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ISRAEL'S PUBLIC HEALTH SYSTEM: THE PROSPECTS FOR CHANGE

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The once highly celebrated Israeli public health system has been in a state of crisis for over a decade. Despite the very high level of physicians and medical technology, health care services have deteriorated greatly. Hospitals and clinics have been plagued by strikes, work slowdowns, decaying facilities, and inefficiency. By the end of the 1980s, tens of thousands of Israelis were waiting for periods of up to two years, and even longer, for vital diagnostic and surgical procedures. Dissatisfaction with the public health system is increasing, and in a recent survey, 25 percent of Israeli families reported having made illegal "under the table" payments for medical services.

Some of the problems which are present in the Israeli system, such as the rising costs of technology, conflicting priorities, and the difficulty in deciding the optimum level of physician reimbursement, are characteristic of the health care crises in North America and Western Europe. However, there are particular factors in the Israeli system which have exacerbated the crisis and blocked significant reform. More than most other countries, the Israeli public system is characterized by a basic resistance to reform and administrative paralysis.

The Jerusalem Center for Public Affairs has initiated a study of the obstacles to reform of the Israeli public health care system, in an effort to determine how changes in the system can be encouraged. In particular, the study has examined the problems of the Kupat Holim Clalit (KHC -- the General Sick Fund of the Histadrut Labor Federation), and on the basis of intensive research, the JCPA team has formulated recommendations for implementing basic reforms in the structure of this system.

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The Kupat Holim Clalit (KHC) System

Over 75 percent of the Israeli population is insured by and receives medical care from the KHC. The KHC operates some 1,300 primary care clinics and 30 hospitals throughout the country, and employs over 5,000 physicians and a total of 30,000 personnel. The system is owned and operated by the Histadrut, and the medical insurance and care provided by the KHC are considered to be a benefit of membership in the labor organization.

Reports from the Government Comptroller (1986; 1982) and from the Government Commission of Inquiry on the Operation and Efficiency of the Israeli Health Care System (August 1990) document major deficiencies in the KHC system. In addition to frequent strikes, KHC hospitals were found to be highly inefficient (surgical and diagnostic facilities are operated only a few hours a day), laboratory work was very slow with test results often taking days or even weeks, and the physical facilities for patients were below acceptable standards. Patients were hospitalized for several days or even weeks for procedures which are done at other hospitals on an ambulatory basis. Almost all of the patients waiting months for elective surgery and diagnostic procedures are members of the KHC. Over half of the KHC doctors are reported to have received illegal payments for services. Many patients have made illegal "under-the-table" payments to KHC doctors in order to move up their surgery dates or to ensure that their case will be handled by a particular doctor.

Public opinion surveys consistently show a high level of public dissatisfaction with the KHC. Its doctors and administrators are generally perceived as patronizing. Clinics and hospitals are operated to meet the needs of the medical staff and administrators, rather than those of the patients. In addition, the KHC's obligations to its members are not formally defined, and in many cases, the right of the members to specific treatment is based on ad-hoc and arbitrary policy decisions.

Many of the KHC's problems, and, in particular, the strikes of physicians and other employees which have paralyzed the system and increased the queues of patients, stem from its chronic operating deficit and the resulting cumulative debt. KHC's annual operating deficit reached 40 percent of its total budget in 1984/5 and as of October 1989, the KHC had accumulated a debt of NIS 1.4 billion ($700 million). A large proportion of the KHC budget goes to pay its personnel, the physicians in particular. In order to end the series of strikes, the KHC increased special payments to physicians for consultations ("sessiot") in 1988 and 1989 (just before general and Histadrut elections) without a commensurate increase in "throughput" or productivity. To pay for this, the KHC took short-term, high interest loans, which increased the interest payments and deficit even further.

In addition, many of the operational difficulties and inefficiencies result from a highly centralized administration. The KHC headquarters in Tel Aviv attempts to maintain tight control over the operations of its network of clinics and hospitals which are spread throughout the country. Like other such organizations, the central administration lacks the detailed knowledge and flexibility to operate the individual regions, clinics, and hospitals. At the same time, local administrators and physicians are given no authority over personnel or budgets, and no incentive to lower costs, provide better service, or improve efficiency.

The History of Efforts to Reform the KHC

The problems of the KHC system are well known and have been studied repeatedly for over twenty years. In 1973 and 1984, the KHC appointed its own panels of experts to study the operational, administrative, and fiscal deficiencies of the system. The Previs and Nagan Committees both proposed the decentralization of the system, providing flexibility and authority, as well as increased responsibility, to the administrators of individual regions, clinics,

and hospitals. The recommendations included the creation of incentives to reduce unnecessary expenditures and improve efficiency, and personnel rotation to prevent stagnation. Changes such as longer operating hours in clinics and pharmacies, providing a choice of physicians, and adoption of an appointment system were also proposed. In general, these recommendations were ignored by the KHC leadership.

