Kingdon's streams model and Political Entrepreneurship: the case of the dying patient law in Israel/ Michal Neubauer-Shani and Omri Shamir

Draft-do not cite

1. Introduction

The issue of dying with dignity has gained broad public resonance in recent decades due to technological developments that have steadily raised average life expectancy, and the deepening internalization of liberal rights discourse in society. Along with these developments, the involvement of institutional entrepreneurship in policy change has been increasing too. Some countries have already regulated dying with dignity in various ways (for example, Oregon legalized assisted suicide in 1998; the Netherlands legalized active euthanasia in 2001). Nevertheless, until 2000, this issue was not regulated in Israel, leaving it in the hands of the court system. That year, Israeli Health Minister Benizri announced the establishment of a public professional committee to compile a comprehensive bill on the matter, which led to a process of thorough legislation that was concluded at the end of 2005, when the Dying Patient Law underwent a second and third reading in the Israeli Parliament (Knesset).

The arrival of the "patient nearing death" issue on the policymakers' agenda invites a fascinating examination of policy entrepreneurs' crucial role in this process. Based on the literature addressing entrepreneurship in politics and policy, and using John Kingdon's agenda-setting model (1984), this chapter presents an analysis of the process by which this issue came to be regulated, led by policy entrepreneurs emulating Kingdon's model. The state of Israel is defined in its declaration of independence and in its basic laws as "Jewish and democratic", but the operational meaning of this unique combination was never agreed on, thus bringing about serious disputes. In Jewish religious law, human life is sacred, infinite and is not given to

division or relativity. Over the years, this meaning of Jewish law penetrated into the legal system in Israel and manifested in various laws. In such circumstances, policymakers usually prefer non-decision, which hinders policy change and thus offers extreme challenges to entrepreneurs.

While Kingdon's model was developed in the American context on the basis of local data, this chapter adds to the empirical literature on its use in different political contexts. Furthermore, it highlights policy entrepreneurs' role in the public policy process, focusing on the agenda-setting phase.

The chapter is organized as follows. It opens with a discussion of policy entrepreneurs in political science and policy studies. Kingdon's discussion of policy entrepreneurs is then presented, accompanied by the streams agenda-setting model, followed by a brief discussion of the development of the issue and its current status. The second section analyses the case of the dying patient act, while differentiating between the three policy entrepreneurs and the three streams. The last section offers conclusions and a summary.

This study used qualitative methods for an empirical examination of a theory-guided case study, which is "explicitly structured by a well-developed conceptual framework that focuses attention on some theoretically specified aspects of reality and neglects others" (Levy, 2008, p. 4). The reason for choosing this specific issue is that in Israel, where there is no separation between religion and state, the issue of the dying patient is even more complex than elsewhere. These circumstances provide a unique opportunity to highlight institutional entrepreneurship in a challenging arena. The data in this study were collected using two tools. First, data were collected through a series of semi-structured interviews and from existing sources – written or online. Twenty interviews were conducted in face-to-face meetings with respondents

identified by convenience sampling. Some of the respondents were asked to recommend others who could expand upon or add to the information that emerged during their interview (snowball sampling). This method was beneficial because it allowed the researcher to focus on the important issues that were being investigated, while simultaneously leaving space for elaboration on new issues that emerged, but might not have been noted previously. Hospital administrators, doctors, a former director of the Ministry of Health and Knesset members past and present were interviewed. The data were analysed qualitatively through major themes emerging from the interviews, focusing on each actor's interests. Additional data included protocols from the committee for formulating a bill for the near-death patient, articles and reports from daily newspapers and websites, reports from the State Comptroller and court judgements. These sources enabled the mapping of the relevant actors for analysis of the case study, added and completed data that did not emerge in the interviews, and served the purpose of cross-referencing data that emerged in the interviews with other existing data sources. Combining the findings from two separate sources of information at the end of the process allowed in-depth analysis; it gives a broad and comprehensive picture of the reality and enables one to derive broader insights.

2. Policy Entrepreneurs and Institutional Change: Kingdon's Theory of Streams

Kingdon (1984), who attributes policy entrepreneurs ("surfers waiting for the big wave") a critical role in putting issues on the agenda, points to three categories of characteristics which enable entrepreneurs' activity: they have some claim to being heard; they are known for their political connections or negotiating skill; they are

persistent (Kingdon, 1984). Kingdon aimed to understand "not only why the agenda is composed as it is at any one point in time but how and why it changes from one time to another" (1995, p. 3). According to his theory, two groups of factors may influence the agenda-setting process. The first is the participant group, which includes the president, Congress, bureaucrats in the executive branch and various forces outside of government (including the media, interest groups, political parties, academics, researchers and the general public). The second group comprises the process elements (streams) by which agendas are set and alternatives specified. This group includes three processes: problem recognition, generation of policy proposals and politics.

In the first process, there is the inexorable march of problems pressing on the system. Various factors might heighten awareness of a problem; for example, a crisis or dramatic event. The second process involves the gradual accumulation of knowledge and perspectives among specialists in a given policy area, and the generation of policy proposals by such specialists. There is a long "softening-up" exercise in which ideas are floated, bills introduced, speeches made, and these undergo a selection procedure in the policy community. The third process includes swings of national mood, vagaries of public opinion, election results and changes of administration. The streams of problems, policies and politics are independent and little related (e.g., policy proposals are developed according to their own incentives and selection criteria, whether or not they are solutions to problems or responsive to political considerations). Political events take place at their own tempo and schedule, regardless of proposals or problems.

