ISRAEL'S HEALTH CARE SYSTEM: A US PERSPECTIVE

ELI GINZBERG, PHD

Toward the end of the 1980s, I had the opportunity, as one of two foreign consultants (Robert Maxwell of the Kings Fund, London, was the other), to testify before the Netanyahu Commission that was engaged in a nonpartisan exploration aimed at reforming the organization and financing of the Israeli health care system.¹ In June 1994, the Knesset passed a new health insurance act that went into effect in January 1995. Dr. Samuel Penchas,* until recently the long-term head of the Hadassah Medical Organization, the hospital partner of the Hebrew University's Academic Health Center, organized a 10-day intensive tour for me that included not only visits to academic health centers in Jerusalem, Beer Sheva, Tel Aviv, and the northern Galilee, but also meetings with two of the nation's largest sick funds, as well as a visit with Gabi Bin-Nun, currently the Deputy Director General of the Ministry of Health for Economics and Health Insurance.† The precipitating event that led to the passage of the new health insurance legislation was the growing financial difficulties of the largest of the sick funds, Kupat Holim Chalit, which provided coverage for 83% of the population in 1984, including disproportionate numbers of the elderly and the poor, as reflected in its ever-growing deficits. Further, the significant growth in the population's average income during the past two decades led to increasing discontent among many consumers about the shortcomings in the delivery system, reflected in

Dr. Ginzberg is Director, Eisenhower Center for the Conservation of Human Resources, Columbia University, Interchurch Center, Room 248, Mail Code 7740, 2960 Broadway, New York, NY 10027.

*I should point out that Dr. Penchas was one of the five members of the Netanyahu Commission who, together with his colleague, Dr. Mordechai Shani, Director of the Chaim Sheba Medical Center at Tel HaShomer, authored an article: "Redesigning a National Health-Care System: the Israeli Experience" (*Int J Health Care Qual Assur.* 1995;8(2):9-17).

†G. Bin-Nun and B. Rosen, Passage of Israel's National Health Insurance Law: a case study of major legislative change, unpublished paper, 1996.

long waiting periods for nonemergency operations and the lack of choice for physician selection, as well as disagreements about the range of services that the various sick funds provided.

The major reforms enacted by new legislation implemented at the beginning of 1995 included the following: universal health insurance coverage, insurance payments geared to income; improved administration by transferring to the Social Security Administration the responsibility for collecting/distributing the premium payments, freedom of choice for all insurees to select (and change) their sick fund, stipulation of a basic basket of services without clearly defining the services, restriction of the ability of the smaller sick funds to reject high-cost enrollees, and direction of the national government to transfer responsibility for operating about 30% of the nation's hospital beds to newly organized nonprofit regional institutions.

Based on my conversations with the senior executives of major hospitals and sick funds that I visited, the principal complaints were directed at the delays and shortfalls in receiving the funds to which they were entitled under the new legislation. The Ministry of Finance, faced with a growing shortfall in tax revenues, has found it necessary, or at least desirable, to slow its payments to the health care funds and other providers.

From an American perspective, special note must be taken of the additional difficulties that the hospital and ambulatory care providers face as a consequence of the rules and regulations that the physician and nurse organizations have been able to establish and maintain concerning their salaries and working conditions. Since these rules and regulations are countrywide, local administrators are forced to comply with these national labor rules and regulations.

One must add quickly, however, that considerable margins of freedom are available to physicians and affluent patients to make "private" arrangements for services, including operations at for-profit hospitals and at public hospitals, during the hours that physicians are not governed by their collective bargaining contract.

The hospital sector dominates the Israeli health care delivery system, accounting for about half of all expenditures. The country was able to absorb about 800,000 immigrants from the former Soviet Union during the past decade without any hospital capacity enlargement by reducing the average stay for medical and surgical patients to around 4 to 5 days.