The government has also made some efforts to change the role and operations of the KHC. In 1979, the Ministry of Health proposed the establishment of a system of national health insurance, under which all citizens would pay the government directly, and the government would then fund health care. This effort, however, which would have severely reduced the role of the KHC, was rejected by the Histadrut and was defeated in the Knesset. In 1981, the government linked the provision of subsidies to KHC agreement to participate in a regional hospital system. This system was designed to limit unnecessary duplication between the KHC, government, and non-profit hospitals (such as Hadassah and Sharei Zedek), thereby increasing efficiency and lowering costs. In reality, however, the KHC continued to operate its hospitals largely independent of the other major facilities, and coordination and cooperation did not increase.

In 1986, during a fiscal crisis which threatened to force the KHC into bankruptcy, the government created a special commission, under former Treasury official Yaakov Gadish, to investigate the KHC fiscal problems and propose solutions. As a result, the government and KHC signed an agreement which linked additional government funds to KHC measures to reduce personnel, increase fees, and sell unnecessary properties. In general, however, the KHC failed to implement the terms of this agreement and the crisis deepened.

Structural Obstacles to Reform: The Histadrut and the KHC

The KHC was founded in 1911 and, after 1920, became an integral component of the network of social and economic institutions and services controlled and operated by the Histadrut. After the establishment of the State of Israel in 1948, the Histadrut continued to operate the KHC. It still makes policy, appoints the directors, collects membership fees, and provides funds. Participation in the KHC is limited to Histadrut members, and the labor federation automatically enrolls tens of thousands of employees from Histadrut factories and firms, as well as employees of other large firms including the Israel Electric Corporation and Israel Aircraft Industries.

The Histadrut, in turn, is closely linked to the Israel Labor party, which has consistently supported the KHC's requests for public funds. During the period when Labor controlled the government (1948 to 1977), the interests of the Histadrut and KHC were protected, and funds for expansion and operations were provided readily. In 1977, the Labor party lost control of the government, but continued to support KHC/Histadrut interests in the Knesset. Following the 1984 elections and the formation of the Government of National Unity, Labor regained control of the Ministry of Health, and in 1989, party leader Shimon Peres became Treasury Minister. Thus, the Histadrut has generally had political support from the government for its policies and operations.

The inefficiency and the rejection of basic reforms in the KHC system is, to a major degree, the result of Histadrut interests and ideology. The labor organization was founded before the state, and has had a significant impact on the nation's economy, social services, and labor relations. Histadrut and thus KHC policies are heavily influenced by a combination of socialist and Zionist ideologies. On that basis, the Histadrut has rejected reforms which would have stimulated efficiency by offering salary incentives to those physicians who increase their productivity. Histadrut ideology demands equal payment to employees, regardless of performance. Proposals to charge small fees for physician visits in order to reduce unnecessary visits (on the average, Israelis visit doctors

three times as often as citizens in most other industrialized countries) and to raise income for the KHC were rejected as a violation of the principle of equality. Histadrut ideologues worried that poorer members would be unfairly burdened, and be likely to postpone treatment, while "wealthy" members would receive better treatment. As a Labor federation, the Histadrut has also resisted all efforts to reduce the staff of the KHC, even though many studies indicate that the ratio of physicians to patients is far larger than that found in other countries.

Despite the massive operating deficit and cumulative debt, the Histadrut has also refused to raise membership fees and has blocked efforts to transfer the collection of fees to the government. While 70 percent of the Mas Achid, the dues which every KHC member must pay, is transferred by the Histadrut to the KHC, the remaining 30 percent is kept by the Histadrut to fund its political, ideological and other activities that are entirely unrelated to the KHC. Thus, control of the sick fund is a very important element of Histadrut funding and of its political as well as economic power. Despite the socialist commitment to equality, the KHC fee structure is, in fact, regressive, so that members with higher income pay a smaller percentage of their income than low-income members. Although the Gadish committee (1986) and other investigations recommended that the KHC alter its fee structure, the Histadrut has refused to raise fees for middle and upper income members out of fear that higher fees would result in mass defections to other sick funds (thereby lowering the membership of the Histadrut and thus reducing its political power as well).

The Role of the Government

With the failure of the Histadrut to adopt reforms in order to increase efficiency in the KHC or to increase income from the Mas Achid, the government has become the major source of funds to offset the operating deficit and interest on its cumulative debt. While the Histadrut claims that the KHC is a "private member-operated sick find," and therefore entitled to full independence, it also seeks public subsidies as a "national health care system."

Between 1948 and 1977, when the Labor party dominated Israeli politics, this view of the role of the KHC and its links with the government was generally accepted. Although the government provided up to 30 percent of the KHC's budget, there was no concomitant effort by the state to influence KHC policies. The operation of the sick fund was considered to be the responsibility of the Histadrut, and the government simply provided funds.