Kingdon wrote that partial couplings between two of the streams may occur: "solutions to problems, but without a receptive political climate; politics to proposals, but without a sense that a compelling problem is being solved" (1995, p. 202).

Governmental agendas (lists of subjects to which governmental officials are paying serious attention) can be set even in a single stream – either the problems or political stream. For example, officials can pay attention to an important problem without having a solution to it. But, "the probability of an item rising on a decision agenda (a list of subjects that is moving into position for an authoritative decision, such as legislative enactment) is dramatically increased if all three elements are linked in a single package. Conversely, partial couplings are less likely to rise on decision agendas" (Kingdon, 1995, p. 202).

The separate streams converge at certain critical times. Solutions become joined to problems, and both are joined to favourable political forces. The greatest policy changes grow out of this coupling, which is most likely when policy windows (opportunities for pushing proposals or conceptions of problems) are open. According to Kingdon, in this agenda-setting process one can detect residual randomness and planning by one or several policy entrepreneurs. Their most prominent and continuous activity is softening up the public, experts and the policy community, where they raise their ideas as experimental balloons, receive responses and improve them. Simultaneously, they play a major role in coupling the problem stream to the policy stream, and then coupling these to the politics stream. Policy entrepreneurs appear again when the policy window opens and they try to promote their proposals. To a great extent, the coupling of all three streams depends on the appearance of the right entrepreneurs at the right time.

This study is based upon Kingdon's model (1984), which serves as a reference point for many political scientists. One of the reasons for the success of the multiple-streams framework is that "issues have grown even more complex and politically more contestable … governments in all advanced democracies often do not fully

understand the problems they have to deal with and they do not know if the policies they choose will solve the problems at hand" (Zohlnhofer & Rub, 2016, p. 3). Thus, rational problem-solving models are highly unconvincing. Conversely, the multiple-streams framework starts out from these conditions. It opposes the notion of events proceeding neatly in stages, steps or phrases, as expressed, for example, in Down's (1972) issue attention cycle, due to the impossibility of identifying them in a complex political process.

At the same time, criticism had suggested that the model is characterized by overgeneralization and amorphousness, impairing its ability to explain the agenda-setting process (Considine, 1998; Mucciaroni, 1992; Stone, 1989). That is, it does not provide details of the methods which the various actors use, but rather contents itself with noting their respective resources and sources of empowerment (Baumgartner & Jones, 1991). Moreover, the model does not recognize the influence of specific factors on various policy issues, thus reducing its applicability to different areas of public policy. Nevertheless, there has not yet been a systematic attempt to assess the potential of such scholarship. **Recently,** Zohlnhofer and Rub (2016) brought together a group of international scholars to assess the strengths and weaknesses of the framework from different angles. They systematically and empirically explored the framework's potential in different national contexts (since it was only illustrated in the US) and in different policy areas. Consequently, the focus of this chapter is to provide a complete explanation of the agenda-setting process and to gain a deeper understanding of the factors influencing the positioning of the different state-religion issues on the policymakers' agenda in the Israeli political context.

3. The Right to Die with Dignity: The Israeli Case

In December 2005, the Dying Patient Act passed its second and third readings in the Knesset. Until then, no specific law had regulated the issue of the right to die with dignity. Consequently, between 1987 and 2002, approximately 20 cases were deliberated in the district and supreme courts of Israel. Throughout this period, no continuum of events relating to the issue could be observed. The issue would appear in the headlines every few months, usually following a court petition by a terminally ill person. This seldom led to a discussion by any of the Knesset committees and even more seldom to a bill, both of which would quickly be dropped. This indicates that the issue was not receiving any "serious attention" from policymakers and thus did not make it onto their agenda.

The major change in the issue's position at the policymaking level occurred at a seminar held in February 2000 at Hadassah Hospital in Jerusalem, when the Minister of Health Shlomo Benizri announced the establishment of a 59-member public governmental professional committee to compile a comprehensive bill on the matter (Barilan, 2013; Steinberg & Sprung, 2006). On 18 January 2002, the Dying Patient Act was submitted to the Minister of Health and was passed in December 2005.

The Dying Patient Act (2005) allows a person to give preliminary instructions that will guide his/her treatment in the event that he/she is dying and not competent to refuse treatment. The legal definition of a dying patient is a "patient, for whom the doctor is responsible, [who] has determined that he suffers from an incurable medical condition and that his life expectancy does not exceed six months, even if medical treatment is administered" (Section 8a). The premise of the law is that all people want to live, and as long as it has not been proven beyond reasonable doubt that the patient does not want his life prolonged, it is necessary to continue treating him (Section 4).

There is nothing in the law permitting a deliberate action to kill, or any action that causes death; for example, administering a fatal drug or aiding suicide (Sections 19–20). The law prohibits stopping the provision of "continuous medical treatment" that has already begun (e.g., taking away a respirator), since the termination of continuous treatment is seen as an action that could cause the patient's death. However, the law allows a physician to abstain from providing a new "cyclical medical treatment", such as dialysis or radiation (Section 21).