I was unable to explore the continuity of care between inpatient and ambulatory settings, but I suspect that it leaves much to be desired. I was informed about the special efforts that major tertiary hospitals must make to prepare for

possible future victims of foreign and domestic calamities, including exposure to chemical or biological warfare.

If inpatient bed capacity is at or close to an optimal level, the same cannot be said for the number of physicians per 100,000 population. Israel has the distinction of being at the top of the list, with over 300 physicians per 100,000; the US rate is still below 270. In addition to absorbing the graduates of its four medical schools, Israel has also made room for many, but not all, of the physicians who have emigrated from the former Soviet Union, as well as absorbing most of the Israelis who study in Europe and then return to Israel to practice.

Israel spends about 8% of its gross domestic product (GDP) on its health care system; in contrast, the US outlay approximates 14% of a considerably larger per capita GDP. In terms of male longevity, the Israelis rank very high, and the nation's female longevity average is also respectable, compared to nations with the best longevity records. The Israelis, however, have had the advantage until now of having to care for a relatively small number of elderly persons with chronic illnesses, an advantage that is being eroded slowly by the passage of time.

It should come as no surprise, at least to Americans, that one of the areas of common discontent in Israel is the ability and willingness of the sick funds to provide enrollees with the newest, and often the costliest, of new procedures and drugs. The tension is heightened because the national health insurance act specifies that the entire insured population (in short, all Israelis) is entitled by law to a basic basket of services, which presumptively, although not explicitly, includes costly new procedures and drugs if they are found to be efficacious. The Knesset had the good sense to leave this part of the statute somewhat ambiguous, however, with the result that it has become a point of ongoing conflict.

One of the more disturbing experiences that I encountered was the fact that, because of the backlog of patients awaiting surgery and the strict rules governing the compulsory working hours of surgeons, a considerable number of patients were seen for the first time by the surgeon scheduled to operate on them when the patients were wheeled into the operating suite. Apparently, the hospital where I stumbled on this scheduling anomaly had not found any other way to ensure that it could keep its operating suites busy, its surgeons working, and its patient backlog under control.

I was also reminded by some of my informants that preferred treatment arrangements were available not only to the wealthy, who sought out physicians with the best reputations by arranging to be seen and treated by them in their

"free time," but also by the politically well connected. In Israel, many have "political connections."

On balance, I was impressed greatly with the leading hospitals and academic health centers that I visited; casual observation impressed me as to how much Israel's leading institutions resembled those that I know at home. Considering the gaps that existed between health care in the US and Israel in my more than 20 visitations since 1953, I could not fail to be impressed as to how far these leading Israeli health care institutions have come in recent decades. Moreover, one could not fail to be impressed that Israel, with health expenditures of 8%, has succeeded in providing basic health insurance coverage for the entire population, whereas the US has currently 43 million persons without health insurance and many more millions with inadequate coverage.

Two tensions continue to exist between the Israeli government's promise and its ability to meet the expectations of all of the public. Many, possibly most, citizens believe that they are entitled when they are sick to more and better services. But, as noted above, the Ministry of Finance is slow in paying the sick funds and the hospitals, which forces the sick funds and hospitals to economize. The gap between the citizenry's expectations and health care appropriations are present in all advanced countries, however, even in the US, and it is difficult to imagine how the gap will ever be closed even if, as appears likely, the US will soon devote at least 16% of its GDP to funding its health care sector.

An upbeat final note about the Israeli health care sector occurred during my latest visit to Israel, which coincided with the signing of the Wye agreement. I was impressed repeatedly with the large number of Arabs, adult and children, who sought and received medical care in the Israeli hospitals that I visited and, as far as I could observe, were appreciative of the treatments they received. Israeli Arabs were represented on the physician and supporting staffs, they worked harmoniously with their Jewish colleagues and coworkers, and everybody was better off, an upbeat sign of potential harmony between the two groups.

REFERENCE

1. Ginzberg E. The Moshe Prywes Lecture in Medical Education. *Isr J Med Sci.* 1987;23(3): 53-156.