When the Likud assumed power in 1977, its leaders sought to change the basic structure of health care in Israel, to increase efficiency, and to end the subsidies which provided the KHC with a competitive advantage over other sick funds. In 1981, Minister of Health Eliezer Shostak sought to introduce a system of national health insurance which would have weakened the Histadrut's control over the KHC, but this effort was defeated by the Histadrut and its allies in the Knesset. The government reduced the direct subsidy provided to the KHC, but funds from the Mas Makbil (a health service tax paid by employees and employers) increased by a similar amount.

Throughout the 1980s, the KHC needed government funds in order to cover its budgetary deficits and repay the cumulative debt. Annual emergency subsidies became a regular focus of government-KHC relations. The Histadrut, however, resisted efforts to link these bail-outs to the acceptance of reforms. In general, the Histadrut and KHC have claimed that the KHC's chronic deficit and debt are not the result of inefficiency and over-staffing, but reflect the cost of services provided on the basis of the KHC's "national role." According to this view, the KHC provides over forty different health services for the government, including the operation of medical and dental schools, the operation

of hospitals in remote areas such as Eilat, and the provision of medical insurance for large families, welfare recipients, and new immigrants. These "services" are not defined by any contractual relationship or formal government undertaking, and the services and funding levels are not negotiated in advance.

By rationalizing public funding as payment for "national services," and using its continued political power, the Histadrut has successfully resisted government efforts to use funding as a lever to induce change and reform in the KHC. Between 1984 and 1990, the Labor party regained control of the Ministry of Health, thereby making it easier for the Histadrut to ignore government efforts to impose change on the KHC. As noted above, the terms of the 1981 regionalization accord and the 1986 agreement based on the Gadish report went largely unimplemented, while government funds continued to flow to the KHC. Thus, to date, government efforts to promote reform in the KHC system have produced little change.

Competition

By 1988, the KHC was losing thousands of members each year to the other sick funds. In particular, young, middle-class families in the Tel Aviv and Jerusalem regions were joining the Maccabi and Meuchedet funds in ever increasing numbers. This population found the other sick funds more responsive, providing a choice of physicians who were available at convenient times and who worked through a system of prior appointments. Members of these funds did not have to wait long periods for surgery or diagnostic procedures, and had ready access to drugs and laboratory services. As queues for surgery and diagnostic procedures in the KHC system grew longer, criticism of the KHC in the media and among the public increased. As a result, some Histadrut leaders began to seek changes in the image and operations of the KHC.

In response, the Director-General of the KHC, Dr. Haim Doron, was replaced by Nahum Fassa, a Histadrut leader. Doron had served in this position for twelve years and was blamed for the lack of change and flexibility in the system. Fassa introduced some personnel changes at the KHC headquarters and in some of the KHC hospitals and regions, replacing individuals who had been in the same positions for many years. The implementation of these personnel changes was, in itself, a considerable change for the KHC.

Fassa and his staff also began a broad effort to improve the KHC's public image and the relations between physicians and patients. After many years of delay, a system of appointments was finally introduced in KHC clinics. Like the other sick funds, KHC clinics began to allow members to select their own physicians. In Tel Aviv and other large cities, pharmacy hours were extended significantly, and other operating changes were introduced to increase convenience for members. The physical appearance of clinics was improved, and the need to improve relations between staff and patients was stressed. Personnel from the KHC headquarters began to make periodic spot-checks at clinics. Despite its large deficit, the KHC began a very wide and expensive advertising campaign.

At the same time, the inefficiency which characterized the operation of KHC hospitals remained largely unchanged; the queues for surgery and diagnostic procedures were still growing. The 1988 agreement which provided physicians with additional income did not lead to greater efficiency in KHC hospitals, or second shifts for surgery. Such changes were confined to ambulatory clinics in some hospitals and a few outpatient clinics. Competition also had no effect on reducing the size of the KHC deficit. Indeed, in the effort to prevent further defections, spending increased, while fees remained generally frozen, leading to an even greater deficit and cumulative debt.

Most importantly, KHC still insures 75 percent of the Israeli population, and in budget and the number of members, it

dominates the other funds. Thus, the competition is limited and its effects reflect these limitations.

The Commission's Recommendations

In the past, most of the efforts to solve the KHC's problems were based on operational reforms, including new modes of physician compensation (i.e., capitation, or fee for service), providing incentives for local administrators, or increasing flexibility through decentralization. None of these measures have or are likely to be implemented in the KHC system. In each case, the implementation of operational reforms are blocked by structural impediments and obstacles, as imposed by the Histadrut, the KHC headquarters, and the reliance on the government for subsidies. Reform of the operation and administration of the KHC requires fundamental structural changes.