The history of the evolution of this issue on the agenda is unique. Two decades passed between it first making the headlines and its regulation through a comprehensive, basic law. Although the enactment of the law was a very important step, it can be defined as a finished but not a completed task since the law that was passed is not being enforced. Moreover, since the law does not apply to people whose life expectancy is estimated at more than six months, it excludes certain groups of patients, such as patients diagnosed as being in a vegetative state. Consequently, the potential for the issue to be placed on the agenda once again is twofold and stems from two factors: the desire to enforce it and the desire to widen its applicability.

4. Policy Entrepreneurs: The Power Inside and Outside of the System

Kingdon points to different possible couplings of two streams, each capable of bringing an issue to the policy agenda. In fact, this result can be reached in a single stream; for example, officials may give an issue serious attention without having any solution or a suitable political groundwork, but the chances of an issue being placed on the decision agenda are much higher when all three streams are coupled together, and when no constraints limit the motion. This is more likely to occur when one or

more policy entrepreneurs are active in the policy venue. In the case of the Dying Patient Act, three such actors were found to be conducting the processes.

The first policy entrepreneur of the Dying Patient Act was an interest group, LILACH (The Right to Live and Die with Dignity), which has been operating intensively and continuously since 1987. It is noteworthy that this secular-oriented interest group was and still is the only one which deals with this issue. LILACH has an organizational structure characterized by a clear, fixed division of functions and powers, with branches nationwide (www.lilach.org.il). At the time the law was legislated, LILACH numbered about 10,000 members; since then, 7,000 more have joined. The majority of members are secular, live in cities all over Israel, and are well acquainted with the Western liberal rights discourse (Bina Divon, interview 2005).

The group's fields of activity are very diverse, and it was active and prominent in all three streams. First, in contrast to Kingdon's findings regarding interest groups' weakness in the process of problem recognition, LILACH was one of the most significant actors in motivating policymakers to give serious attention to the issue. It has operated a permanent lobby at the Knesset, focusing on Members of the Knesset (MKs) who did not have a firm opinion, or did not have enough knowledge about the issue (Bina Divon, interview, 2005). LILACH was not always pro-legislation; it had also considered leaving the matter in the hands of the court system. In the late 1990s, however, LILACH decided to support a legislative process (Bina Divon, interview, 2015). Initially, it had wanted to legalize active euthanasia or assisted suicide but, realizing that this was an unachievable target, it was willing to cooperate with a more moderate option. LILACH is also an active participant in deliberations held by the Knesset Health Committee and Constitution Committee, where it has the right of speech. It was involved in formulating all relevant bills, beginning with the Patient's

Rights bill, advising and making proposals. Last, to influence public opinion and the political atmosphere, it has been presenting the topic in different venues, including medical schools and nursing schools, homes for the aged, community centres, etc. In addition, in the years before the law was passed, whenever a case relating to the issue arose, the group contacted the media, requesting that it be reported and sending information to the media about events in Israel and abroad on the subject.[1]

Professor Avinoam Reches, the second policy entrepreneur, is a well-known neurologist, and at the time was head of the Israel Neurology Association (since 1999). He was active from the very beginning in making the public and policymakers aware of the need to regulate the issue, and is pushing for an extension of the law. The regulation he seeks is physician-assisted suicide, a bill enacted for the first time in Oregon in 1998. To that end, he has been writing newspaper articles and professional academic papers, in addition to giving lectures to various audiences. Prof. Reches was the initiator and organizer of the conference at which it was decided to establish the public committee.

The third policy entrepreneur was the Minister of Health during the 15th Knesset (1999–2001), Shlomo Benizri, a member of the Ultra-Orthodox party Shas. He was made aware of the issue by LILACH, the media, Prof. Reches and his advisor Rabbi Dr Mordechai Halperin, who all emphasized the importance of regulating the issue as well as the ability to do so. In light of the extreme opinion of Prof. Reches and LILACH, Minister Benizri decided that he should be involved in the process. In addition, he felt that an issue of such magnitude, one which involves human suffering, should be dealt with and not ignored (Shlomo Benzri, interview, 2015). As a first step,

[1] In 2001, the tables turned, and now it is the press which turns to LILACH whenever a relevant case arises.

he consulted with Rabbi Ovadya Yosef, the top Sepharadi religious authority, who was himself interested in the issue, and received his approval to set up a legislation process.

Kingdon explains that the entrepreneur's activity comprises two tasks: advocacy and brokerage. When there is more than one entrepreneur, each usually specializes in one kind of activity. In this case, LILACH and Prof. Reches were heavily engaged in promoting their ideas and making relevant actors aware of them (Bina Divon, Interview, 2015; Avinoam Reches, interview, 2015). Two of the three characteristics that contribute to entrepreneurs' success are reflected in their activity. First, both have some claim to a hearing: Prof. Reches is an expert in the field and LILACH has legitimacy to speak for others. Second, both are willing to invest large and varied resources. LILACH is a volunteer interest group whose only income is the annual membership fee. Despite this, it always worked intensively and demonstrated outstanding persistence although during its first decade it was delegitimized by large parts of the public, media and policymakers, and its own membership was sceptical about its chances of success (Bina Divon, interview, 2015).

