficult isolation to impose and maintain. Irrespective, the close contact of all members can lead to considerable problems in such a case and a rapid spread of infection.

Developing Personal Skills

Clearly the nurse in a kibbutz faces a number of challenges. The nurse must possess considerable personal communication skills. Tact and adherence to strict confidentiality must be maintained and this can be difficult in such a tightly knit community. Furthermore, nurses need to employ skills that encourage prevention of illness through behavioural changes and model health behaviours themselves. In some instances this can be a challenge, where the nurse may recommend a change in employment for members. For some members, this can be interpreted as a dramatic change in perceived status within the community.

Reorienting Health Services

In recent years, there has been a concerted effort to provide more preventive care within the kibbutz framework. Such preventive work includes immunization of adults and children. This is a significant issue as members may work in agriculture and industry and the immunization of adults may become a factor in preventing further harm in the event of injury. Other initiatives include bowel cancer screening programs offered within the kibbutz clinic; reminders to women who require periodic mammograms, PAP smears, and other screening procedures; and developmental testing for all children. Health education may be provided at the individual or group level, depending on the nature of the issue. The health of the children may be an issue discussed with all childcare workers and parents, while occupational health and safety issues may relate only to specific workers. In these instances, health literature may be tailored to specific requirements of the individual or the group. As such, the nurse serves as a resource to its members and actively involved in health education, a significant undertaking that is aligned with primary health care strategies,(Dean & Cameron-Traub, 1994).

Conclusion

While there are obvious issues, such as "burnout" of the kibbutz nurse and the difficulty in maintaining a balance between professional hours and leisure time, a significant responsibility is undertaken by most kibbutz nurses to anticipate and provide health services for all the settlement members. The role of the kibbutz nurse is challenging and complex. The priority of preventive care may not always be considered by members to be as important as acute care. Nor may they see the link between prevention and acute care. Nevertheless, the nurse is an exemplar of primary health and works within the principles of the Ottawa Charter. The diversity of the role is a challenge and may lead to curative care taking precedence over preventive care.

Despite many social changes that have taken place in the kibbutz during the past decade, the nature of kibbutz, its social structure, philosophy, and intention make it clear that health and health care will continue to remain the responsibility of the collective in terms of all members. The kibbutz is not likely to relinquish this responsibility and place the burden on individuals. While the kibbutz model may not be adaptable for all communities, it does provide a significant example of a flexible and practical framework with ideas that can be adapted for rural communities internationally. Notably, in a world where increasingly, responsibility for health care has been shifted onto the individual, the kibbutz adheres to its original philosophy of collective responsibility and caring about and for each other, a social ideal that has not eroded with time. The idealistic goals of the founders of kibbutz are still apparent in the underlying sense of community and responsibility toward each other as human beings. This attitude may be found in rural towns in a number of countries, where at least some of the approaches to health care that are utilized in kibbutz may be adaptable.

This transfer of principles that encompass community action can be illustrated by a new concept in Israel based on kibbutz philosophy. Small "urban kibbutzim" have been established recently within Israel. These involve caring behaviours toward members of the community and establishment of a support structure within a small neighborhood. With true community engagement, at least some of the principles of the kibbutz philosophy may be suited to other locations. In turn, this has potential to lead to more care delivered within the community and decreased cost to overburdened health care systems in so many western countries. Nevertheless, it must be acknowledged that many kibbutz nurses do experience burnout; it is not uncommon for them to request a relief from a twenty four hour a day job that is physically and emotionally demanding.

Despite the lofty goal of "health for all by the year 2000," this ideal has not been achieved in many instances. The kibbutz philosophy, and its trust in its basic framework engendered in its nurses, has met the criteria evoked in the Ottawa Charter. This framework may provide examples of health care delivery for other communities and lead to better care for all.

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