In August 1990, the Government Commission of Inquiry on the Operation and Efficiency of the Israeli Health Care System recommended a number of structural reforms for the system in general, and the KHC in particular. The Commission recommended the adoption of a system of national health insurance, through legislation which would include a clear definition of services to which all citizens are entitled (and the time frame in which they are to be provided). Primary care would be the responsibility of autonomous regional sick funds, funded by fees paid directly to the national health insurance system on a capitation basis, and operated by administrators chosen directly by their members. The Commission recommended that membership be open to all, without restrictions based on age, state of health, or membership in trade unions. It also called for the operation of all hospitals, including those currently in the KHC system, on an autonomous basis.

Many of these proposals, which center on a fundamental change in the relationship between the Histadrut and the KHC, were evaluated independently in the JCPA study. It is clear that the control and provision of most of the nation's public health services by a labor organization is not justified operationally, and this arrangement is politically volatile and a major source of inefficiency. If a new national health system were to be created now, it would certainly not be controlled and operated by the Histadrut. Ideally, sick funds and medical providers should be founded strictly for this purpose, without particular interests, ideologies, or political constraints and conditions.

Historically, however, the KHC did develop under the control of the Histadrut, and this relationship continues to be of central importance to the labor federation. Although it is likely that the KHC would provide a higher level of medical services with more efficiency were it to be separated from the constraints of Histadrut interests and ideology, as recommended by the Report of the Commission of Inquiry, this process is not readily implementable. Previous reform programs that were seen as a threat to KHC/Histadrut interests and relations were fiercely opposed by the Histadrut and this was sufficient to quash them. Similarly, Yisrael Kessar, the current Secretary-General of the Histadrut, and Dov Peleg, the head of the Histadrut's Social Welfare Committee, quickly rejected the Commission report of August 1990 and its recommendations regarding the KHC. While the power of the Labor party and the Histadrut has been weakened, the effort to forcibly separate the KHC from the Histadrut (the practical implication of national health insurance) through legislation in the Knesset, or to remove control of the KHC hospitals from the rest of the KHC system, will be difficult or impossible to implement.

Structural Reforms Which Can be Implemented

The JCPA study of the KHC system therefore sought to identify structural measures which are also implementable in the current Israeli political environment. The JCPA recommendations focus first on changing the relationship between the government and the KHC. The KHC claims to be a private member-owned and

-operated sick fund, and, as such, it is not entitled to public subsidies. Government funding for any private organization should be regulated contractually. The transfer of public funds for specific services must be based on competitive bids and negotiated agreements. The state, and not the KHC, should define the services to be provided for new immigrants, welfare recipients, psychiatric and geriatric patients. There is also no reason that taxes paid by members of other sick funds should go to subsidize the inefficiency of the KHC, or the political activities of the Histadrut.

Instead of ad-hoc "emergency bail-outs," all funding should be based on closed bidding for services such as hospital operation in peripheral areas, defined in advance. If the KHC wins a contract, all sides will be bound by its terms. If the KHC wishes to suspend services not regulated by contract (such as the operation of the Soroka Medical School, or clinics in peripheral regions), it is free to do so. At the same time, if the government decides that these services are in the national interest, operation should be based on contracts and competitive bidding.

Despite the claims of the KHC and the Histadrut, there is no evidence that the KHC system can make the necessary structural reforms if left on its own. The flexibility and development of incentives for increasing efficiency in individual clinics, regions, and hospitals is not possible without decentralization of authority over budgetary and personnel decisions. The KHC administration has discussed decentralization, created committees to study the issue, and prepared pilot programs for several years, but, given the internal resistance from headquarters and some district heads, the results have been and are likely to continue to be very limited.

However, if government subsidies for KHC cease, the KHC may be forced to implement internal reforms, including decentralization, in order to increase efficiency. If survival depends on cutting costs, budgeting according to priorities, increasing throughput, and adapting each unit, including clinics, regions, and hospitals, to local needs and conditions, decentralization might be feasible.

To date, the only changes and reforms which have taken place in the KHC system have resulted from the pressure of competition over the past two years. Increased competition would accelerate the pace of reform. The end of government subsidies for the KHC, and the development of competitive bidding for services which would be open to the other sick funds, would force the KHC to increase efficiency. The government should also insure that all citizens have a free choice of sick funds, and that workers who choose to belong to a sick fund other than the KHC are not coerced or intimidated by the Histadrut.

These relatively small steps will not provide a quick solution to all the deficiencies of the Israeli health care system, but, in contrast to other proposals, they are politically and fiscally feasible. They can correct some of the most critical inadequacies of the KHC rapidly without causing major political conflicts and paralysis in the system. By sorting out the relationship between the government and the KHC, encouraging greater flexibility within the KHC, and fostering increased competition among the sick funds and other health care providers, these steps provide a necessary foundation for improving the Israeli medical care delivery system.

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