Prof. Reches also worked on a voluntary basis and, by virtue of his senior position at the hospital, he was also a member of various public committees. In addition, he promoted his ideas through the media and professional journals, lectured on any podium offered to him and cooperated with LILACH, by providing medical consultation and lecturing on its behalf whenever needed. While they were focusing on advocacy, Minister Benizri, the third entrepreneur, was focusing on brokerage. As an experienced politician, he had political contacts and was known for his negotiating skills, which he used to build a consensus. Like LILACH and Prof. Reches, he also

had a claim to a hearing, deriving from his authoritative position in the decision-making process.

5. Establishing the Public Committee and Formulating the Bill: Streams, Windows and the Decision Agenda

In this section, we describe the three streams in the context of the Dying Patient Act in Israel. The presentation of the different actors who took part in placing the issue on the agenda is integrated into these processes.

5.1. The Problem Stream: Problem Recognition Process

According to Kingdon (1984), there are policy fields in which a focusing event is necessary to make policymakers aware of a problem. In others, such as health issues, the aggregate of private events may be sufficient. In the case of dying patients, both strategies of problem recognition were employed. Some 20 cases were discussed in the court system from 1987, and all were covered by the media (e.g., CA 506/88 Yael Shefer vs State of Israel, ruling 1141/90 Benjamin Nachman Eyal vs Dr Wilensky). Generally speaking, the court system tended to avoid ruling on the matter, since it involves basic discussions over issues which are not judicial *per se*. However, regarding decisions over specific cases, the district court's verdicts were autonomy-oriented, while the Supreme Court rulings emphasized the value of life.

Ruling 1141/90 Benjamin Nachman Eyal vs Dr Wilensky was a historical precedent in two senses; first, for the first time a verdict was given in the course of a direct and fundamental discussion of a near-death patient's right to refuse medical treatment. Judge Uri Goren wrote at the time that when medical treatment offers no

real chance of improving the patient's condition, then "the principle of the sacredness of life is not that sacred" and if the doctor responds to the patient's request to die, the attorney general will not indict him. Second, for the first time the verdict was in favour of the petitioner, the patient.

Court ruling 2242/95 Itai Arad vs Clalit HMO and others was given exceptional intensive media coverage and alarmed medical and ethical communities. Arad, a former navigator in the Israeli army, was suffering from ALS(Amyotrophic lateral sclerosis**)**; in 1996 he appealed the district court to have the right to end his life. Even though Judge Moshe Talgam (known for his active pro-euthanasia attitude) had ruled that his request must be respected, Arad's physicians refused to implement the order and took life-prolonging actions instead (PEG - Percutaneous endoscopic gastrostomy, Tracheostomy). Two years later, Arad contacted a neurologist from another hospital, Prof. Reches, who had met him before the court ruling was given, and asked for his help. Prof. Reches informed the CEO of Hadassah Hospital and called a meeting of the hospital ethical committee, which had requested a renewal of the court order. Judge Moshe Talgam ruled that the attending physician should decide. Prof. Reches disconnected Arad from his ventilator and he died 23 hours later. Prof. Reches did not ask for anonymity and was willing to be prosecuted for actively causing his death. Following this event, hundreds of people signed supportive letters and the Minister of Health, Joshua Matza, announced the establishment of a special ethics committee which would decide on cases of dying patients, while another committee was supposed to set directing rules for these cases. The second part of the directive was never implemented.

Another salient, precedent-setting ruling was passed by Judge Moshe Talgam (10403/99 Lubetzky vs Clalit HMO and the attorney general) giving a directive to

actively bring about the death of an elderly woman in a "vegetative" state, by disconnecting her from an artificial feeding device. The Attorney General appealed against the ruling to the Supreme Court, arguing that from a medical viewpoint, the elderly woman was not terminally ill. Although the Supreme Court accepted the case as presented by the appellant, the matter did not end there. The Supreme Court then called on the Knesset to regulate by law the circumstances under which terminally ill patients could be cut off from resuscitation devices. In the same year, there were two incidents of terminally ill patients committing suicide, which were followed by doctors and lawyers calling for legislation to prevent future suicides.

Another event which took place in the political venue contributed to the process of problem recognition. The Patient Rights Act (1996) grants any patient the right to refuse medical treatment. Yet a doctor may give such a treatment without the patient's consent if the latter is in a life-threatening condition and it is very probable that the treatment will improve his condition significantly. The Act was approved but with the omission of the section on refraining from giving life-prolonging treatment to near-death patients. Opinion on the reason is divided; according to one view, the religious parties objected to the section's inclusion due to the upcoming elections (Bina Divon, interview 2015). Another explanation of this omission is LILACH's refusal of such a moderate version, which might have closed off the opportunity to bring the issue onto the agenda once again and legalize active euthanasia (Mordechai Halperin, interview 2015). One way or another, the controversy regarding the inclusion of this section was covered thoroughly by the media and made other MKs realize that the near-death patient issue was important and deserved their serious attention.

According to Kingdon's findings, the media plays a secondary role in the problem recognition process in the US, choosing whether to broaden the attention given to an issue already raised by other actors, or to ignore it. In the case of the dying patient issue in Israel, the media chose to give added volume to each related incident by covering every detail and publishing opinion articles throughout the period up to the establishment of a public committee in 2000 by the Health Minister Benizri (Neubauer-Shani, 2007).

Several MKs also contributed to the problem-recognition process in the years preceding the establishment of the public committee. Religious MKs were not especially active in raising the issue for discussion in the plenum. They raised one parliamentary question (considered a relatively weak parliamentary tool) while secular MKs raised a motion for the agenda and introduced a bill. Neither deliberation on the issue in the Knesset plenum followed the typical format of disagreements on the relationship between religion and state. Instead, the initiators used arguments that stressed the urgent need for legislation on such a complex and sensitive issue, while also stressing consensus and the fact that the complexity of the issue did not stem from differences of opinion between religious and secular. Other participants in the deliberations also used this kind of argumentation (Neubauer-Shani, 2007).

Discussing the bureaucrats' role in this stream creates a distinction between different levels of bureaucracy; first, civil servants in the Ministry of Health were indifferent to the issue and therefore neither took part in the process nor opposed it. Second, the interest of hospital administrators and department heads is to maintain routine within the system as far as possible. Consequently, regulating the dying-patient issue was desirable for them because it would ensure uniformity of treatment, and would avoid cases being brought before the media and undesired court cases. This

second group of actors was only sporadically active, giving a few interviews to the media and infrequently writing on professional platforms (Ron Arnon, interview 2013).

Regarding street-level bureaucrats, two groups of doctors were found: young, inexperienced doctors who want precise instructions that avoid the need to exercise their own judgement in each case, and experienced physicians who see an imprecise framework as better for their activity. Of course, this distinction is not all-inclusive, but it does represent the majority of doctors (Ron Arnon, interview 2013). These young doctors are not in a position to take public action so they did not contribute to the process (Avraham Steinberg, interview 2013; Boaz Lev, interview 2013; Charles Sprung, interview 2013). Furthermore, former MK Anat Maor, who presented her bill on the subject, indicates that there was a lack of interest among doctors, and MK Haim Oron, who served as chairman of the lobby for medicine, suggests that the bureaucrats of all three levels showed no interest in it (Anat Maor, interview 2013; Haim Oron interview 2013).

5.2. The Policy Stream: Looking for Policy Alternatives

Throughout the period between the late 1980s and the establishment of the public committee, only two private bills came up in the Knesset Commission for Constitution, Law and Justice, both in 1999. The first was The Right to Die with Dignity bill by MK Avi Yehezkel, which gives the near-death patient the right to sign a document that would prevent life-prolonging medical treatment. The second was an amendment to the penal law (The Right to Decide on Life-Prolonging) by MK Anat Maor, which focused on the legal protection for doctors who avoid giving life-prolonging treatment to the near-death patient. In 2001, both bills were combined into

a single one which passed its first reading, but was later dropped, due to its promoters' retirement from the Knesset (Public Affairs Committee Report for the Near-Death Patient, 2002). Yet the bill's promoters were not the only actors active in generating alternatives for a solution. Prof. Reches and LILACH contributed by advising the Knesset Health Committee and Constitution Committee and other MKs and by softening up the public and policymakers (through writing and lecturing). In addition, policy community specialists from different disciplines (law, medicine and ethics) were active in the selection of the policy proposals.

5.3. The Politics Stream: Swings of Political Mood

During the 1990s the religious-secular rift was deepening due to several factors, such as the mass immigration of non-religious Jews from the former USSR. One of the factors most influential in this socio-political process was the adoption of the attitude of "Judicial Activism" by the court system, headed by Judge Aharon Barak (Gavison, Kremnitzer, & Dotan, 2000). The Ultra-Orthodox sector was not pleased with this change and felt that the legal system was trying to delegitimize them and weaken their influence. The distrust felt by this sector of society led to an escalating antagonism towards the court system, climaxing in a mass demonstration initiated by Ultra-Orthodox religious leaders in 1999.

Another factor that deepened the rift during the 1990s was the constant increase in the electoral power of the Ultra-Orthodox party, Shas, which hit its peak in the 1999 elections at the expense of the moderate religious parties (Guttman, 1996; Cohen & Zusser, 2003). Simultaneously, and probably as a backlash, the anti-religious parties were also becoming stronger. Thus, in the 15th Knesset, 43 of 120 members (in comparison to 32 in the 14th Knesset) represented either religious or anti-

religious parties. This rift was also reflected in the composition of the governing coalition, 45% of whose members (in comparison to 34% in the former government) came from these parties, including Shas. Naturally, the more the parliament and/or the government includes parties whose platforms focus on the issue of relations between religion and state, the more fertile is the ground for raising the issue on the agenda.

The 1990s brought also a tremendous change in the concept of human rights and their status in the Israeli legislative and judicial systems. The constitutional revolution, headed by Aharon Barak, president of the Supreme Court and supreme court justice, started with two basic laws in 1992 which established the right to dignity as part of the material constitution of Israel (see e.g., Gavison, 1997; Kretzmer, 1996; Meydani, 2011; Sapir, 2009). The Supreme Court determined that existing laws must be interpreted according to the principles of the right to dignity and liberty. This Israeli revolution was part of the liberal tendency of all Western-democratic countries to focus on individual and human rights (e.g., the Human Rights Act enacted in the United Kingdom with the aim of incorporating the rights contained in the European Convention on Human Rights into the state law), which led to the centrality of the right to autonomy in the social and political discourse. Consequently, the doctrine of informed consent was developed, gaining professional and public attention during these years (see, e.g., Gostin, 1995; Wear & Moreno, 1994).

These developments led to a change from a paternalistic attitude to an autonomy attitude in medicine (Rehbock, 2011; Taylor, 2014), particularly regarding the end of life issue (Billings & Krakauer, 2011; Turner, 1996). The requirement for informed consent had already appeared in Israeli rulings of the 1960s; nevertheless, the attitude which emphasizes the patient's right to autonomy developed only two or three decades later.

On the other hand, the value of life in Jewish religious law is sacred, infinite, and not subject to division or relativity. It is a value in itself, whose sanctity stands above almost all other commandments (Barilan, 2003; Yakubowicz, 1965; Steinberg, 2003; Toktz'inski, 1947). Over the years this interpretation of Jewish law has penetrated into the legal system of Israel and received expression in various laws. For example, one Israeli law is actually entitled "Do Not Stand Idly by thy Neighbour's Blood" (1998) and states that the duty to save life is a legal obligation, not just a moral one as it had been considered previously.

Public opinion is thus comprised of two contradicting dimensions. Yet careful attention should be paid to the extent to which the sanctity of life is expressed. Apart from a few cases, when the family of a terminally ill patient appealed to the courts to give specific help to their loved one, the general public has remained indifferent (Haim Oron, interview 2013; Anat Maor, interview 2013). This can be attributed to the public's not wanting to deal with an issue connected to the termination of life. In the words of former MK Haim Oron, who served as chairman of the public health lobby in the Knesset, there is an "irrational fear of dealing with this stage of life, which does not come from specific religious beliefs, but from tradition and cultures which large segments of the population share" (Haim Oron, interview 2013).

The media also play a role in creating public opinion by publishing articles that influence and shape prevailing trends. In this case, we see articles aimed at having the issue reach the decision agenda by emphasizing the urgent need for regulation (the terrible helplessness of the patients, their families, and their doctors), but without presenting it as part of the debate on the relationship between religion and state. That is, reporters warned about the seriousness of the problem, but did not stir

up political disputes, thus creating the impression that the issue could be resolved through regulation (Neubauer-Shani, 2007).

The streams described above were accompanied by the action of three policy entrepreneurs which tried to influence the process so that the policy outcomes will be the one that each of them supported. LILACH was involved in all three streams. As Kingdon argues, entrepreneurs try to push their proposals and to make couplings throughout the process, whether they recognize a policy window or not, relying on luck (Bina Divon, interview 2015).

Prof. Reches, too, acted as an advocate through involvement in all three streams, but when he thought about coupling all three streams together at the conference he organized, he waited for a suitable moment when the discourse has moved far enough from the very emotional case of Itai Arad (Avinoam Reches, interview, 2015).

Minister Benizri, as a member of the Shas Ultra-Orthodox party, was motivated by fear of the Supreme Court and its alleged anti-religious rulings. Thus, he was determined that these issues would not be decided by the judicial system, but by a law which would be in accordance with Jewish law. Another motive for Benizri's involvement in the legislation was his concern that the two private bills proposed by MKs Yehezkel and Maor in 1999 would be passed (Shlomo Benizri, Interview, 2015). Benizri chose Prof. Avraham Steinberg, an observant Jew and a well-known neurologist and ethicist, as an entrepreneur to engage in brokerage and to head the committee. Deciding on a legislative procedure was beneficial for Benizri in two ways: first, he showed himself to be a liberal and, second, he brought about a law which would significantly limit the court's involvement in the matter.

Examining the different actions and factors within the three streams reveals that some were not intentionally directed at engaging the legislation process; for example, the constitutional revolution or the composition of the Knesset at the time. This emphasizes that the presence of entrepreneurs was critical in coupling the three streams, and that the legislative process's success actually depends, significantly, on the activity of these actors.

6. Conclusion

The process of placing the issue of the near-death patient on Israeli policymakers' agenda and regulating it was characterized by both planning and randomness. The establishment of the public committee which formulated the Dying Patient Act was the result of a unique combination of three simultaneous processes converging at a rare moment. Nonetheless, this alignment did not take place all by itself, but was conducted by three policy entrepreneurs: LILACH, Prof. Reches and Health Minister Benizri. This chapter has analysed the process in which the issue reached the decision agenda in the year 2000 in light of Kingdon's streams model, focusing on the crucial role of entrepreneurs.

Several factors made policymakers aware of the issue: different court rulings in private cases, including the focusing event of Arad in 1996, in which the Supreme Court advised MKs to regulate the issue. There was also the omission of the section that referred to the near-death patient from the Patient's Rights Law, the intense media coverage, and the activity of a few MKs in the plenum. LILACH contributed to problem-recognition by lobbying in the Knesset, as did Prof. Reches, by being active and prominent in Itai Arad's case.

In the policy process, two similar bills were raised by MKs in a lengthy softening-up undertaking led by Prof. Reches and LILACH. The political stream was characterized by a deepening of the religious-secular rift due to several factors, among them the adoption of judicial activism and the increased electoral power of the Ultra-Orthodox parties.

Another characteristic of this stream was the developing discourse concerning autonomy and the patient's informed consent. The media influenced the public atmosphere with articles that emphasized the need and the ability to regulate the issue. In order to influence the public mood, LILACH presented the issue to various audiences and informed the media about all aspects of the issue, and Prof. Reches published articles on a wide range of platforms throughout the process.

As Kingdon writes, each of the three streams can serve as either an impetus or a constraint. In February 2000, none of the three processes was limiting the motion of coupling all the streams together; no actor used the negative blocking strategy with the aim of preventing the issue from reaching the agenda; there was no relevant change in the administration. Since the regulation was not expected to be significantly expensive, no budgetary limit was relevant either. In addition to the approval that Minister Benizri had received from Rabbi Yosef, the top Ashkenazi religious authority Rabbi Auerbach had ruled some years before the law passed, as well as during its legislation, that there was an option to regulate the issue in a way that would not contradict Jewish law. Thus, once Benizri wanted to establish the committee, the Ultra-Orthodox politicians were prepared and not expected to oppose it, so the political climate was ripe for dealing with the issue. The window through which the three streams were coupled together was the conference initiated by Prof. Reches in February 2000.

As mentioned above, the chances of the issue being placed once again on policymakers' agenda are high; the need to implement the current act and the willingness of some actors and policy entrepreneurs to expand it may create a different picture of the streams model. Shlomo Benizri is no longer a part of the political system, nor is he involved in the issue. In contrast, LILACH and Prof. Reches are still active. At present, there are almost no court rulings that can pave the way to problem recognition; and only one bill to legalize assisted suicide has been raised, by MK Offer Shelach. Much has changed in the politics stream; principally, a growing percentage of the population is affiliated with tradition and religion (Arian & Keissar-Sugarman, 2011). The rift has not deepened and the atmosphere in this context is less charged. Will a substitute for Benizri emerge? Will the policy entrepreneurs succeed this time? Time will tell.

This case study validates Kingdon's model by exhibiting the motion of the three streams being conducted by policy entrepreneurs along with randomness. It also shows that the process is not rational and is therefore characterized by simultaneous occurrences rather than chronological stages. Nevertheless, as was mentioned above, Kingdon's model was formulated in the American political context and therefore it is not generalizable to other countries. Furthermore, Kingdon's model does not recognize the influence of specific factors on various policy issues, thus reducing its applicability to different areas in public policy. This chapter highlights the unique characteristics of the agenda-setting process in the Israeli context, thus enabling the adoption of the model. Likewise, it has identified specific factors which influence the sphere of state-religion issues in Israel, thus reducing overgeneralization.

7. References

Arian, A., & Keissar-Sugarman, A. (2011). *A portrait of Israeli Jews: Beliefs, observance and values of Israeli Jews.* Jerusalem: Israel democracy institute. (in Hebrew)

Bakir, C. (2009). Policy entrepreneurship and institutional change: Multilevel governance of central banking reform, *Governance*, *22*(4), 571–598.

Bakir, C. (2013). Bank *behaviour and resilience*: The *effects* of *structures, institutions* and *agents*. Basingstoke: Palgrave Macmillan.

Bakir, C., & Jarvis, D. (eds.) (forthcoming 2017). Institutional and policy entrepreneurship and policy change in public policy making. In *Institutional entrepreneurship and policy change: Theoretical and empirical explorations*. Basingstoke: Palgrave MacMillan.

Bakir, C., & Jarvis, D. (forthcoming 2018). Institutional entrepreneurship and policy change. *Policy and Society*.

Barilan, Y. M. (2003). [Dying patient: Halachic background, Steinberg report and bio-ethical discourse in Israel]. *Medicine, 142*, 562–558 (in Hebrew).

Barilan, Y. M. (2013). *Jewish bioethics: Rabbinic law and theology in their social and historical contexts*. Cambridge: Cambridge University Press.

Baumgartner, F. R., & Jones, B. D. (1991). Agenda dynamics and policy subsystems. *The Journal of Politics, 53*(4), 1044–1074.

Billings, J. A., & Krakauer, E. L. (2011). On patient autonomy and physician responsibility in end-of-life care. *Archives of Internal Medicine, 171*(9), 849–853.

Campbell, J. L. (2004). *Institutional change and globalization*. Princeton, NJ: Princeton University Press.

Cohen, A., & Susser, B. (2003). *From accommodation to escalation*. Tel-Aviv: Schocken Press. (in Hebrew)

Considine, M. (1998). Making up the government's mind: Agenda setting in a parliamentary system. *Governance, 11*(3), 297–317.

Dahl, R. A. (1961). *Who governs*? New Haven, CT: Yale University Press.

Dees, J. G. (1998). *The meaning of social entrepreneurship: Comments and suggestions contributed from the Social Entrepreneurship Funders Working Group.* Retrieved from http://scholar.google.co.il/scholar?hl=iw&q=social+entrepreneurship&btnG=

Downs, A. (1972). The issue-attention cycle and the political economy of improving our environment. *The political economy of environmental control,* Berkeley: University of California Press, 9-34.

Drucker, P. (1985). *Innovation and entrepreneurship*. New York, NY: Harper Collins.

Edwards, C., Jones, G., Lawton, A., & Llewellyn, N. (2002). Public entrepreneurship: Rhetoric, reality and context. *International Journal of Public Administration, 25*(12), 1539–1554.

Gavison, R. (1998). [Constitutional revolution: A description of reality or self-fulfilling prophecy]. *Misphatim, 21*, 34–47.(in Hebrew)

Gavison, R., Kremnitzer, M., & Dotan, Y. (2000). Judicial activism: For and against: The role of the High Court of Justice in Israeli society. Jerusalem: Magnes-Hebrew University Press (in Hebrew).

Gostin, L. O. (1995). Informed consent, cultural sensitivity, and respect for persons. *JAMA, 274*(10), 844–845.

Guttman, E. (1996). The religious divide. In M. Lisak & B. Kani-Paz (Eds.), *Israel towards the new millennium: Society, politics and culture.* Jerusalem :Magnes, Hebrew University. (in Hebrew)

Hart, M. M., Stevenson, H. H., & Dial, J. (1995). Entrepreneurship: A Definition Revisited. In W. D. Bygrave et al. (Eds.), *Frontiers of entrepreneurship research* (pp. 75–89). Wellesley, MA: Babson College.

Kingdon, J. W. (1995). *Agendas, alternatives, and public policies* (2nd edition) Boston, MA: Little Brown.

Kretzmer D. (1996). The new basic laws on human rights: A mini-revolution in Israeli constitutional law? *Neth. Q. Hum. Rts.* 14, 173.

Levy, J. S. (2008). Case studies: Types, designs and logics of inference. *Conflict Management and Peace Science, 25,* 1–18.

López, E. J. (2002). The legislator as political entrepreneur: Investment in political capital. *The Review of Austrian Economics*, *15*(2–3), 211–228.

McCaffrey, M., & Salerno, J. T. (2011). A theory of political entrepreneurship. *Modern Economy*, *2*(4), 552–560.

Meydani, A. (2009). *Political transformations and political entrepreneurs: Israel in comparative perspective*. London: Palgrave Macmillan.

Meydani, A. (2011). *The Israeli Supreme Court and the human rights revolution: Courts as agenda setters.* Cambridge: Cambridge University Press.

Meydani, A. (2015). Political entrepreneurs and institutional change: Governability, liberal political culture, and the 1992 electoral reform in Israel. In M. Lee, I. N. Aflaki, & P. Petridou, (Eds.), *Entrepreneurship in the polis: Understanding political entrepreneurship*. Abingdon: Ashgate Publishers.

Mintrom, M. (2000). *Policy entrepreneurs and school choice*. Washington, DC: Georgetown University Press.

Mintrom, M., & Norman, P. (2009). Policy entrepreneurship and policy change. *Policy Studies Journal, 37*(4), 649–667.

Mucciaroni, G. (1992). The garbage can model & the study of policy making: A critique. *Polity, 24*(3), 459–482.

Neubauer-Shani, M. (2007). Agenda-setting in the Israeli context: State and religion issues. Unpublished doctoral dissertation, The Hebrew University, Jerusalem (In Hebrew).

Petridou, E., Aflaki, I. N., & Miles, L. (2015). Unpacking the theoretical boxes of political entrepreneurship. In M. Lee, I. N. Aflaki, & P. Petridou, (Eds.), *Entrepreneurship in the polis: Understanding political entrepreneurship*. Abingdon: Ashgate.

Rehbock, T. (2011). Limits of autonomy in biomedical ethics? Conceptual clarifications. *Cambridge Quarterly of Healthcare Ethics, 20*(04), 524–532.

Roberts, N., & King, P. (1991). *Institutions, institutional change and economic performance*. Cambridge: Cambridge University Press.

Sapir, G. (2009). Constitutional revolutions: Israel as a case-study. *International Journal of Law in Context, 5*(04), 355–378.

Schneider, M., & Teske, P. (1992). Toward a theory of the political entrepreneur: Evidence from local government. *American Political Science Review, 86*(3), 737–747.

Schneider, M., Teske, P., & Mintrom, M. (1995). *Public entrepreneurs*: *Agents for change in American government*. Princeton, NJ: Princeton University Press.

Sheingate, A. D. (2003). Political entrepreneurship, institutional change, and American political development. *Studies in American Political Development, 17*(2), 185–203.

Steinberg, A. (2003). Decision-making process at the end of life. *Medicine, 142*, 672–673. (In Hebrew)

Steinberg, A., & Sprung, C. L. (2006). The dying patient: New Israeli legislation. *Intensive Care Medicine, 32*(8), 1234–1237.

Stone, D. A. (1989). Causal stories and the formation of policy agendas. *Political science quarterly, 104*(2), 281–300.

Taylor, H. (2014). Promoting a patient's right to autonomy: Implications for primary healthcare practitioners. Part 1. *Primary Health Care, 24*(2), 36–41.

Toktz'inski, J. (1947). [Bridge of life]. Jerusalem: Chabad Library.(In Hebrew)

Turner, L. G. (1996). Bioethics in a pluralistic world: Truth telling, informed consent, and euthanasia. *Health Care Analysis, 11*(2), 99–117.

Wear, S., & Moreno, J. D. (1994). Informed consent: Patient autonomy and physician beneficence within clinical medicine. *HEC Forum, 6*(5), 323–325.

Yakubowicz, A. *Medicine and Judaism*. Jerusalem: Mossad Harav Kook. (In Hebrew)

Zohlnhofer, R., & Rub, F. (Eds.) (2016). Decision-making under ambiguity and time constraints: Assessing the multiple-streams framework. Colchester: ECPR Press.